REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Chief Constable of Suffolk Constabulary** **2 The Chief Executive of Suffolk County Council**
1	**CORONER** I am Peter TAHERI, HM Assistant Coroner for the coroner area of Suffolk
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 04 December 2023 I commenced an investigation into the death of **Anthony Robert CARD** aged **48.** The investigation concluded at the end of the inquest on 06 November 2025. The conclusion of the inquest was: **Narrative Conclusion - Tony died by way of Suicide** The medical cause of death was confirmed as: **1a Suspension by Ligature** **1b** **1c** **1d** **2**
4	**CIRCUMSTANCES OF THE DEATH** **The Jury's findings on the questions of how, where and when Anthony Robert CARD ('Tony') came by his death were:** **"Suspension by ligature.** **Between about noon on 21 November 2023 and about noon on 22 November 2023.** **15 Duke Street, Ipswich."** **The relevant circumstances for the purposes of this report are as follows:** **(a) Shortly before noon on 21 November 2023, Tony was dropped off outside the hotel at which he was staying, at 15 Duke Street, Ipswich, by two police officers.** **(b) These police officers assessed Tony as not appearing to be both suffering from mental disorder and in immediate need of care and control. They decided that they therefore did not have power to detain Tony under section 136 of the Mental Health Act 1983. The police officers also considered that they had no other legal**

	power to interfere with Tony's liberty at the time he left their company. **(c) One of these police officers, after their interaction with Tony, submitted a 'Protecting Vulnerable Persons' report ('PVP') on police computer systems. In this report, he described the risk to Tony as a Medium risk, as, he said in evidence, he considered that there was some risk to Tony associated with his mental health; but it was not a High risk as Tony was not in need of immediate care and control.** **(d) Both front-line police officers in this case understood the PVP to have the effect of communicating, via the Multi-Agency Safeguarding Hub ('MASH'), the information about Tony's contact with police that day to the appropriate agencies who could contact Tony in due course in 'slow time', if they deemed it appropriate, to offer him support. These agencies would include Tony's primary / secondary medical / mental health care providers, bearing in mind that Tony lived in Doncaster and so would not be under the care of any Suffolk NHS Trust.** **(e) I subsequently received evidence from Suffolk Constabulary that both officers were in fact mistaken in their understanding that a PVP, concerning a Medium risk to self from mental ill-health, would be communicated on to other agencies via the MASH.** **(f) From the evidence received, including a statement from Detective Chief Inspector [redacted] of Suffolk Constabulary, it appears that in fact there is no mechanism that facilitates such communication.** **(g) DCI [redacted]' statement explained that:** **"MASH will process adult mental health-related referrals from police only if the individual has care and support needs that meet the threshold for a Section 42 enquiry under the Care Act 2014."** **"A care and support need goes beyond a mental health concern alone. It refers to situations where an individual's ability to live safely and independently is compromised because they cannot meet essential daily living tasks without help. For example, an adult with severe depression who is also neglecting personal care and living in unsafe conditions, or a person with dementia who cannot manage medication or nutrition and is at risk of harm."** **Referrals to MASH that do not meet this threshold "are not shared with partner agencies. This approach has been jointly agreed by Suffolk Police and Adult Social Care".** **"[T]here is no referral pathway through MASH for mental health support outside safeguarding criteria."**
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 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: **Outside of situations where section 42 of the Care Act 2014 applies, there appears to be no mechanism available to enable front-line police officers who wish, of their own volition and with the subject's consent, to communicate risk information, arising out of an interaction with an adult at Medium risk to self from mental ill-health, to medical or mental health care providers, whom may be the right person or agencies to provide support in the medium term.**

	The information that an individual has, for example, been reported as presenting in such a way that police have had to consider detaining them under section 136 of the Mental Health Act 1983 could be important risk information that would assist medical or mental health care providers. **Not having this risk information available in future assessments may adversely affect decision-making - e.g., not having this information available could contribute to a decision not to admit compulsorily the patient for mental health care if they were to present again in, say, one week from the police interaction.** **If such risk information is not received by treating medical or mental health care providers, there may be omission to offer vital further mental health support.**
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 January 02, 2026. 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 have also sent it to who may find it useful or of interest. 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 other 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.
9	**Dated: 07/11/2025**

	[redacted] **Peter TAHERI** **HM Assistant Coroner for Suffolk**