H M Area Coroner for Gloucestershire
Mr Roland Wooderson

REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Roland Wooderson Area Coroner, for the coroner's area of Gloucestershire.
2.	**DATE OF REPORT** 16 April 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** The Chief Constable for the Gloucestershire Constabulary You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 June 2026 I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** During the inquest it appeared that recommendations had been made by the Police Professional Standards Department. It was unclear whether the following recommendation had been actioned. *Front of House (Receptionists) to be trained on recording a VIST (Vulnerability Investigation Screening Tool) for these types of events. If a victim reports an assault but does not wish to take it further, and the staff member can see that the victim is distressed, then this could be completed to highlight that the victim is vulnerable which may trigger other support.*
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 19 July 2024, I commenced an investigation into the death of Roger John Ginger, aged 77 years. The inquest was concluded on 8 April 2026. The jury found that: Mr Ginger died as a result of the combined effects of hypertensive heart disease, severe coronary artery atherosclerosis and diltiazem toxicity and that he died on 16 July 2024 at 26 Brannigan Court Northway Tewkesbury. The conclusion of the jury as to the death: Suicide
8.	**CIRCUMSTANCES OF DEATH** The deceased was found at his home address with paramedics confirming death at the scene. The cause of death was associated at post mortem with drug toxicity and the jury returned a conclusion of suicide. The deceased had, shortly prior to his death, been concerned about the possibility of an assault from a third party. He had attended a local police station and spoken to a customer contact advisor and expressed his concerns. He did not say he wished matters to be taken further. A subsequent police enquiry concluded (inter alia) with a recommendation

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9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: The recommendation of the Professional Standards Department may not have been actioned despite the recommendation being made in a report dated 9 July 2025
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: Mr Ginger's family Chief Constable for Gloucestershire Constabulary I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE *Area Coroner Roland Wooderson*