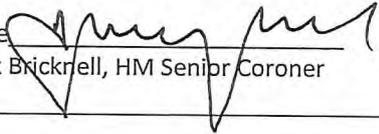




**H G Mark Bricknell**  
**Senior Coroner**  
**for County of Herefordshire**

26th June 2024

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> Robert Mackie, Chief Executive, Herefordshire and Worcestershire Health and Care NHS Trust.</p>
1	<p><b>CORONER</b></p> <p>I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p> <p><a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 13 January 2023 I commenced an investigation into the death of Nicola Jane LACEY. The investigation concluded at the end of the inquest on 12 June 2024. The conclusion of the inquest was suicide.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Nicola Jane Lacey lived alone in a large property in rural Herefordshire. She had recently separated from a partner.</p> <p>On the 30th December 2022, the deceased did not attend work and did not call anyone. This raised concern. As a consequence a member of staff who worked with the deceased attended her address. There was no answer at the address and therefore the Police were called.</p> <p>Police attended the scene and forced entry. The Police established that Nicola Jane Lacey had died. A note identified the deceased's intentions.</p> <p>Nicola Jane Lacey had a responsible position within Healthcare.</p>

5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>(1) Procedures should be clear and known to employers concerning the appropriate disclosure of a colleagues ongoing mental health difficulties for the benefit of both the individual concerned and the safety of the wider public.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you, Robert Mackie have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 August 2024 I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>26th June 2024</p> <p>Signature </p> <p>HG Mark Bricknell, HM Senior Coroner</p>