REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Swindon Borough Council, Civic Offices, Euclid Street, Swindon, SN1 2JH**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Wiltshire
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 12th June 2018 I held an inquest into the death of Karen Diane Wiggins. The conclusion of the inquest was that the deceased who had suffered multiple traumatic injuries following a fall from height, died by suicide.
4	**CIRCUMSTANCES OF THE DEATH** Shortly before 6.20 am on Friday 1st December 2017 when she was found, Karen Wiggins jumped from an upper floor of the Fleming Way Car Park and landed in Gordon Gardens Road, dying instantly.
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. – I learned that there had been a number of suicidal falls from multi storey car parks in Swindon, with previous occurrences at the Fleming Way Car Park, together with a number of instances where suicidal individuals had been successfully talked down uninjured. An investigation by the Council is called for. Inter alia such an investigation might explore the possibility of creating physical barriers to prevent individuals jumping from height and / or the posting of notices giving contact details for the Samaritans, a strategy that has been employed at some railway stations in an attempt to avoid suicidal leaps in front of trains.
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 8th August 2018. I, the assistant 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 namely the family of the deceased. 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	**Dated 13th June 2018** **SIGNED** **Assistant Coroner**