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 Executive, Isle of Wight NHS Trust**
1	**CORONER** I am Jason PEGG, HM Area 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 19 February 2025 I commenced an investigation into the death of Lucy Ann THORNTON aged 25. The investigation concluded at the end of the inquest on 26 January 2026. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 18th February 2025 [redacted]. The deceased [redacted] suspended herself [redacted] The last known contact with the deceased was at 1209 hours. An ambulance arrived at Omega Street at 1233 hours. The ambulance crew did not enter 61, Omega House because the deceased was known to have a knife and the ambulance crew believed the attendance of the police was necessary for their safety. The ambulance service contacted the police at 1236 hours requesting the police to attend [redacted]. The deceased was found at 1300 hours. It cannot be ascertained when the deceased suspended herself and died. It cannot be ascertained whether there was a missed opportunity to stop the deceased suspending herself. The deceased had a history of suicide ideation. The deceased ingested a substantial quantity of alcohol which impaired the deceased's judgement and contributed to the death.
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) The level of training and understanding of relevant call handling procedures and processes by those employed as call handlers in relation to incidents concerning hanging: 1 The procedures direct a Category 1 response (7 minutes) when the person has the means to suspend themselves and has stated that is there present intention. The call handler believes that a Category 1 response is, "When they are going to die now".

	2 The procedures direct that when the call handler does not have all relevant information they should telephone the person and ask questions in relation to the person's present situation. The call handler was on the Isle of Wight. THORNTON was in Southsea. The call handler did not call THORNTON as she felt she was too remote (geographically).
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 March 24, 2026. 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 **Isle of Wight Ambulance Service** [redacted] 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. They may send a copy of this report to any person who they believe 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: 27/01/2026** [redacted] **Jason PEGG** **HM Area Coroner for** **Hampshire, Portsmouth and Southampton**