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 Queen Alexandra Hospital Legal Department**
1	**CORONER** I am Sarah WHITBY, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 September 2022 I commenced an investigation into the death of Samantha Jane ANGEL aged 55. The investigation concluded at the end of the inquest on 25 April 2024. The conclusion of the inquest was that: On the 16th September 2022, the deceased, Samantha Jane Angel, was found hanged at her home at [redacted] Hampshire. She was under stress, as a result of a work investigation. The deceased further discovered on the 16th September, that she had been consistently lied to and her money misused leading to great distress. Acting on impulse, she took the action to end her life that evening.
4	**CIRCUMSTANCES OF THE DEATH** On the 16th September 2022, the deceased, Samantha Jane Angel, was found hanged at her home at [redacted], Hampshire. She was under stress, as a result of a work investigation. The deceased further discovered on the 16th September, that she had been consistently lied to and her money misused leading to great distress. Acting on impulse, she took the action to end her life that evening.
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) 1. The delay in resolving the investigation commissioned into the deceased behaviour at work. 2. The ease with which the circumstances leading to the allegation were made public amongst the deceased's' work colleagues and the consequences of that. 3. The recognition that the distress caused to the deceased by the publication of the circumstances, should be a factor in accelerating a conclusion to an investigation, not just the consequences of any findings of an investigation if negative to the deceased.
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 July 03, 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] 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: 09/05/2024** Sarah Whitby **Sarah WHITBY** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**