HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) NHS England** **PO Box 16738** **Redditch** **B97 9PT** **(2a)** [redacted] **Trust Solicitor and Risk Manager** **Oxford Health NHS Foundation Trust** **Littlemore Mental Health Centre** **Oxford 0X4 4XN** **(2b)** [redacted] **Joint Senior Partner** **White Horse Medical Practice** **Faringdon** **SN7 7YU**
1	**CORONER** I am David Ridley, Senior Coroner for Wiltshire and Swindon
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 1 October 2024, I opened an Inquest into the death of Christopher John Bird ("Chris"). Chris died tragically when he placed his head on a railway line near South Marston adjacent to the A420 in Swindon late afternoon on the 19 September 2024 in front of an approaching freight train. His death was instantaneous when he was struck by the freight train. Chris was 49 years old when he died. I concluded Chris' Inquest on the 17 September 2025. I found the medical cause of death was as follows:- Ia. Traumatic Head Injury Ib. Impact from a Train 2. Anxiety and Depression I additionally recorded that Chris' death was suicide, as a short form conclusion. In response to the question as regards when, where and how (by what means and circumstances Chris came by his death) I recorded in box 3 on the Record of Inquest as follows: - Christopher died from a traumatic head injury when he was struck by a scheduled freight train service as it was travelling on the main railway line near South Marston adjacent to the A420 at approximately 1745 on 19 September 2024.Christopher had chronic mental health issues (mixed anxiety and depression) which were more likely than not were exacerbated as a result of him not being updated by primary care prior to his death as regards the progress of a recent GP referral seeking mental health input. A response from mental health was sent but was not received by the GP practice on 28 August 2024.

CIRCUMSTANCES OF THE DEATH

Expanding on what 1 recorded as regards the when, where and how Chris came by his death, Chris had a history of depression dating back to around 2008. In 2024 his condition began to deteriorate, and he had been off work for a considerable period of time in the lead up to his death. Chris had been diagnosed earlier in the year with low testosterone levels, and 1 heard evidence from those supporting him in that respect that low testosterone can induce low mood and 1 found as a fact that his low testosterone levels were probably one of the factors in relation to his deteriorating mental health and in particular increased anxiety and depression. His brother Tim Bird did in his statement describe Chris as somebody who would overthink problems and during the course of the Inquest although not strictly given as evidence, he did have concerns that potentially his brother may have had autism, but this was never formerly pursued as a diagnosis.

Chris sought help from his GP on 27 August 2024, in which he reported that he had been suffering and struggling with severe anxiety recently and was not in a good way. Chris mentioned some suicidal thoughts and the discussion with the GP discussed Chris' desire to recommence a drug called Quetiapine, a mood stabiliser. Chris mentioned that he had taken the drug previously and recalled that he felt it helped with his symptoms. The GP promptly made a referral to the mental health teams, as Quetiapine needed to be authorised by a psychiatrist, and also whether or not Chris needed special mental health input. The referral was received by the mental health team the following day on the 28 August 2024 and a response was sent back using the nhs.net e-mail system the same day in which it was confirmed that a psychiatrist had approved recommencing Quetiapine and additionally confirming that mental health was comfortable with Chris' condition being managed at primary care level. There was no evidence that pointed to this e-mail not having been sent by mental health and the e-mail including address was copied into mental health records was confirmed as being accurate. That having been said there was no evidence that the e-mail was received by the White Horse Medical Practice even having forensically examined their records. Those on the front line were unaware of the response from Mental Health until Chris' case was discussed during a mental health hub meeting during lunchtime on the 19 September 2024. It was not clear as to what triggered Chris' case to be discussed and it could have been either or a combination of an e-mail sent by another GP in the practice following a conversation with Chris on the 16 September 2024 to the embedded mental health social worker in the practice or another branch of mental health to do with talking therapies which had made contact with the GP Surgery to do with the mental health referral on the 18 September 2024. Before the embedded mental health social worker could try and contact Chris he had tragically died. I found as a fact that Chris' mental health issues and in particular his mixed anxiety and depression were more likely than not exacerbated as a result of him not being updated by primary care prior to his death as regards the status of the recent mental health referral but that having been said my findings also reflected that the response sent by mental health was not received by the GP practice on the 28 August 2024 and therefore primary care was unaware of the response and the direction from mental health.

5 **CORONER'S CONCERNS**

a. NHS England

During the course of the Inquest, I heard evidence from [redacted] the joint Senior Partner at The White Horse Medical Practice. Having asked colleagues to carry out a forensic search for evidence of the e-mail having been received and finding none he did allude to a view that was not shared by him alone, but by colleagues both within the Surgery and it appears colleagues in other surgeries that there were concerns that when using the nhs.net e-mail that e-mails had gone missing and were not received through the system questioning its 100% reliability. I personally have not come across another case where this issue has been raised but there is no evidence that I saw that pointed to the e-mail having been incorrectly sent by mental health to the GP practice and I have to accept [redacted] evidence that there is no evidence to support it was in fact received. The systemic failure here in my view more than minimally contributed to the deterioration in Chris' mental health that led to his death late afternoon on the 19 September 2024. When Chris spoke with another GP on the 16 September 2024, she was unaware of the response from mental health because the e-mail indicating in detail the nature of that response was never received by the GP practice. She in turn contacted the embedded mental health

	social worker the next day via e-mail although however he was not available that day hence the assumption that that was the reason if not a combined reason for Chris' case being discussed at the hub meeting on the 19 September 2024. If there is a reliability issue with the use of nhs.net for whatever reason such as old infrastructure, then that clearly is a concern and one which I am of the view could impact on future deaths if important information having been sent through the system is not guaranteed to be received and is lost; **b. Oxford Mental Health Services and White Horse Surgery** During the course of the Inquest it became clear that there had been a systemic failure in relation to the communication from mental health to primary care on the 28 August 2024 and I asked and indicated that I would like both organisations to work together to reflect on the finding in relation to ways of working relative to the interaction between secondary and primary care levels to see if there are any measures that could be undertaken to minimise and ideally exclude the repetition of such an incident occurring again. It is not the job of a Coroner to make recommendations. You are aware of my concern here and I am sure that Chris' brother, [redacted] would equally welcome your joint input in respect of the matter.

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 18 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, [redacted], Secretary of State for Health and Social Care, and [redacted] (brother) 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 23 September 2025 [redacted] Signature _____ _____ David Ridley, Senior Coroner for Wiltshire & Swindon __