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 Department for Science, Innovation and Technology** **2 National Police Chiefs' Council**
1	**CORONER** I am Laura BRADFORD, Senior Coroner for the coroner area of East Sussex Coroners Service
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 13 May 2024 I commenced an investigation into the death of Thomas Alexander Ferdinand MAYHEW (known as Ned), aged 16. The investigation concluded at the end of the inquest on 21 April 2026. The conclusion was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of 6 May 2024, Ned Mayhew, attended a revision session at school. At shortly before 16:30, he left the school premises near to Coldharbour Road. At 17:17, a member of the public made an emergency call to police after a body was found hanging in a tree in a wooded area off Coldharbour Road. ID was found in the pocket which confirmed the person was Ned. It is understood from the evidence that the [redacted] ligature was taken from the school sports center on 2 May 2024. Paramedics were able to achieve a return of spontaneous circulation and Ned was conveyed to the Royal Sussex County Hospital. Ned sadly did not regain consciousness and on 9 May 2024, Ned's death was confirmed following brain stem testing.
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) I heard expert evidence from a Consultant Intensive Care Physician, who explained that there is a limited window of time (approximately ten minutes) during which emergency life-saving treatment can be provided to a person who has applied a ligature, such that cerebral hypoxia may be prevented. Cerebral hypoxia, if not reversed, may ultimately lead to cardiac arrest and death. The expert confirmed that if medical intervention is delivered within this critical period, death may be prevented. The expert further confirmed that a person who has applied a ligature may appear deceased to an observer, for example, displaying no movement and being unconscious,

	while nevertheless remaining within that ten-minute window during which the outcome may still be altered. I also heard evidence regarding the Public Emergency Call Service Code of Practice ("PECS"). I was told that where a member of the public contacts emergency services to report the discovery of an apparently deceased person, the call would likely be directed to the police in line with the PECS. In addition, I heard that where a caller is unsure which emergency service they require, the operator must connect the caller to the police, in accordance with a request made by the National Police Chiefs' Council. Having considered the expert evidence, I am of the view that in these critical circumstances every second is of importance. The process of routing a caller to the police, who may then refer the matter to the ambulance service and/or instruct an ambulance to attend, carries a risk that valuable minutes may be lost.
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 June 18, 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 **Ned's family** **Solicitors on behalf of Bede's School** **Solicitors on behalf of Sussex Police** 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: 23/04/2026** [redacted] **Laura BRADFORD** **Senior Coroner for**

	East Sussex Coroners Service