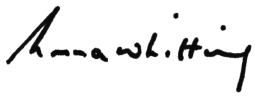
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Constable** [redacted]
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 20 January 2023 I commenced an investigation into the death of Sylvia Dawn CROWTHER aged 58. The investigation concluded at the end of the inquest on 25 January 2024. The Conclusion of the Inquest was that the Deceased died as result of **Suicide**.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased suffered with physical disabilities, mental health issues, and alcoholism. Her husband of 39 years was her main carer. At around 19.15 hours on 3 January 2023, the Deceased reported to Police that her husband was being violent towards her. On attending, the Police could see no visible marks or cuts but arrested her husband; the Deceased made it clear that she did not support any criminal action against him. On 4 January 2023, her husband was bailed until 28 February 2023 with conditions that he was not to return to the marital home. Police also made a Safeguarding Referral to Social Services who organised an urgent welfare visit to the Deceased that same evening. The Deceased refused all care services offered during the visit and stated that she would kill herself if her husband did not return home (but not that evening). The Deceased continued to refuse care when contacted by Social Services the following morning but was provided with the telephone number for the Safeguarding Team. Sometime between 14.45 and 15.45 on 6 January 2023 and, in a distressed state, Sylvia left a message on the Safeguarding Team's phone requesting help. At 15.06 hours, she also sent a text to her Victim Engagement Officer stating that she could not cope on her own and requesting a call. Although a member of the Safeguarding Team spoke briefly to her on the phone at 16.30 hours, they requested Police to make an urgent welfare visit; a 'prompt response' was organised by Police Control Room at 16.56 hours but, owing to service demand, they arrived at 19.24 hours and found the Deceased unresponsive on the living room floor. Despite all resuscitation efforts, paramedics confirmed her death at 20.25 hours. [redacted] and notes to her husband and to Police were found at the scene. The notes confirmed an intention to end her life and the note to Police indicated that she felt that they had not listened to her.
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: (brief summary of matters of concern) Although the Domestic Homicide Review (DHR) carried out in this case has already recommended a number of issues for agencies to consider, additional matters have been observed by the Court in relation to Police action: (i) Whilst some officers carried out their tasks effectively and appropriately, overall important steps in the Deceased's husband's arrest and subsequent conditional pre-charge bail did not appear to have been followed. (ii) In particular, S47ZZA PACE 1984 requires the investigating officer to seek the views of the alleged victim on whether relevant conditions should be imposed on the person's bail and then to inform the custody officer of these views but this was not done in this case: the first time that the Deceased was made aware of the nature of her husband's bail conditions was when the Police brought him home after his release on bail to collect his belongings. (iii) An earlier discussion between Police and the Deceased might have highlighted the Deceased's deep emotional and physical dependence on her husband and the need to consider alternative options to criminal investigation with potentially more supportive care attached to them, such as the use of a DVPN/DVPO as highlighted by the DHR.
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 April 24, 2024. 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 [redacted] **- Head of Social Care, Central Bedfordshire Council** I have also sent it to [redacted] **– DHR Report Author** 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: 28/02/2024**  **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**