REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Suzette Davenport, Chief Constable, Gloucestershire Constabulary** **A separate report is being sent to the Chief Constable of Thames Valley Police and a copy of this report is also provided due to the fact that one of the matters of concern is regarding communication between the two forces.**
1	**CORONER** I am Mr D M Salter, Senior Coroner, for the coroner area of Oxfordshire.
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 the 14 October 2013 I opened an Inquest into the death of Suzanne Cammell, aged 71, who died on 3 October 2013 at a layby on the A361 near Burford Golf Club. I concluded the case at Inquest on 16 July 2014 at Oxford Coroner's Court. A copy of the Record of Inquest is attached. It will be seen that I gave a conclusion of Suicide and stated that… *"At approximately 06.00-07.00 hours on 3 October 2013 Suzanne Cammell lay underneath the wheels of a lorry trailer parked in a layby on the A361 near Burford Golf Glub and was killed instantly when the lorry drove off at approximately 07.00 hours."* An investigation was initially carried out by TVP and a file of papers was submitted to me. There was oral evidence from [redacted] of Gloucestershire Constabulary, TVP Officers and from Mental Health Professionals.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death may be known to you. A copy of the Inquest file was disclosed prior to the Inquest. Consequently, I have not provided you with a copy of the Inquest file with this report. At approximately 01.20hours on 3 October 2013 a call was made to TVP by the owner of a kebab van situated in the layby on the A361 near Burford Golf Club. He reported that he was concerned about a woman in the layby (Suzanne Cammell) who was seen lying or trying to lie under a lorry parked in the layby to go to sleep. He went on to say that he woke her up when he saw her under the lorry as he was concerned she may get run over in the morning. TVP Officers attended. [redacted] and [redacted] took Ms Cammell and her vehicle back to her home in Lechlade. They left her at her home address at approximately 02.20. There was communication between TVP and Gloucestershire Constabulary and at about 03.30 [redacted] and another Gloucestershire Officer attended and spoke to Ms Cammell at her home to check on her welfare. The Gloucestershire Officers then left.

	According to CCTV footage at Burford Golf Club, it appears that Ms Cammell returned and parked her car up in the grounds of the Golf Club at approximately 05.30. At 07.00 hours the lorry in the layby (the only one parked there overnight) drove off. Ms Cammell appears to have been lying underneath the wheels of the lorry and sustained devastating crush injuries to her head, chest and abdomen. The medical cause of death from the Pathologist, [redacted], was severe blunt head injuries.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you. The **MATTER OF CONCERN** is as follows: (1) There was also an incident on 23 September 2013 in Gloucestershire when Ms Cammell had been sectioned under Section 136 of the MHA because she had been seen placing her head under the wheels of a recycling lorry where she lived. She was seen by neighbours and/ or the driver in time. This information about the incident on 23 September 2013 was held on the Police National Database which, presumably, Gloucestershire control and [redacted] would have had access to. The concern therefore is in relation to communication between TVP and Gloucestershire Constabulary and, in turn, communication between Gloucestershire Control and its Officers. At Inquest, I did not have available to me details of the specific information passed by TVP control to Gloucestershire control in the early hours which subsequently led to [redacted] and his colleague carrying out the welfare check at approximately 03.30. The evidence of [redacted] at Inquest is that he did not know that she had been found lying underneath the wheels of the lorry earlier in the morning. He gave evidence that, if he had known this, he would have put in hand arrangements for a MHA assessment. [redacted] also gave evidence that he did not know about the previous similar incident on 23 September despite the fact that it was on the PND and, furthermore, on Gloucestershire's "Unify" Intelligence database. The issue of concern therefore is the fact that specific information, of a high risk nature, was not or may not have been passed by TVP to Gloucestershire Constabulary or, if it was, it may not have been available to [redacted]. I appreciate that [redacted] carried out a prompt welfare check and that Ms Cammell's presentation was such that [redacted] did not consider her to be at risk but it appears he did not have available crucial information.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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. I may extend the period on request. 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 Interested Persons. 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**MONDAY 28 JULY 2014** **Mr D. M Salter – HM Senior Coroner**