ANNEX A

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. Air Chief Marshall Sir [redacted]** **2. Dr [redacted] Consultant Psychiatrist and Clinical Lead Department of Community Mental Health (DCMH) Woolwich Station Medical Centre** **3. Air Vice-Marshall [redacted] Director of Legal Services**
1	**CORONER** I am Sonia Hayes assistant coroner, for the coroner area of North East Kent
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5th May 2020 an investigation was commenced into the death of PAUL HILLS. The investigation concluded at the end of the inquest on 30th October 2020. The conclusion of the inquest was Suicide due to Suspension by the neck
4	**CIRCUMSTANCES OF THE DEATH** Paul was found deceased at home in his garage on 24th April 2020. He had tied a red rope around his neck and suspended himself from the rafter and placed electrical items around the space to make access difficult. He has over 20 years in the armed forces with two tours of duty and was diagnosed with post-traumatic stress disorder and was receiving treatment. He reported two episodes of self-strangulation on 28th February 2020 and 16th April. He had reported dry run attempts to harm himself.

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 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. – Sgt Paul Hills was an Royal Air Force Firefighter Trainer, had served over 20 years and had completed two tours of duty in Afghanistan. He experienced mental health problems and was diagnosed with post-traumatic stress disorder and received treatment from DCMH Woolwich a three hour round trip from his home. His treatment continued during the COVID-19 pandemic. 1. No risk assessment was completed on the issue of moving mental health appointments to virtual during the COVID-19 pandemic and how patients could be kept safe in the event of deterioration in his mental health. There was no plan in place for patients that required urgent assessment/review due to deterioration in their mental health. 2. Care plan had not been updated since October 2019 and his risk assessment remained the same even when the scores changed and there was evidence of escalating risk behaviour. 3. Risk issues were not shared with the family even though Sgt Hills was in lockdown with them and there were no discussions regarding sharing of information. He disclosed his dry runs of self-strangulation on 28th February and 16th April and his withdrawal/isolation from his family who had been very supportive of him. On 22nd April he disclosed he was looking for a rafter to harm himself from and there was an overreliance on his family as a protective factor in the absence of this knowledge being shared with them. 4. His risk assessment was not up-to-date and his disclosures during April were not documented. 5. Sgt Hills was advised not to drive with his wife and children in the car when he disclosed strong thoughts to drive head long into oncoming traffic. This advice would not have protected Sgt Hills or other road users. 6. Evidence was heard during the inquest that RAF Manston was being decommissioned and this impacted on the treatment available locally for Sgt Hills and impacted on communications with the DCMH and the sharing of relevant information.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 12th January 2021. 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 [redacted] (Wife of Sgt Hills) . I have also sent it to [redacted] C2 (DJEP-DIU-Sec1a) 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 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	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **North East Kent** 19th November 2020