## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 [redacted], Assistant Director, Northamptonshire Healthcare NHS Foundation Trust**<br>**2 Northamptonshire Integrated Care Board** |
| **1** | **CORONER**<br><br>I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 04 November 2024 I commenced an investigation into the death of Wendy Siobhan EYLES aged 55. The investigation concluded at the end of the inquest on 15 December 2025. The conclusion of the inquest was that:<br><br>Wendy Siobhan Eyles died on the 31st October 2024 when she was struck by a train at Kettering station, [redacted] Appropriate mental health support and intervention had not been provided. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Wendy Siobhan Eyles died 31.10.2024 when she was struck by a train at Kettering Station [redacted]. Appropriate mental health support and intervention had not been provided.<br><br>The medical cause of death was:-<br><br>1a Multiple traumatic injuries.<br><br>The conclusion was Suicide. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>One of the findings of the the Patient Safety Incident Investigation (PSII) was that ".. there is no protocol for patients open to private and NHS psychiatry at Northamptonshire Healthcare Foundation Trust. The Psychiatrist's role in patient care is to review and recommend appropriate medication and it is problematic if two Consultants are overseeing this at the same time. It can cause confusion and detriment to the patient if medication changes are not communicated between parties and represents a risk to patient safety… It |

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| | is notable that CMHT operational managers from across the service differ in their views on the appropriateness of a patient being open to NHS and private services at the same time..".<br><br>It also emerged at Inquest that a NHS Consultant may not be aware that the patient is also receiving private psychiatry. Where the GP is notified of private psychiatry, it does not trigger a notification to NHS mental health services. Notification of the dual treatment may then be entirely dependent upon the information being shared by the patient. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by February 16, 2026. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted]<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 22/12/2025**<br><br>[redacted]<br>**Hassan SHAH**<br>**Assistant Coroner for Northamptonshire** |