REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Manager of The Spindles Town Square Shopping Centre 2. [redacted] Asset Manager, Kennedy Wilson Europe (as Landlord) 3. [redacted] Health & Safety Manager – Associate, Savilles Management Resources (as the Landlord's Managing Agent) 4. [redacted] Commercial Health & Safety Regulator/Health & Safety – Public Protection, Oldham Council, Chadderton Town Hall
1	**CORONER** I am Lisa Hashmi, Assistant Coroner for the coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 04/07/2012 the Senior Coroner commenced an investigation into the death of Lisa Jane CLAYTON, then aged 44 Years. The investigation was concluded at the end of the inquest on 15/11/2013. The conclusion of the inquest was the deceased took her own life whilst the balance of her mind was disturbed. The medical cause of death being 1a) multiple Injuries
4	**CIRCUMSTANCES OF DEATH** Ms Clayton had been suffering serious and significant mental health issues following the birth of her second child in late 2010. She was cared for by both inpatient and community mental health teams and received significant care and support from her family and friends. She had been diagnosed with a severe form of clinical depression. She had attempted to self harm on previous occasions and had subsequently been hospitalised as a 'voluntary patient'. On the evidence, it appeared that ideation was an ever present risk. On the 27th June 2012 she went missing from home, within a very short timeslot of less than five minutes (between her mother leaving and her mother's partner arriving). Police were contacted. At around the same time, Police were also called to attend the Spindles shopping centre car park. At around 15:20, Ms Clayton was found at the foot of The Spindles car park, at the kerbside. When police subsequently examined CCTV security recordings, Ms Clayton was initially noted to have entered the Spindles car park by the 'out' barriers. A short while later, she was captured on the wall surrounding the 7th floor of the car park. She was seen to 'shuffle to the edge and disappeared.
5	**CORONER'S CONCERNS** 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:-

	1) The wall surrounding the 7th floor of the car park has a metal barrier/bumper situated low down on the wall, designed to prevent damage to the wall by parking cars. It equally provides a sturdy foothold allowing adult pedestrians, children etc to climb onto the wall itself. 2) Whilst the wall has two distinct horizontal metal rails fixed to the top of it, the gaps between the two rails are relatively large. The rails themselves potentially provide an effective anchor-point for an individual to climb onto the wall, particularly when combined with the barrier/bumper mentioned at point 1. 3) The wall/rails are an insufficient deterrent/preventative measure. 4) The level and extent of CCTV monitoring – particularly of the 7th floor, which is usually coned off to prevent public usage (save for at the busiest times) - is insufficient. The building has 24 hour security officers in attendance and it is accepted that at night, the building is physically secured. However, day time monitoring is limited (see point 5 below) and in all probability not as effective as it might be in terms of keeping a check on who is accessing a (top) floor that has been coned off to the general public. There has been no allocated/fixed camera covering or monitoring access and usage of the 7th floor. 5) The staffing levels within the security control room are insufficient. There is one guard, watching 6 screens, covering 40 cameras. In addition, the same guard is required to complete paperwork and liaise, assist and co-ordinate security colleagues 'on the ground'. Even at the busiest times, only one guard is on duty in the control room. 6) There have been previous acts and attempts by others to take their own life, at the same location. Her Majesty's Senior Coroner for the Manchester North area has previously put his concerns in writing to the Manager of The Spindles. In addition, the Senior Investigating Officer (Greater Manchester Police) has also expressed his concerns directly to the same. Despite this, little direct action has (or appears to have) been taken.
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 the 15th January 2014. I, the Assistant 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] (the deceased's mother) [redacted] (the deceased's partner) Pennine Care NHS Foundation Trust (the Mental Health Trust) I have also sent it to: [redacted] (Senior Investigating Officer, Greater Manchester Police) 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 from. 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	21 November 2013. Signed