In the South London Coroners Court
Inquest touching the death of Colette Hughes

Regulation 28: Report to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Hammerson PLC
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South London
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 7th July 2014 I commenced an investigation into the death of Colette Hughes (50). The investigation concluded at the end of the inquest on 20th May 2015. The conclusion of the inquest was that she had committed suicide, and that she died of multiple injuries sustained on 7th July 2014 when at about 4.30 p.m. she jumped from the top storey of the multi-storey car park at Centrale Shopping Centre in Croydon. She had been suffering from an undiagnosed psychiatric condition.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Hughes spent some time sitting on the flat and wide perimeter wall surrounding the top level of the multi storey car park at Centrale Shopping Centre, before standing on it and jumping to 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. – The wall is easy to access and at least two previous deaths have occurred in similar circumstances since 2006. Whilst recognising that barriers cannot be provided at every location above ground, and the fact that the building complies with regulations , there is a concern that others may die in the same manner. There is also a concern that the wall presents a danger to those who may decide to use it as a seating area, particularly after taking drink or drugs. In the absence of some physical modifications, the notices advising visitors of the services of the Samaritans recently installed may not be sufficient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 the 27th August 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 following Interested Persons : The family of Colette Hughes [redacted] South London and Maudsley NHS Trust I have also sent it to the Planning and Regeneration Department at Croydon Council and to the Health and Safety Executive 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.
	30th June 2015 **SIGNED BY CORONER** [redacted]