Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Principal, Hands of Light Academy**
1	**CORONER** I am CRISPIN OLIVER, Assistant Coroner for the coroner area of West Yorkshire (Western) Area.
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 12 November 2021 I commenced an investigation into the death of Kate Angharad HYATT aged 32. The investigation concluded at the end of the inquest on 09 June 2022. The conclusion of the inquest was: Suicide
4	**CIRCUMSTANCES OF THE DEATH** Pronounced dead at 03.31 on 31 October 2021 at Widdop Road, Hebden Bridge. Died of [redacted] toxity and the conclusion of the inquest was suicide.
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 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: The evidence at the inquest was that Kate had become depressed for the last 12-18 months of her life. Her family described her as displaying signs of psychosis. Obviously, the causes of the decline in her mental health toward the end of her life were likely complex and multiple. The evidence was however, that she had become particularly disturbed over the 3-4 months immediately prior to her death. Specifically, these symptoms had worsened significantly subsequent to her attendance at a Hands of Light Academy course in Worcestershire; which took place on 18th-22nd June 2021. [redacted], [redacted]. My concern is that hallucinogenic substances are being dispensed by the Hands of Light Academy to attendees on its courses, potentially and/or actually mentally unwell people, without proper, or any, consideration of the impact that they may have on them. In particular is the effect of hallucinogens on psychosis sufferers.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 August 16, 2022. 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 I have also sent it to [redacted] who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 21/06/2022**  **Crispin OLIVER** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**