ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. His Majesty's Prison & Probation Service (HMPPS) – Ministry of Justice
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 29th April 2022, I commenced an investigation into the death of Angela Christine Thompson, aged 62 years. The investigation concluded at the end of the inquest on 22nd September 2025. The conclusion of the inquest was: SUICIDE
4	**CIRCUMSTANCES OF THE DEATH** Angela Christine Thompson was diagnosed with emotionally unstable personality disorder and had a long history of self-harm. She had been the subject of admissions under various sections of the Mental Health Act 1983. At the beginning of 2022, she received a 12-week custodial sentence and was released to an address in Hull on 6th April 2022. On that day, she was found lying on Sutton Road in an attempt to kill herself by being run over by the traffic. She was detained under S136 of the Mental Health Act 1983 and taken to Miranda House where she had a mental health assessment. This resulted in her being released from section and being offered support in the community. On 11th April 2022, she laid down in the road in the path of a lorry, which stopped in time to avoid a collision. She was again taken to Miranda House under S136 and had a further mental health assessment. She was offered informal admission, but declined, as in the past she had fund such admissions unhelpful. She was released from section. Later that day, [redacted] was ran over by a taxi. She was attended by paramedics who continued resuscitation that had been started by bystanders and was conveyed to Hull Royal Infirmary. Despite the implementation of Advanced Trauma Life Support, she failed to rally and was declared deceased at 21:50 hours on 11th April 2022. There were no suspicious circumstances or third-party involvement surroundings. She knew that her actions would result in her death.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Evidence was heard that in some instances within the prison estate of England and Wales, there may be a lack of liaison in patients who have on-going psychiatric issues at the time of release from custody between the prison medical services and the psychiatric services in the area where the released prisoner lives. This was felt to be of particular concern when a person is incarcerated at a prison geographically distant from their home address. Evidence suggested that such liaison would ensure and enhance continuity of care following release from prison.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has 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 2nd December 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] – Daughter; Humber Mental Health NHS Trust; Greater Manchester Mental Health NHS Services. I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom. 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	[redacted] **7th October 2025**