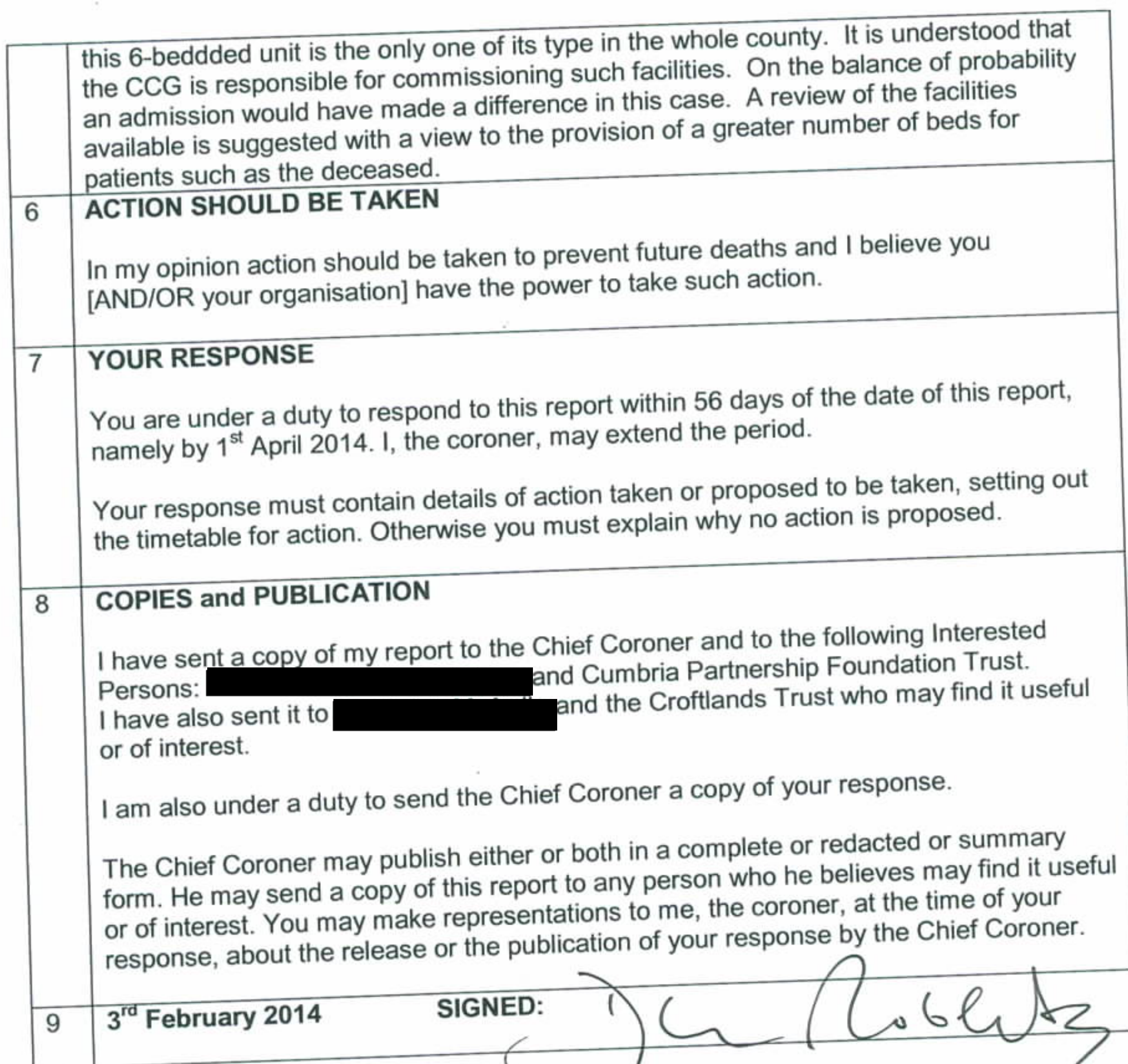
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **RE: Amanda Jane Vickers, Deceased** **THIS REPORT IS BEING SENT TO:** [redacted] **NHS Cumbria Clinical Commissioning Group** **Lonsdale Unit** **Penrith Hospital** **Bridge Lane** **Penrith** **Cumbria CA11 8HX**
1	**CORONER** I am David Llewelyn Roberts, senior coroner, for the coroner area of North & West Cumbria.
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 28th August 2013 I commenced an investigation into the death of Amanda Jane Vickers, age 47 years. The investigation concluded at the end of the inquest on 27th January 2014. The conclusion of the inquest was cause of death 1(a) Hanging. Conclusion: Took her own life whilst the balance of her mind was disturbed.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a long history of depression and suicidal ideation. Over the days before her death she had daily contact with her mental health nurse. She was to be referred to a residential crisis home, but no room was available immediately. On the evening of the 22nd August 2013 the deceased was found hanging by the neck from a fabric ligature attached to a roof beam at her home address.
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 lady died whilst awaiting a place at 81 Lowther Street Crisis Home. She had been there before and found it therapeutic. No space was available, and no date when one might arise was known. She died whilst waiting for admission. The evidence was that



	this 6-beddded unit is the only one of its type in the whole county. It is understood that the CCG is responsible for commissioning such facilities. On the balance of probability an admission would have made a difference in this case. A review of the facilities available is suggested with a view to the provision of a greater number of beds for patients such as the deceased.
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 1st April 2014. 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] and Cumbria Partnership Foundation Trust. I have also sent it to [redacted] and the Croftlands Trust who may find it useful or of interest. 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	**3rd February 2014** **SIGNED:** [signature]