Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **National Police Chiefs' Council** **1st Floor, 10 Victoria Street** **London** **SW1H 0NN**
1	**CORONER** I am Nigel PARSLEY, HM Senior Coroner for the coroner area of Suffolk
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 7th April 2022 I commenced an investigation into the tragic death of- **Anthony John Raymond INGRAM** The investigation concluded at the end of the inquest on 26th January 2023. The conclusion of the inquest was that:- **Anthony Ingram, died as the result of suicide** The medical cause of death was confirmed as: **1a Hanging**
4	**CIRCUMSTANCES OF THE DEATH** Anthony Ingram was found deceased at his second home in Westleton, Suffolk, on the 29th March 2022. When found, Anthony was inside the property, suspended by a rope around his neck. Anthony lived in London, and his mental health had been deteriorating over a period of time. On 29th March 2022, at approximately 13:30 Anthony left London and headed towards his second home in Suffolk. Anthony was known to be in possession of rope and a 'collapsible' bicycle when he left. The information regarding the rope and the bicycle was not passed to Suffolk police at the time the case was reported to them. At 17:50 a Suffolk officer attended Anthony's second home but did not enter although keys were available from a neighbour. Anthony's vehicle was not present, and the officer formed the opinion that he had insufficient information to enter the premises under Section 17,

	Police and Criminal Evidence Act at that time. Shortly after this time, Anthony's vehicle was found in a car park more than two miles from his second home, and police search activity was focussed there. At approximately 20:00, once Suffolk officers became aware that Anthony had a rope, and the search of the car park area had failed to locate him, they returned to the second home and entered, finding Anthony deceased. The collapsible bicycle was found in the hallway. Poor communication between the Metropolitan Police and Suffolk Constabulary meant that the officers on the ground were missing information which would have informed their decision making regarding the search for Anthony and informed their use of police powers. This resulted in a missed opportunity to find Anthony earlier than he was found.
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: Evidence was heard from police officers from both the Metropolitan Police and Suffolk Constabulary. The officers provided evidence of the details they respectively held regarding the missing person investigation surrounding Anthony's disappearance from London and subsequent death. It was clear that crucial information (that Anthony had a rope in his possession, and a collapsible bicycle providing a secondary form of transport) was not passed between the Metropolitan Police and Suffolk Constabulary. It was heard that there was no set format, or prescribed information requirements to be shared by officers reporting missing persons between one force and another. Investigating officers in the Metropolitan police spoke to the Suffolk Constabulary control room, whose staff logged what they were told onto the CAD record. This information was then relayed to the officers on the ground. Witnesses in this case stated that there is no standardised information sharing requirement or protocol for cross border missing persons investigations (including missing persons with suicidal ideation). I am concerned that, as there is no standardised information sharing requirements or protocols in such cases, in the future a force receiving details of a suicidal missing person may also not be informed that an individual has taken a means of suicide with them. In addition, other important information that may assist in the search for that person may also not be passed.
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 April 20, 2023. 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 **1. Anthony's next of kin.** **2. Chief Constable for Suffolk** **3. The Commissioner Metropolitan Police** 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 Senior Coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 23/02/2023**  **Nigel PARSLEY** **HM Senior Coroner for Suffolk**