



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: [REDACTED] Operational Team Leader, Liaison and Diversion Team, Northamptonshire Healthcare NHS Trust, Newland House, Campbell Square, Northampton
1	CORONER I am Anne PEMBER, Senior Coroner for the coroner area of Northamptonshire
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 On 25 February 2025 I commenced an investigation into the death of Paul John APPLEBY aged 62. The investigation has not yet concluded and the inquest has not been heard.
4	CIRCUMSTANCES OF THE DEATH Paul Appleby had been arrested for a drink driving offence on Friday 21 st February 2025. He was charged and remanded in custody. Late on the evening of 21 st February 2025, Mr Appleby was assessed by Dr [REDACTED] (Forensic Medical Examiner) who advised that Mr Appleby should be seen by Court Liaison and Diversion before release from custody. In the early of Saturday 22 nd February, the detention officer at Wheatley Wood Justice Centre, Cherry Hall Road, Kettering, sent an email to the community psychiatric nurse at the Criminal Justice Centre to inform him or her that Mr Appleby should be reviewed prior to being released. Mr Appleby was not seen by the Liaison and Diversion Team. At around lunchtime on Saturday 22 nd February 2025 Mr Appleby was found deceased having jumped from the Grosvenor Centre, Northampton.
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: I understand that the Liaison and Diversion Team at Northampton has not operated a Saturday Court Service for several years. Previously an 'On Call' service has been provided. I am concerned that this lack of service could give rise to future deaths.
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 16, 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 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	Dated: 21/10/2025 [REDACTED] Anne PEMBER Senior Coroner for Northamptonshire