


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. [REDACTED], National Risk and Safety Manager, Campus Living Villages, Quay West at MediaCityUK, Trafford Wharf Road, Stretford, Manchester M17 1HH2. Secretary of State for Education, Right Hon Nicky Morgan MP, House of Commons, London SW1A 0AA
1	<p>CORONER</p> <p>I am M Jennifer Leeming, Senior Coroner, for the Coroner Area of Manchester West</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On Tuesday 3rd November 2015, I commenced an investigation into the death of Samantha MacDonald, 20 years, born 12th August 1995. The investigation concluded at the end of the inquest on Monday 25th January, 2016.</p> <p>The conclusion of the inquest was Suicide.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the 25th October 2015 Samantha Jane MacDonald jumped from the window of her bedroom on the 14th floor of student accommodation at Eddie Coleman Court, Salford.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>Samantha Macdonald jumped from the window of her bedroom on the 14th floor of her student accommodation in Salford. The window was not required to be used as a fire exit because it was too high. The window was fitted with a device that restricted the distance for which it would open. Evidence was heard that</p>

	<p>the device complied with the relevant British Standard and Planning regulations. If it had been in good working order it would have prevented the window from opening sufficiently to allow Samantha's exit. It was, however, broken. Evidence revealed that the device could be broken by the application of force without the use of any tool. It was not possible to discover exactly when the device had been broken although it had been working during Samantha's tenancy. Similar devices fitted to other bedrooms in the building had been found to be broken from time to time. The building is a non-smoking building that is entirely devoted to student accommodation, and witnesses believed that the devices had probably been broken so that students smoking in their rooms could avoid detection. Evidence was heard that in accommodation occupied by adults who might be determined to forcibly defeat window restrictors, for example in a healthcare setting, risk assessments were recommended to be reviewed and consideration given to replacing restrictors with more substantial or robust devices, and /or adding a second restrictor to better resist determined efforts to open the window, thus lessening the risk of persons falling either accidentally or otherwise. It is considered that such assessments would also be appropriate in student accommodation such as that occupied by Samantha Macdonald.</p>	
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.</p>	
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st April 2016. I, the coroner, may extend the period.</p> <p>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.</p>	
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <p>1. [REDACTED] father of the deceased.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>	
9	<p>Dated</p> <p>5th February 2016</p>	<p>Signed </p> <p>M Jennifer Leeming</p>