	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable, Durham Constabulary**
1	**CORONER** I am Andrew Tweddle, Senior Coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On10th June 2013 I commenced an investigation into the death of Robert Wilkinson aged 65 years. The investigation concluded at the end of the inquest on 18th October 2013. The conclusion of the inquest was that the deceased intentionally took his own life **Medical Cause of Death** 1a,. Fatal Gunshot Injuries
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been a firearms and shotgun certificate holder for a number of years. Although there had been some historic incidents with regard to his licence, no issues of concern had been raised with the Constabulary for many years. In late 2012, the Police became aware, through a change in family circumstances, that a question of the deceased's suitability to continue being a certificate holder was raised and enquiries and reports received led to Deputy Chief Constable [redacted] signing a Letter of Revocation for the certificates on 3rd May 2013. It was intended that the revocation letter being personally served upon the deceased. It was not so served prior to his death. The deceased was a very keen shooter and was suffering from a terminal illness. The deceased shot himself with one of his firearms the day after being discharged from hospital. It was never thought by the Police that the deceased was a threat to any third party.
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. – (1) As part of the process leading to the decision to revoke, although there had been contact with the deceased/his family/medical practitioner, there had not been a face to face meeting between a member of the firearms licensing team and the deceased. Such a meeting would have provided better quality of information to enable those considering the issue of revocation to have made the decision on the best possible information (2) The revocation letter was never personally served. The deceased was in hospital for some of the time. Contact had been made with the deceased's family, in particular his son, and whilst it may not have been said in clear terms, the inference clearly was that the deceased was to have his certificates revoked and it was the deceased's son who communicated this information to his father and not the Police. Further consideration needs to be given as to the most appropriate means by which a decision to revoke should be made known to the certificate holder. It is accepted that this was a difficult case for the Police to manage, but clearly if the deceased had not had access to his

	guns on the day that he shot himself then he would not have been able to take his own life in the way that he did on the day that he did. Thus, an objective review how this case was managed should be undertaken so that improvements to the system might be identified with the result that similar fatalities in the future might be avoided.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 16th December 2013. 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 Person [redacted] 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	**21st October 2013** **Signed……** **HM SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**