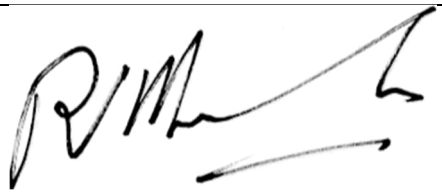
ANNEX A

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. Chief Executive of NHS England**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 11th June 2024, I commenced an investigation into the death of John Michael Kirkman, aged 36 years. The investigation concluded at the end of the inquest on 26th June 2025. The conclusion of the inquest was: **SUICIDE**
4	**CIRCUMSTANCES OF THE DEATH** John Michael Kirkman had a long history of paranoid schizophrenia which was difficult to control despite appropriate medication. He had a number of detentions and admissions pursuant to various sections of the Mental Health Act 1983. In the weeks leading up to his death, he is likely to have researched the toxicity of [redacted] products, and indeed, arranged for a number of packs of [redacted] to be purchased on his behalf. I have found that John was alive at 22.15 hours on 26th December 2023 and is likely to have ingested [redacted] some time between then and 03:00 hours on 27th December. He is likely to have died around 07:51 hours on 27th December 2023. There was no realistic opportunity to have saved his life by the staff at the home. There were no suspicious circumstances or third-party involvement surrounding his death. I have found that John knew that taking these [redacted] would result in death

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. The **MATTERS OF CONCERN** are as follows. – Evidence was heard that if a mental health *screening assessment* is carried out in one part of the country, the results and conclusions reach may not necessarily be immediately available in another part of the country, when a further assessment is carried out. Evidence suggested that such assessments capture important clinical information and the lack of availability of preceding data may adversely influence subsequent assessments. Screening may form the basis for onward referral for formal mental health assessments. Absence of vital background information could result in an incorrect prioritisation for onward referral as it did in this case. The situation is not ubiquitous but does occur due to the use of different I.T. systems in various institutions.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action, possibly by reviewing the compatibility of IT systems within the NHS.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd September 2025. 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 NHS England; MIND; Royal College of Psychiatrists and Family. 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	 **8th July 2025**