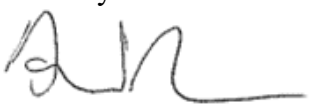
Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Constable of Northumbria Police and their Solicitors and Counsel** **The Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and their Solicitors**
1	**CORONER** I am David Place, His Majesty's Assistant Coroner for the City of Sunderland
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29th September 2021 I opened and adjourned an Inquest into the death of Mr John Paul Hurst, who was born on 19th May 1972 and who died [redacted] on 15th September 2021 aged 49 years. The Inquest was heard on 9th October 2024 and concluded on 11th October 2024. The conclusion of the Inquest was 'John Paul Hurst had a diagnosis of paranoid schizophrenia with a long history of mental health difficulties and was the main carer for his father. Having initially been arrested in connection with the death of his father and subsequently de-arrested and then re-arrested on suspicion of an offence of possession of a controlled substance he was released from custody under investigation and then died [redacted] on 15th September 2021 from the effects of bleeding from trauma consistent with the amputation of the lower half of his right leg which is consistent with impact with a passing train in circumstances which cannot be explained.' The medical cause of death was: - Ia Right Lower Limb Injury
4	**CIRCUMSTANCES OF THE DEATH** John Paul Hurst had a medical history of a diagnosis of paranoid schizophrenia. He had previously attempted to take his own life on three occasions between 2000 and 2002, and had been sectioned under the Mental Health Act during the same period.

	John lived with his father and was his main carer. His father sadly passed away on 12th September 2021. Due to concerns around the length of time before John had sought assistance from emergency services, his demeanour upon police arrival and notes containing disturbing content within the premises, John was initially arrested on suspicion of involuntary manslaughter. He was quickly de-arrested for that offence and re-arrested on suspicion of possession of a controlled substance. Concerns were raised by police officers involved in the investigation about his mental health due to John's demeanour, the volume and content of the notes found at the scene and detailed concerns expressed by his sister regarding a risk of him ending his own life upon release. John was assessed by Criminal Justice Liaison and Diversion Service (CJLD) and deemed fit for interview and release from custody. Following his interview, John was released from custody at around 4pm on 13th September 2021. He last spoke to his sister at around 9.44pm on 13th September 2021. On the afternoon of 15th September 2021, John was found by a passer-by in undergrowth near to the train tracks [redacted]. John died due to the effects of haemorrhage from the tearing and loss of the lower half of his right leg consistent with impact with a train moving at high speed.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is: – At the Inquest I heard evidence that, following John's arrest, concerns were expressed by police officers involved in the investigation as to his mental health, and by John's sister as to his risk of ending his own life. These concerns were repeated by John's sister to the Criminal Justice Liaison and Diversion Service (CJLD) prior to his assessment. The evidence was that when completing the release risk assessment, the custody sergeant had been greatly assisted by the information recorded on the electronic custody record regarding the concerns that led to the mental health assessment and the assessment itself, in addition to the custody sergeant's own observations. The evidence highlighted that the electronic custody record contained limited information about the concerns of police officers and John's sister, and there was a distinct lack of detail about the assessment itself and very little analysis of the concerns and reasoning for the CJLD conclusion. I am concerned that the information on the electronic custody record was inadequate and lacked detail regarding the concerns for the detained person's mental health, as identified by police officers and family, including the risk of suicide, the content of notes found and the detained persons history of suicidal ideation and previous engagement with mental health services. In addition, I am concerned that the record also lacked a detailed analysis of those concerns by CJLD and comprehensive reasoning for the assessment conclusion. Deaths may be prevented if the recording of information in such cases is reviewed.

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 19th December 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: - • Family and their Solicitors and Counsel • Care Quality Commission 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	Dated this 23rd day of October 2024 Signature:  HM Assistant Coroner for the City of Sunderland