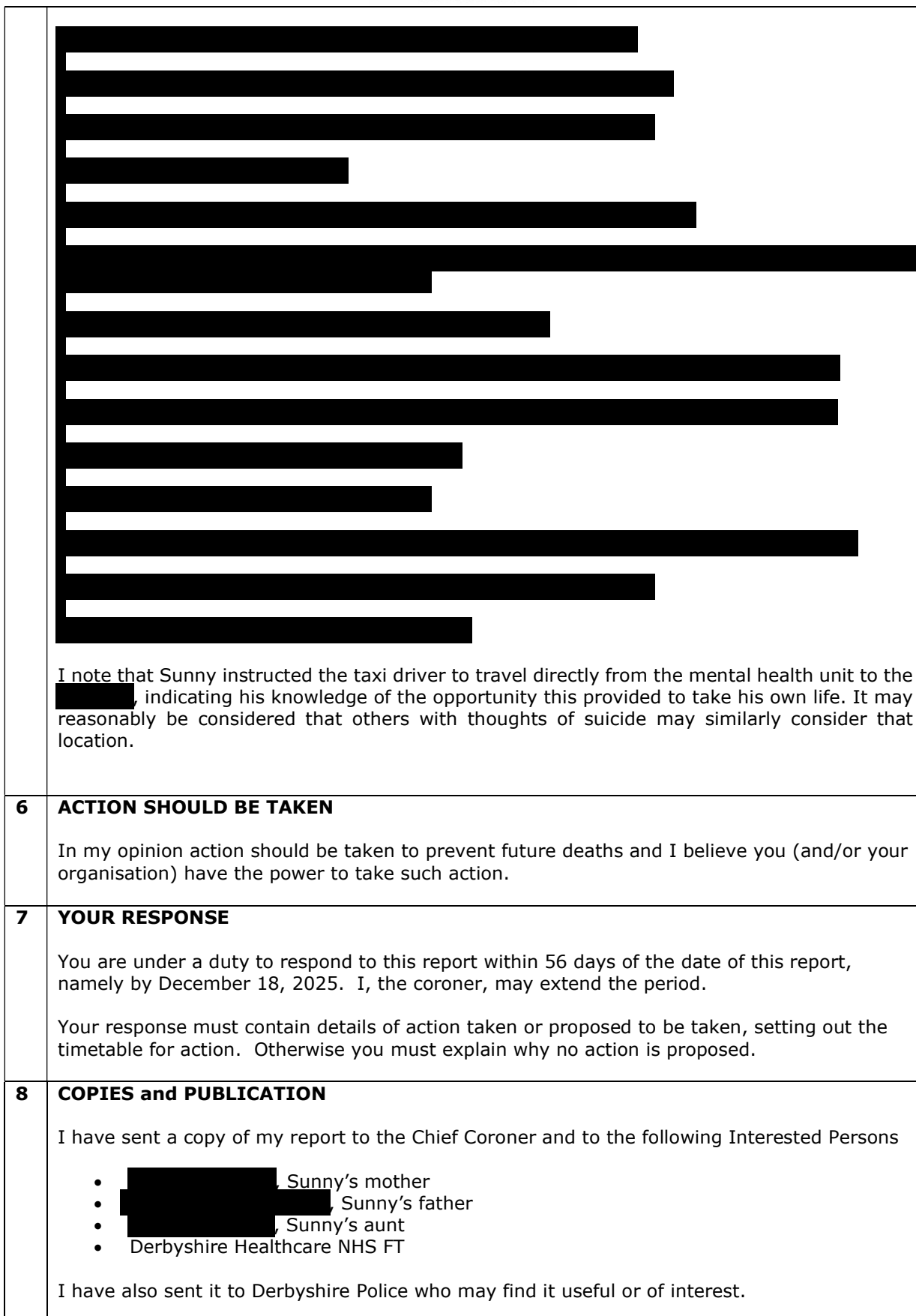




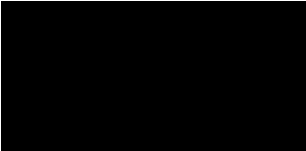
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: Chesterfield Borough Council
1	CORONER I am Peter Nieto, senior coroner for Derby and Derbyshire coroner's area.
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 29 February 2024 I commenced an investigation into the death of Mr Saranveer Singh Sihota aged 42. The investigation concluded at the end of the inquest on 25 September 2025. The inquest was a jury inquest as Mr Sihota was a detained patient under the Mental Health Act 1983 at the time of his death. The conclusion of the inquest was: - Suicide
4	CIRCUMSTANCES OF THE DEATH Mr Saranveer Singh Sihota (known as Sunny) died on Friday 23 February 2024 at [REDACTED] in Chesterfield. He died due to injuries sustained [REDACTED] a height of approximately 70 feet. Immediately before he had been perched on the low perimeter wall of the top storey. Sunny was a detained patient at the then Hartington mental health unit at the Callow site in Chesterfield. He had left the unit without permission and without the knowledge of staff [REDACTED] staff and police were unable to dissuade Sunny from his actions.
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: It is reported to me that the [REDACTED] has a relatively low wall to it. Given the height of the top floor there appears to be a clear risk that, either deliberately or accidentally, people might fall to the ground with high chance of death. I am not aware of what barriers there may be to the perimeters of the lower floors. The police officer who enquired into Sunny's death has provided the following list of incidents to me (please note this was a quick search which is believed to be an underestimate of the number, and notably does not include Sunny's tragic death): -





	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: 23 October 2025  Peter Nieto Senior coroner Derby and Derbyshire