REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Greater Manchester Integrated Care Board.
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 10th May 2023 I commenced an investigation into the death of Lee-Ann Sarah INCE. The investigation concluded on the 22nd May2024 and the conclusion was one of suicide. The medical cause of death was **1a) hanging.**
4	CIRCUMSTANCES OF THE DEATH Lee Ann Sarah Ince was a victim of domestic abuse, who was in a coercive and controlling relationship. The prolonged exposure to domestic abuse during the relationship had a significant impact on her mental health. On 9th May 2023 she was found unresponsive attached to a ligature.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. 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 report to you. The MATTERS OF CONCERN are as follows. – The inquest heard evidence that agencies involved in supporting her in the months leading up to her death had a limited understanding of how behaviours could be twisted in a coercive and controlling relationship to make it appear as if the victim was part of the problem. In this situation it was clear that Lee-Ann was the victim of so called "love bombing" which meant that she was barraged with messages from the perpetrator. The impact of that on a victim's mental health was not recognised.

	Her children had expressed their concerns to their school. The school had been proactive in sharing those concerns but there was little evidence that other agencies were then listening to "the voice of the child". This meant that agencies who had direct contact with her did not have a full grasp of the situation or her vulnerability. The inquest was told that if information is not effectively shared and the voice of the child is lost there is an increased risk to the victim. A feature of her vulnerability was her physical health and how dependent she was, as a consequence, on the perpetrator to help care for her. The additional vulnerability and impact of this was not recognised by agencies involved in supporting her. The inquest was told that where vulnerability is not properly understood the risk presented to a victim of domestic abuse increases.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 15th August 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 namely [redacted] on behalf of the family, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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	**Alison Mutch** **HM Senior Coroner**  **20.06.2024**