


## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li><b>Surrey Police</b></li><li><b>Metropolitan Police Service</b></li></ol>
1	<p><b>CORONER</b></p> <p>I am Jonathan Landau, assistant coroner for the coroner area of South London</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 11 March 2024 an investigation was commenced into the death of Neil John Woodley. The investigation concluded at the end of the inquest on 17 July 2024. The conclusion of the inquest was suicide.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Neil Woodley was found [REDACTED] at 7.25 am on 4 January 2024. Evidence from suicide notes suggest he killed himself some time overnight.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>Mr Woodley's brother and sister-in-law gave evidence at the hearing that a colleague of Mr Woodley called the police on the morning of 4 January concerned that he had not arrived at work. Their evidence was that an ambulance arrived to carry out a welfare check the following day (5 January) at around 1pm. They were told that the reason for the delay was confusion between Surrey Police and the Metropolitan Police.</p> <p>On the evidence before me, including that of Mr Woodley and his wife, I am satisfied that an earlier attendance would not have affected the outcome. However, I am concerned that failures in communication could result in avoidable fatalities in future cases.</p>

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report,</p>
	<p>namely by 17 September 2024. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I am 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 other person who I believe may find it useful or of interest.</p> <p>In this case, I have sent it to Mr Woodley's brother.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	 <p><b>Jonathan Landau, HM Assistant Coroner</b> 23 July 2024</p>