REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Highways department of West Sussex County Council** **2. Chief Constable of Sussex Police**
1	**CORONER** I am Michael Burgess, assistant coroner, for the coroner area of West Sussex
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 7 May 2014 an investigation into the death of Alasdair Neal PENNY aged 23 was commenced. The investigation concluded at the end of the inquest on 17 March 2015. The conclusion of the inquest (as found by the jury) was Name of Deceased: **Alasdair Neal Penny** Medical Cause of Death: 1(a) **Multiple injuries** Circumstances and How, when and where the death came about: **Unable to determine his intention** **4th May 2014** **Underneath Beeching Bridge, A22, East Grinstead, West Sussex** Conclusion of the inquest: **Alasdair Penny Jumped from the College Lane Bridge, East Grinstead onto the A22 but the evidence does not fully disclose what his intention was.**
4	**CIRCUMSTANCES OF THE DEATH** This case concerned a 23 year old man who on Sunday 4 May 2014 jumped from a road bridge onto the road below. It had been the site of a similar suicide 3 years before (Will RAYNOR - in fact the 3rd anniversary was a couple of days before this incident) and there were floral tributes to be found there and friends of the previous case had gone there. The deceased was suffering from Paranoid Schizophrenia and had various difficulties with his family, as well as a pending court case. He was refusing to take medication. In the 2 days before his death he was seen by several people loitering on the bridge. At different times, police units attended and questioned him but none found him in a condition that warranted using their s.136 Mental Health Act 1983 powers. Eventually on 4 May 2014 he jumped just as a further police car approached (in a non-threatening way – i.e., no blue lights or sirens). There was evidence from the Healthcare professionals as well as various police officers.
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. – This Bridge has been the site of 2 suicides in 2011 and 2014; I am unaware if there have been any other successful suicides at this location before then, but if so, not in the very recent past. In each of the 2 cases the deceased jumped from the bridge on to the road below, a distance of 10-11 metres. The 2 footpaths that bound the carriageway each have a metal railing and the height of the railing is such that they can be quite easily mounted.

	There is a series of discrete notices on the mesh infill to the railings, giving details, I understand, of the Samaritans I cannot, and do not, offer a solution I certainly recognise that merely raising the level of the railing may not prevent the determined person to climb up and jump. But it might well stop the spontaneous jumper. I understand that I do not know whether it is possible/feasible to provide extra/or some other form of protection in order to make it more difficult for the bridge to be used as a suicide site. However, I do believe that the whole situation should be reconsidered in case something can be reasonably implemented to minimise the possibility of a recurrence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisations 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 12 May 2015. 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 solicitors for the following Interested Persons [redacted] (Parents), The Sussex NHS Partnership Trust and The Chief Constable. 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 pp	**17 March 2015** **M.J.C. BURGESS - ASSISTANT CORONER**