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:** **CEO - Hampshire and Isle of Wight Healthcare NHS Foundation Trust**
1	**CORONER** I am Robert SIMPSON, HM Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 16 September 2024 I commenced an investigation into the death of Naomi AYLOTT aged 46. The investigation concluded at the end of the inquest on 22 September 2025. The conclusion of the inquest was that: On the 12th September 2024 Naomi Aylott died on the Mid Hants Heritage Railway near Four Marks. She jumped from a railway bridge with the intent to end her own life after suffering from a relatively short period of poor mental health which started after she contracted viral meningitis in July 2023. She had made previous attempts to end her life and spent time under the care of both the crisis and community mental health teams.
4	**CIRCUMSTANCES OF THE DEATH** In July 2023 Naomi contracted viral meningitis and, whilst she made a full physical recovery from this, she suffered from poor sleep and developed some erratic behaviours. She was initially treated by the GP and her mental health improved by the end of 2023.

	However in early 2024 she reported fleeting negative thoughts and on the 5th February 2024 attempted suicide. She was swiftly assessed by the Mid and North Hampshire Crisis Home Resolution Team who provided daily interventions until the end of May. By the end of this period Naomi had been assesed as posing a low risk to herself and repeatedly denied any ongoing suicidal thoughts. Naomi's care was then transferred to the Andover Community Mental Health Team (CMHT) for long term management of what was thought to be bi-polar disorder. Following her transfer Naomi was not once seen face to face by her care co-ordinator. No formal risk assesments were completed or updated. No formal care plan was completed nor was a formal crisis plan. On the 6th August 2024 Naomi reported a significant deterioration in her mental health and on the 15th August reported suicidal thoughts. The care co-ordinator still did not prepare a formal risk assesment or see Naomi face to face. She was due to go on holiday and the care co-ordinator did not arrange any contact with Naomi for her return and left it for her to contact him. On the 9th September Naomi was reviewed by a consultant psychiatrist. On the 12th September Naomi jumped from a railway bridge near her home address.
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) 1. I am concerned that Naomi was never seen face to face by her care co-ordinator over the 3 – 4 month period that she was under the care of the CMHT. I heard evidence that the Andover CMHT, in particular, was impacted by a

	change in the way that primary care networks (PCNs) refer patients to secondary services. Due to Naomi's GP surgery being within a particular PCN she was referred to the Andover CMHT even though she lived in Four Marks, a 40-50 minute drive from Andover. This is much further than would have been the case had Naomi come under the care of the Winchester CMHT. The Andover CMHT has not been able to arrange as many face to face appointments with care co-ordinators due to the time they would have to spend travelling. Naomi's care was not referred to the Winchester CMHT originally nor was it transferred from the Andover to the Winchester CMHT after the referral was accepted. 2. I am concerned that within the Andover CMHT the training around risk assessments and the auditing of compliance with risk assessment policy is not adequate. In relation to Naomi I heard evidence that the completion of formal risk assessments was not carried out in accordance with the CMHT policy. I heard evidence that Andover CMHT had undergone risk assessment training at around the time they were involved in Naomi's care. Despite this no formal risk assessments were completed. In addition I heard that the process for auditing risk assessment compliance had not identified this failure in respect of Naomi's care. I also heard evidence that the Andover CMHT had requested further training from the Hampshire and Isle of Wight Trust but that this had not taken place. 3. I am concerned that the Andover CMHT do not appear to have considered how to keep a person's family involved in their care (when there is the appropriate consent to do so) when meetings with the care co-ordinator take place over the phone and not face to face.
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 November 25, 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 **Mrs Aylott's family** 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: 29/09/2025** [redacted] **Robert SIMPSON** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**