REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
THIS REPORT IS BEING SENT TO:

1. NHS England
2. Department of Health
3. South West London and St George's Mental Health Trust

1 **CORONER**

I am Ellie Oakley, Assistant Coroner for Inner West London

2 **CORONER'S LEGAL POWERS**

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 **INVESTIGATION and INQUEST**

On 12 July 2023 I commenced an investigation into the death of Judith Maike OBHOLZER. The investigation concluded at the end of the inquest on 11 July 2024. The conclusion of the inquest was: Judith Maike Obholzer died on 12 July 2023 at [redacted], from injuries caused from jumping in front of a moving train (suicide) following a significant period of worsening depressive illness for which she was receiving treatment. Delays by the Wandsworth SPA team in assessment and to being added to the waiting list for a full assessment by a Consultant, and the private psychiatrist not being able to directly access crisis support may have contributed to the death.

4 **CIRCUMSTANCES OF THE DEATH**

Mrs Obholzer took her own life by jumping in front of a moving train at [redacted] Train Station on 12 July 2023. From at least March 2023 Mrs Obholzer was suffering from depression and anxiety. She was receiving treatment through her GP in the form of antidepressants and had attended weekly Cognitive Behavioural Treatment (CBT) since 12 March 2023 with a private practitioner. Mrs Obholzer was referred to Wandsworth SPA team by her GP on 15 May 2023 and assessed by a triage nurse on 18 May. I found that there was a delay within the Wandsworth team following the initial triage assessment which led to a delay in Mrs Obholzer being put on the waiting list for assessment by a consultant psychiatrist, but that given the waiting times at that stage it was unclear whether or not she would have been assessed by the time of her death (as she had triaged as being a routine patient). She was not put on the waiting list for assessment by a consultant psychiatrist until 10 July. Throughout, Mrs Obholzer was experiencing thoughts of suicide and planning. Due to the deterioration in her condition and the wait for NHS care, Mrs Obholzer attended a consultation with a private consultant psychiatrist on 11 July 2023. The private consultant psychiatrist diagnosed her as suffering from severe post natal depression and presenting with significant suicidal risk. He recommended informal admission to a private hospital, but Mrs Obholzer was against this due to financial concerns. The private consultant psychiatrist planned to write to Mrs Obholzer's GP to request an urgent assessment by her local Home Treatment/Crisis resolution team, but that letter was not sent on that day for a variety of reasons. The private consultant psychiatrist gave evidence that he was not able to refer Mrs Obholzer to those teams directly.

Following a post mortem examination the medical cause of death was determined to be:
1a Multiple Traumatic Injuries

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

1. In the course of the evidence it was confirmed that there is a significant pressure on NHS mental health services. It seems likely that there will be an increase in patients obtaining private support while waiting for NHS support (and often only being able to afford such support for a limited time and to a limited extent and doing so only while waiting for NHS support), as happened in this case. Consideration should be given to ensuring that there is sufficient clarity in processes such as referrals and crisis support where private practitioners are providing treatment as well as the NHS, ensuring sharing of information and notes where relevant and necessary and ensuring that the NHS provision is not assessed as unnecessary simply because someone has obtained private support as an interim measure.
2. In the course of the evidence the private consultant psychiatrist gave evidence that he was unable to refer patients directly to NHS provided crisis teams as a direct alternative to informal treatment at a private hospital. The evidence from the South West London and St George's Mental Health Trust was that direct referrals can be made although the evidence on the exact mechanism was unclear. In Mrs Obholzer's case, the (apparent) lack of ability of the private consultant psychiatrist to directly refer to the crisis team meant that she did not receive the community crisis support alternative to hospital admission that she required. Consideration should be given to ensuring that the pathway for urgent/crisis referrals from private practitioners to the NHS are clear to all (both for this area and throughout the country) and, if it is not already the case, to ensuring a process that allows private practitioners to arrange crisis support through the NHS directly.
3. In the course of the evidence it was confirmed that the private consultant psychiatrist was unable to send the urgent letter to Mrs Obholzer's GP in part because their details had not been provided. Consideration should be given to ensuring that all medical practitioners (private and NHS) can access GP registration details for patients and GP contact details to avoid delays where there is an urgent need to contact a person's GP.
4. In the course of the evidence it was confirmed that there is no sharing of medical notes between private practitioners and NHS providers. This (along with other factors) led to delays in a treatment plan being set by Wandsworth SPA as they had to obtain further details regarding Mrs Obholzer's CBT from Mrs Obholzer rather than being able to access the notes through a shared system. Consideration should be given to ensuring a system is in place to allow the sharing of medical information between practitioners across Trusts and also between NHS and Private providers.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 September 2024. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 **COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

[redacted]

South West London and St George's Mental Health Trust

I have also sent it to Royal College of Psychiatrists and CQC, who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 12 July 2024

Signature:

Ellie Oakley
Assistant Coroner for Inner West London