Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] – CEO Berkshire Healthcare NHS Foundation Trust** **2 British Transport Police** **3 [redacted] – Interim Managing Director South Western Railway**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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 04 July 2023 I commenced an investigation into the death of Daniela Vitalia PANI aged 57. The investigation concluded at the end of the inquest on 28 March 2024. The conclusion of the inquest was that: On the 29th June 2023 Daniela Vitalia Pani died at [redacted] after deliberately leaving the platform as a train approached and remaining on the tracks until she was struck by the train. She had suffered from a serious and enduring mental health problem for most of her adult life and was under the care of the mental health services at the time of her death.
4	**CIRCUMSTANCES OF THE DEATH** Daniela had suffered from bi-polar affective disorder for many years. Over the course of 2022 her mental health deteriorated and she then came under the care of the Community Mental Health Team (CMHT) and Crisis Resolution Home Treatment Team (CRHTT); which are services provided by the Berkshire Healthcare NHS Foundation Trust. In May 2023 this culminated in her admission, as a voluntary patient, to an in-patient ward at Prospect Park Hospital. Daniela was discharged from Prospect Park Hospital on the 26th June 2023 after her condition appeared to have stabilised. There was a care package in place for her in the community involving the CMHT and a care agency. On the 28th June 2023 Daniela was due to have a review meeting with a member of the CMHT. This is known as a 72 hour review and is required due to the knowledge that there is a heightened

	risk to persons at periods of transition; such as discharge from an in-patient unit. Daniela telephoned the CMHT on that morning to say that she was unwell and to cancel the visit to her. The CMHT best practice guidance states that a 72 hour review should take place face to face and that telephone reviews should only be used as a rare exception once all avenues to arrange a face to face meeting have been exhausted. After speaking to her manager, the CMHT member undertook the 72 hour review meeting with Daniela via telephone on the 28th June 2023. During this review Daniela denied that she had any intent to harm herself. Later that day Daniela twice called the CRHTT Crisis Line. The CRHTT nurse on duty reassured Daniela, carried out some safety planning and assessed Daniela as not posing an imminent risk to herself such that required an immediate intervention. On the 29th June 2023 Daniela got a taxi to [redacted] and entered the station. As a train approached the platform shortly after 9.00am Daniela jumped onto the tracks and was struck by the train. The impact caused a severe head injury and Daniela was sadly declared deceased at the scene.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) <u>Concerns regarding the train station</u> After Daniela's death British Transport Police (BTP) prepared a 'Post Incident Site Report'. I understand that this report was undertaken in conjunction with the station operator; in this case South Western Railways, and Network Rail. This report detailed a number of potential problems at [redacted] and proposed mitigation measures. These included: 1. A lack of Samaritan signs on the platforms or within the stations. The mitigation proposed was conspicuously placed posters and/or additional signage. 2. Car park line side fencing being too low. The proposed mitigation was replacement of the fencing. The report was submitted on the 25th July 2023. Despite the passage of nearly 9 months from submission of the report to the date of the inquest the BTP officer giving evidence could not inform me whether these changes had been actioned. I was advised that this information had been requested from South Western Railways but had not been provided. On the 18th March 2024 I requested an update from BTP about the actions taken

	and invited them to attend the final hearing on the 25th March 2024. No information was submitted and no-one from BTP attended the final hearing. I am therefore concerned that measures to mitigate the risk of future suicides at the train station have not been implemented. <u>Concerns regarding the 72 hour review meeting</u> I heard evidence from a number of members of the CMHT regarding the policies, procedures and training around the completion of this important review meeting. During the course of this I heard that training and guidance did not specifically address how to deal with service users declining a visit or meeting. This is a complex area with competing demands of the duty of care, mental capacity and the autonomy of an individual to make decisions about their own care and treatment. The evidence from the CMHT Joint Service Manager was that guidance and/or training would be important for staff seeking to deal with this challenging area. This gap had not been identified by the NHS Trust in their Serious Incident Report in 2023. Following the evidence at inquest the matter has been raised internally but no changes have yet been introduced. I am concerned that the staff not being able to carry out face to face assessments in all possible cases gives rise to the risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 May 28, 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 **The family of Miss Pani**

	I have also sent it to **Network Rail** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 28/03/2024**  **Robert SIMPSON** **Assistant Coroner for** **Berkshire**