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 Chief Constable of Cheshire Police**
1	**CORONER** I am Sarah Murphy, assistant coroner for the coroner area of Cheshire.
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 30 September 2024 I commenced an investigation into the death of Charlotte Tetley aged 33. The investigation concluded at the end of the inquest on 5 September 2025. The conclusion of the inquest was that: Death was due to being struck by a train having deliberately sat on the tracks with an intention to end life. She had suffered a deterioration in mental health following a decision to remove her from the inpatient bed list on the 25 June 2024, and subsequent accommodation difficulties.
4	**CIRCUMSTANCES OF THE DEATH** On the 24 September 2024, Charlotte Tetley was hit by a train travelling though Macclesfield after she had been sat on tracks. There was no easy access to the tracks at this point. Ms Tetley had a complex longstanding mental health history and was a victim of the Rochdale Grooming where she suffered significant sexual abuse. She was diagnosed with Emotional Unstable Personality Disorder and had previously been diagnosed with Post Traumatic Stress Disorder and substance misuse causing behavioural and mood disorder. Drug dependence was a coping mechanism. At the time of her death, she was prescribed medication, but her concordance was sporadic and influenced by whether she had accommodation. She had taken multiple previous overdoses with intent to end life. She had been under the Macclesfield Community Mental Health Team since July 2023 when she moved from Rochdale after her abuser returned to the area. On the 18 June 2024, Ms Tetley attended the Accident and Emergency Department at Macclesfield Hospital voicing concerns for her safety and thoughts to jump in front of a train. An informal admission was found to be clinically indicated to commence depot injection and to maintain safety. She was reviewed daily until the 24 June where on each day, the clinical records document that an informal admission was necessary. The minutes of the bed management meeting on the 24 June recorded that the Home Treatment Team did not think that Charlotte required a mental health inpatient bed but that the homeless pathway needed to be explored before taking off the inpatient list. This was not recorded in Ms Tetley's clinical records for the 24 June 2024. The clinical records for the review on the 24 June 2024, document that Ms Tetley felt that the only option for her to get better was for admission. On the 25 June, Ms Tetley was discharged from the inpatient bed list by the bed management team at 10:37 hours. This was before an attempted review by a Mental Health Practitioner at

	11:30 hours who did not complete a review due to finding Ms Tetley asleep. A handover had been obtained from Accident and Emergency nursing staff who reported no concerns or change in presentation. It was concluded that Ms Tetley did not appear to require a mental health inpatient admission but might benefit from an admission to a medical ward to address homelessness. It was documented in the clinical records that she was amenable to a discharge. Charlotte left the department at 12:57 hours. It was documented in the clinical records on the 25 June that after discharge, she called her probation officer and was noted to be "screaming" down the phone stating that she was going to the railway line to kill herself. She had also phoned her family expressing dismay about the discharge from the inpatient bed list. The community Consultant Psychiatrist and other mental health practitioners had concerns about the safety of the discharge on the 25 June 2025 which were documented in the clinical records. Ms Tetley's whereabouts were unknown to the community mental health team until the 2 July when they were contacted by her probation officer. On the 3 July, Ms Tetely received a psychiatric review by a Specialist Registrar, and it concluded that there was no clinical indication for a mental health act assessment or informal admission. Ms Tetley subsequently engaged with the community mental health team and community drug services, but on the 18 September 2024, she was removed from railway tracks by British Transport Police and taken to the Accident and Emergency Department of Macclesfield Hospital. She had reported feeling suicidal to workers who had found her, but she left the hospital before being reviewed by the Mental Health Liaison Team. The police were contacted by the Accident and Emergency Department to report Ms Tetley as a high-risk missing person, but they were informed that under the "Right Place Right Person" policy, nobody would be deployed. The Liaison Psychiatry Clinical Lead requested for this to be escalated to a supervisor and duly spoke with a supervisor. She expressed concerns about an immediate risk to safety for Ms Tetley but was informed that as Ms Tetley had not voiced intention to end her life, it could not be known that this was her intention when she left the department. It was explained by the Liaison Psychiatry Clinical Lead that the fact that Charlotte was not engaging had concerned her more about her immediate safety. The Police maintained that nobody would be deployed and suggested that response vehicle should go out. The ambulance service was duly contacted to request a response vehicle, but the Clinical Lead was informed that as the whereabouts of Ms Tetley was unknown, they would not deploy anyone. Ms Tetley's keyworker was able to contact her by telephone on the 18 September and arranged to see her the following day. She was reviewed by her keyworker on the 19 September where Ms Tetley requested that an outpatient appointment with her psychiatrist was re-arranged from the 24 September as she had a court hearing that day. On the morning of the 24 September, Ms Tetley did not attend the court hearing and spoke by phone with her mental health keyworker and expressed longstanding suicidal ideation without immediate intent. She attended the office of the community drug and alcohol team and was noted to be tearful and in low mood. She was later fatally struck by a train when she deliberately sat on the tracks.
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) That despite Ms Tetley being found on train tracks on the 18 September 2024, and reporting to workers who found her that she felt suicidal, the police would respond when she absconded from the Accident and Emergency Department the same day. When the Clinical Lead of Psychiatric Liaison escalated the matter and expressed concern of an immediate risk for safety given her extensive medical history, and her lack of engagement in the department that day, she was informed that as Ms Tetley had not expressed an intention to end her life

	before leaving the department, it could not be known that it was her intention to end life. The police informed the Clinical Lead to contact the ambulance response vehicle. When she did this, they declined to respond as they were unaware of Ms Tetley's wherabouts. I am concerned that if a very narrow interpretation of policy is applied by the police when professionals report a concern for a high risk missing person in circumstances where they consider there to be an immediate risk to life, there will be a risk of future deaths occurring. If the policy is interpreted such that police resources will only be deployed if the missing person has expressed an intention to end life as they leave the hospital, there is a risk that future deaths will occur. It is unlikely that the ambulance response vehicle will be deployed if the whereabouts of the missing person is unknown, which will result in the missing person not being able to receive medical attention until their whereabouts are known. By the time that they are located, there is a risk that they will no longer be alive.
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 9 November 2025 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 Charlotte Tetley** 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: 14.9.25**