



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

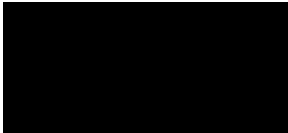
NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Ministry of Defence
1	CORONER I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York
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 20 July 2023 I commenced an investigation into the death of Malik BUNTON aged 21. The investigation concluded at the end of the inquest on 03 October 2025. The conclusion of the inquest was that he died as a result of suicide.
4	CIRCUMSTANCES OF THE DEATH On the evening of the 17th of July 2023 Malik Bunton was found suspended from a ligature [REDACTED]. His death was confirmed at the scene on the same date. During the inquest I heard evidence in relation to two separate incidents of self harm/suicidal ideation which preceded Mr Bunton's death. The first occurred on 26 March 2023 when Mr Bunton entered the River Ouse while intoxicated and with suicidal intent. The second occurred on 11 July 2023 when Mr Bunton consulted with a GP in the Defence Medical Service in relation to self harm [REDACTED]. He was referred to secondary defence mental health services for assessment but sadly took his own life six days later.
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: (brief summary of matters of concern) While I was unable to conclude that the following concerns caused or contributed to Mr Bunton's death, I make this report as I consider they impeded the ability of the RAF to properly assess Mr Bunton's suicide risk and, if repeated, will continue to impede the ability of the RAF to learn lessons from his death and mitigate future risk to other service personnel. 1. There was insufficient inquiry made of Mr Bunton and those service personnel most closely involved with the 26 March 2023 incident as to the circumstances in which it occurred. While it was accepted that Mr Bunton chose to minimise the incident, it could easily have been established by proper inquiry of these parties that Mr Bunton had sent a concerning message before entering the water with suicidal intent, and then been taken by the police to hospital where he was offered psychiatric assessment. The results of these



	inquiries would have better informed subsequent oversight of Mr Bunton's welfare by his Chain of Command. 2. There were weaknesses in the Clinical Care Review process undertaken by the Defence Medical Service following Mr Bunton's death. While the review of the 11 July 2023 consultation occurred very promptly after Mr Bunton's death, the GP involved in the consultation was unaware that her informal discussion of the case with a senior colleague was being captured as part of a formal review process. She was also never asked to check the accuracy of the contents of the review document produced following this discussion, which compromised the accuracy of the review document itself, as well as impacting on evidence subsequently available to the Service Inquiry and the inquest. The purpose of the Clinical Care Review process is to identify any concerns around clinical decision-making and mitigate the risk of recurrence of the same, and should therefore be based on a clear and verified record of events. 3. There were inexplicable delays and some apparent deliberate obstructions to the gathering of important evidence from key witnesses. This impacted on the extent and quality of evidence ultimately available to both the Service Inquiry and the inquest. Examples of this were – - The long delays in obtaining formal accounts from key witnesses either in writing or via an interview process. - The absence of any account from Mr Bunton's colleague who attended hospital with him following the 26 March 2023 incident. Such an account would have informed the process of inquiry referred to at point 1 above as well as the Service Inquiry and inquest. - The decision to delete Mr Bunton's service email account without consideration of its potential importance in the context of a suspected suicide. - Withholding statements of two key witnesses from the Service Inquiry panel for some months following Mr Bunton's death. - The absence of a clear and contemporaneous account of the 11 July 2023 GP consultation, either in the Clinical Care Review document and/or a separate formal account of events obtained from the doctor concerned.
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 December 03, 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 [REDACTED] 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 coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	Dated: 15/10/2025  Catherine CUNDY Area Coroner for North Yorkshire and York