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. [redacted] – Director of Public Health, Cornwall Council, Sedgemoor Centre, Priory Road, St Austell**
1	**CORONER** I am Elizabeth Emma Carlyon, Senior Coroner for the coroner area of Cornwall
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	**INQUEST** On the 9th January 2014 I commenced an inquest into the death of STUART MILES LONG, otherwise known as, CAMERON TURNER, then aged 38. The inquest was concluded on the 7th May 2014. The conclusion of the inquest was open, the medical cause of death being multiple injuries.
4	**CIRCUMSTANCES OF THE DEATH** Stuart Long was a pedestrian on the A30 eastbound lane just past Launceston when he was seen to step/run out into the carriageway at around 05:50 on 22nd December 2013. He was struck by a Peugeot Boxer van registration number [redacted] resulting in him lying prone on the road carriage way. He was run over/hit by at least three other vehicles that did not see him or were unable to avoid him in the road. As a result he received fatal non-survivable injuries. He had been seen stepping/running out in front of vehicles earlier that morning. He suffered from low mood/anxiety/ alcohol misuse and had told health professionals he had thoughts of self-harm by stepping out in front of vehicles/trains. He had been removed from his home address in Launceston by the police earlier that morning due to being drunk (212 mg/100 post mortem blood alcohol) and being aggressive to another. He was known to have mental health issues after using alcohol by front line workers
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. – In the early hours of the morning of his death, Mr Long was removed by police from his home address due to inappropriate behaviour (involving a vulnerable adult) while in drink. Mr Long had long term mental health issues and misused alcohol and was known to behave inappropriately when both of these issues deteriorated. On this occasion he was seen by members of the public to be jumping in front of cars. These behaviour was

	known to the mental health professional who worked with him. It appeared from the inquest that there was some confusion as to how to appropriately dead with anti-social behaviour when someone was in drink/mentally unwell. If Mr Long had been taken to a place of safety he would not have been able to jump in front of cars/die. In addition, his actions could have caused more accidents and/or led to the death of others.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your partnership have the power to take such action. I attach details of a national conference which appears to indicate that this is a national interagency problem. It maybe that you feel this report should be sent to others or a more appropriate agency and I would welcome some direction from you if this is the case.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday, 5 September 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 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	**11th July 2014** **Dr Emma Carlyon**