Senior Coroner's Office (Peterborough)
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David C Heming
Senior Coroner for Peterborough

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hammerson PLC** **2. Peterborough City Council** **3. Pelican Partners (Peterborough) Ltd**
1	**CORONER** I am DAVID HEMING, Senior Coroner, for the coroner area of Peterborough.
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** On 23 December 2013 I commenced an investigation into the death of LYNN MARGARET GRAHAM GORMLY then aged 50 years. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 12:20 on 23 December 2013, the deceased jumped from level 11 of Queensgate Car Park. She died of multiple injuries.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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) There have been a number of suicides from 2006 onwards, where individuals have taken their own lives by jumping from the Queensgate Car Parks. The current design of the car park is not effective in preventing jumps and the recent refurbishment of the car parks did not lead to the erection of barriers/increasing the height of the walls. Of note is the paper (attached) by [redacted] and others (BMC Public Health 2013, 13:214) which concluded that notwithstanding certain limitations of the review undertaken, reducing access to means through the installation of barriers can be effective in averting suicides at hotspots and does not lead to substitution effects.

	(2) The car park at Peterborough City Hospital which was opened in 2010 and is therefore of modern design, was constructed in such a way as to provide a significant obstacle to jumping as the wall on the top floor is approximately 3 meters high. By contrast, the walls at the upper floors of the Queensgate Car Parks and other City Centre car parks, are at a low level and do not operate as an effective barrier to jumping. (3) Falls from the car parks have been into areas where the public use pavements and there is clearly a risk of death to pedestrians also. (4) There is evidence in the medical notes and records of some of those who have taken their own lives, that car parks are seen as a means of effecting death by jumping.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 **24 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 have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- 1. [redacted] – Father of the deceased 2. [redacted] – Mother 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	**30 July 2014** David Heming **……..** **David Heming – Senior Coroner (Peterborough)**