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:** **1. EEAS** **2. Essex Police** **3. 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 27 June 2019 I commenced an investigation into the death of Sharon Louise Kelly aged 44 years old. The investigation concluded at the end of the inquest on 12 November2019. The conclusion of the inquest was Sharon Louise Kelly killed herself. The contributing factors were as follows:- • The timing of the Mental Health Act assessment was inadequate • Failure to initiate the risk assessment upon arrival at the property by the EEAS • Widespread insufficient communication between all services. including medical cause of death and short-form conclusion or narrative conclusion summarised]. The medical cause of death was 1a) hanging 11) alcohol and multiple drug overdose
4	**CIRCUMSTANCES OF THE DEATH** Ms Kelly had a long history of mental health and alcohol problems with frequent suicide attempts. She informed a family member that she would kill herself on the anniversary of her baby son's death. The ambulance attended her property but did not enter, awaiting police attendance which was delayed. When, eventually the services entered the property Ms Kelly was deceased.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – • Whether there is sufficiently clear training at EEASin relation to (1) identifying

	relevant flag markers to ensure police attendance ata property where appropriate and 2) communicating relevant information from relevant records to ambulance crews to ensure that dynamic risk assessments take place on the basis of all relevant information (in light of decision making and delays on 27 June 2019) • Whether lines of communication and the modus operandi between EEAS and Essex Police are sufficiently clear in relation to a potential joint attendance at a property where there is a risk marker (given the delays on 27 June 2019) • Whether there is sufficient clarity in the training for Essex Police Comms Officers as to the circumstances in which a blue lights response should be mandated (in light of the evidence of Insp [redacted] as to the response on 27 June 2019) • Whether EPUT can review its arrangements for convening an urgent MHS assessment, in conjunction with social services. (in light of the jury's findings with regard to the MHA assessment in June 2019)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 8th January 2021. 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 who may find it useful or of interest. ECC Social Services I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 24 November 2020 Caroline Beasley-Murray**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)