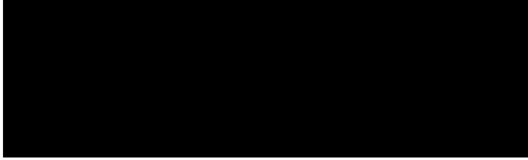
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Cheshire Police**
1	**CORONER** I am Elizabeth WHEELER, Assistant Coroner for the coroner area of Cheshire
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 15 July 2025 I commenced an investigation into the death of Lisa Marie Elizabeth Beatrice TAYLOR-PENNY aged 63. The investigation concluded at the end of the inquest on 26 March 2026. The conclusion of the inquest was that: Narrative Conclusion - Had probably formed the intention to end her own life, but whether she probably undertook a fatal act cannot be ascertained as the likely mechanism of death is unascertained.
4	**CIRCUMSTANCES OF THE DEATH** Ms Taylor-Penny was found deceased at her home address on 11 July 2025. She had last been seen alive the day before. Concerns had been raised earlier on 11 July- from 13:30- and carers and social workers from the local authority had attended outside her house for hours throughout which they were repeatedly and persistently calling other emergency services to try and obtain access and help. After nearly seven hours of carers and social workers trying to obtain assistance to enter the premises, at around 20:00 a police officer took an appropriate operational decision to enter Ms Taylor-Penny's house and she was found deceased, with rigor mortis present. Ms Taylor-Penny had a long standing history of mental health problems. Her daughter had died by suicide in September 2024 and this was associated with a further deterioration in Ms Taylor-Penny's mood. In 2025 she had spoken about feeling suicidal but had denied plans or intent to professionals. When she was found, there were a large number of empty blister packs next to her from a variety of medications. An undated note consistent with intent to take her life was left prominently on the kitchen side and she had very recently updated her will. However, post mortem toxicology has not indicated any fatal level of drugs or other substances. No probable mechanism of death has been established.
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) "Right care right person" (RCRP) is being implemented in a very rigid manner suggesting that call handlers may be using it as "tramlines not guidelines". I am concerned that it does not leave sufficient scope for call handlers to escalate calls for a senior member of staff to consider exercising professional judgment. In particular, where other professionals who are familiar with RCRP are nevertheless indicating a professional view that they need police attendance to secure entry and are expressing a concern for life and limb.
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 June 10, 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 I have also sent it to 1. Ms Taylor-Penny's family 2. Cheshire and Wirral Partnership NHS FT 3. North West Ambulance Service 4. Cheshire West and Chester 5. Cheshire Fire and Rescue Service 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: 15/04/2026**



Elizabeth WHEELER
Assistant Coroner for
Cheshire