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:** **EPUT**
1	**CORONER** I am Caroline Beasley-Murray, Senior Coroner, for the Coroner area of Essex
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 21 February 2018 I commenced an investigation into the death of Kelly Marie Campbell. The investigation concluded at the end of the inquest on 8 August 2018. The conclusion of the inquest was that Kelly Marie killed herself. The jury added a narrative conclusion – Numerous failings of the state to protect her life contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Kelly was a 17 year old girl who had suffered from bulimia nervosa for about a year. She had a history of self-harm and suicidal feelings. At the time of her death she was detained under s3 Mental Health Act in Rochford Hospital. She was found hanging bay ligature of shoe laces from light fitting in her bathroom.
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. – (1) The evidence revealed that some time previously Kelly's shoe laces had been returned to her. The court accepts that this sort of decision is a clinical decision but wants to be assured that there are rigorous trust policies surrounding such decisions. (2) Kelly's mother lamented the fact that the physical surroundings in the rooms were so dreary – she cited magnolia paint everywhere, no colourful pictures to brighten up the environment etc. She observed that the lack of mobiles, a clock etc. in the rooms led to boredom in the long night hours. Cont….

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 3rd October 2018. 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 The Care Quality Commission 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	**9 August 2018** **Caroline Beasley-Murray**