

A R W Forrest LLM, FRCP, FRCPath GMC Number: 1333523 Her Majesty's Senior Coroner for South Lincolnshire

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:		
	1. Assistant Chief Constable, Lincolnshire Police		
ı	CORONER		
	I am M J Spittal, Assistant Coroner for the Coroner's area of South Lincolnshire.		
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 3 rd November 2015 I commenced an investigation into the death of David Palmer, age 59. The investigation concluded at the end of the inquest on 10 th February 2016. The conclusion of the inquest was Narrative Verdict.		
	CIRCUMSTANCES OF THE DEATH Mr Palmer had a licence for 3 firearms which were kept in a locked cabinet. He		
	also had a shot gun with a 5 cartridge magazine which was unlicensed and which		
	he did not keep in his gun cabinet in against the possibility of a spot check by		
	Police Officers. He suffered from Lung Cancer and died as a result of a massive head in jury from his unlicensed shot gun.		
	[장면 맛집 기계 그리기가 보고 그렇게 된다. 아이를 살림하게 되고 말했다. 수 없었다.		



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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.

In the three and a half years I have investigated 4 deaths resulting from self-inflicted firearm wounds. Three of those involved unlicensed weapons. These weapons are generally not stored securely and are thus available for impulsive use.

The MATTERS OF CONCERN are as follows. -

1 Making public the practice I understand to be in place to the effect that the surrender of an unlicensed firearm does not usually result in prosecution might usefully be considered.

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 11th April 2016. 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
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	25 th February 2016	10/2 11
		M J Spittal

Assistant Coroner for South Lincolnshire