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 Leicestershire Partnership NHS Trust**
1	**CORONER** I am Rebecca CONNELL, His Majesty's Assistant Coroner for the coroner area of Rutland and North Leicestershire.
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 27 November 2023 I commenced an investigation into the death of James Ralph COCHRANE aged 36. The investigation concluded at the end of the inquest on 27 August 2025. The conclusion of the inquest was that: Mr James Ralph Cochrane died on 17 November 2023 when he jumped from the [redacted] overbridge, [redacted] into the carriage way. He was struck by a passing vehicle and sustained catastrophic head, chest and pelvic injuries which resulted in his death. James had schizoaffective disorder which lead to fluctuations in his mood and level of psychosis. It is unclear as to whether he was having a depressive or psychotic episode at the time of the incident and therefore it is not possible to say whether James intended the consequence of the act. The cause of death was established as: I a Catastrophic head, chest and pelvic injuries I b I c II Schizoaffective disorder
4	**CIRCUMSTANCES OF THE DEATH** Mr James Cochrane was diagnosed with Schizophrenia in 2012 following an admission to the Bradgate Mental Health Unit. His diagnosis was later changed to Schizoaffective disorder due to his the symptoms of psychosis and mood change that he was experiencing which fluctuated over short periods. James was initially under the care of the Psychosis and Early Intervention Recovery (PIER) Team

before being transferred to the care of Charwood Community Mental Health Team (CCMHT) which continued until James passed away.

During this period James also had three short episodes of care from the Crisis Resolution and Home Treatment Team (CRHTT), the latter being from 25 October 2023 – 7 November 2023. In October 2022 James medication was changed from Olanzapine to Ariprazole. James' GP reported that following the change in James medication he became less sleepy but he in fact became hyperactive and psychotic to a certain extent, and although James lost a lot of weight his mental health issue resurfaced.

James family shared with the CPN concerns that the change in medication was having a negative impact on his mental health. James Community psychiatric nurse felt that the negative effects of the change in his medication were outweighed by the fact that he was more active. These concerns were not shared with his consultant psychiatrist in the community.

On 25 October 2023 James went to see his GP stating that he was considering self-harm and wanted to jump off a motorway bridge. James was referred to the mental health Central Access Point (CAP), following which he was referred to the CRHTT. James was seen by the CRHTT on seven occasions during which it was reported that although his suicidal thoughts remained they had decreased.

James' Community Psychiatric Nurse (CPN) indicated by email that it would be preferable for the CRHTT involvement with James to be reduced, due to a risk of over reliance on services. However, evidence was heard that from the CRHTT that their input was appropriate at that time. James was discharged from the CRHTT on 7 October 2023. His CPN declined a joint visit and advised that [redacted] would not have advised James to CRHTT originally, as it made things difficult to have lots of difficult perspectives.

On the morning of Friday 17 November 2023, James' mother called CCMHT as [redacted] had concerns about James as he was presenting with psychotic symptoms.

As James had expressed a wish to alter his CPN, the team lead returned Mrs Cochrane's call, rather than his usual CPN. James' mother told the team lead that James was the worst he had been since his admission to the Bradgate Mental Health Unit 12 years earlier, which is when he previously self harmed, that he had lost insight and was walking around in circles thinking he was god. The team lead considered it appropriate to review James in person.

Prior to the visit she reviewed James risk assessment and his recent discharge letter from the CRHTT which referenced the fact that James had been referred to them having reported that he had planned to jump off a bridge and had written a suicide note. She also spoke to the CPN who advised that James had not been a risk to himself for 12 years, and that James' beliefs that he was God were chronic in nature.

On arrival at James' home at approximately 3.30pm, the team lead initially spoke to James in the absence of his parents. She assessed James as having insight into his mental health. James brother showed her a video of James that had been taken at 1.21pm in which James was saying that he was god. We have heard evidence that James was potentially in psychosis and lacked capacity at the time of the video.

The team lead only watched the first 19 seconds of the video which lasted 3 minutes and 27 seconds. [redacted] did not watch the video in its entirety as [redacted] felt uncomfortable, as James appeared uncomfortable and [redacted] didn't have his consent to watch it, albeit [redacted] does not believe that [redacted] sought James consent. Having spoken to James, the team lead asked James' parents what had changed since the time of the video and they confirmed that they had managed to talk James round.

	They said that the episodes come and go and appear to build to a peak. The team lead said that [redacted] didn't understand James baseline. [redacted] believed that James presentation was longstanding, and initially considered that the video may have been staged. However [redacted] did not check further with James' usual CPN how this presentation compared to his baseline. Following the meeting the Team lead prescribed additional medication, namely [redacted] Lorazepam, [redacted] Zopiclone, to assist James with sleeping and to reduce agitation levels for collection the next day, and [redacted] advised that he increase his Quetiapine to [redacted]. A follow up review was arranged with the CMHT consultant psychiatrist. James' parents were advised to contact the CCMHT on Monday if there was no improvement. James went to bed and at approximately 2100 he left home on foot and went to the [redacted] overbridge. Having realised that James has left the house, his brother [redacted] followed him. James made his way to the [redacted] overbridge where he jumped into the oncoming traffic and sadly James subsequently died as a result of the injuries that he sustained
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) I indicated at the conclusion of the inquest that would be making a prevention of future death report in relation to the following three areas: The extent to which additional evidence such as video footage and carers views should be taken into account. I heard evidence that work and training has been done to encourage staff to listen to careers views. However, it remains unclear as to whether any views obtained are subsequently used to inform any follow up safety plan made by the health care professionals. The extent to which staff should consider evidence provided in alternative formats such as video evidence. It was acknowledged during the inquest that recordings from mobile phones can provide helpful evidence of a patients presentation. I understood that a question had been raised internally at the trust as to what extent such evidence should be viewed, and used to inform decisions, however a final decision has not been made. Given the use of mobile phones etc in modern society, I am concerned that there is no clear guidance to staff as to how such evidence should be used. Support offered to carers who are providing support to mental health patients. It was acknowledged that carers have an important role. I heard evidence regarding mechanisms that have been put in place via systmone to record carers views, but it is unclear as to what checks are in place to ensure that carers are equipped to support patients in their home environment.
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 October 31, 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 **Leicestershire Partnership NHS Trust** I have also sent it to [redacted] 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: 05/09/2025** [redacted] **Rebecca CONNELL** **His Majesty's Assistant Coroner for Rutland and North Leicestershire**