

**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 \(2026\)](#).

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| 1. | <p><b>CORONER</b></p> <p>I am Anne PEMBER, Senior Coroner, for the coroner area of Northamptonshire.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 2. | <p><b>DATE OF REPORT</b></p> <p>14 August 2026</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 3. | <p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 4. | <p><b>THIS REPORT IS BEING SENT TO</b></p> <ol style="list-style-type: none"> <li>1. Department of Health and Social Care</li> <li>2. NHS England</li> <li>3. East Midlands Ambulance Service</li> </ol> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by October 09, 2026. I, the coroner, may extend the period if an appropriate application is made.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 5. | <p><b>YOUR RESPONSE</b></p> <p>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.</p> <p>I have a duty to send a copy of your response to the Chief Coroner.</p> <p>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.</p> <p>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.</p> <p>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages <a href="#">Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary</a>.</p> |

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| 6.  | <p><b>SUMMARY OF CORONER'S CONCERN</b></p> <p>See below</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 7.  | <p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 8.  | <p><b>INVESTIGATION AND INQUEST</b></p> <p>On 24 March 2025 I commenced an investigation into the death of Samuel HAND aged 32. The investigation concluded at the end of the inquest on 12 August 2026. The conclusion of the inquest was that:<br/> Samuel Hand contacted both the Mental Health Hub and East Midlands Ambulance Service in the early hours of the morning of 22nd March 2025, seeking help with his suicidal ideation. He was let down by both services. He took an excess of [REDACTED] together with alcohol which led to his untimely death on 23rd March 2025.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 9.  | <p><b>CIRCUMSTANCES OF DEATH</b></p> <p>CIRCUMSTANCES OF DEATH</p> <p>Samuel was a 32 year old gentleman with a long history of mental health problems, emotional unstable personality disorder, drug overdose, bi-polar disorder and suicidal ideation.</p> <p>At 3:48 hours on the morning of 22nd March 2025, he contacted the Integrated Response Hub saying he was going to hang himself- he stated in 2022 that he jumped in front of a train to kill himself. He wanted staff to take him to a place where he could have immediate support.</p> <p>As a result of the above call, a call was made to East Midlands Ambulance Service at 04:03 hours from the Integrated Response Hub explaining the situation. EMAS explained there could be an 8 hour wait and the call received a category 3 disposition. At 04:36 hours Mr Hand made a 999 call to EMAS saying he had taken a significant overdose- [REDACTED] mg tablets of [REDACTED] and an unknown quantity of [REDACTED] mg [REDACTED].</p> <p>He advised EMAS that he had got it in his head what he wanted to do to end his life but would not disclose it and would just go and do it. Again this was given a category 3 disposition.</p> <p>It was not until 07:17 hours the following morning that Mr Hand's case was given a category 2 disposition.</p> <p>A double crewed ambulance was allocated at 07:47 hours. The first ambulance arrived at Mr Hand's address at 08:01 hours- 357 minutes after the 999 call.</p> <p>Mr Hand was confirmed deceased at 08:40 hours by a paramedic from EMAS.</p> |
| 10. | <p><b>CORONER'S CONCERNS</b></p> <p>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</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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|     | <p>the circumstances it is my statutory duty to report to you.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:</p> <p>Mr Hand made a 999 to EMAS at 04:36 hours. During this call he clearly stated he had taken a significant overdose- [REDACTED] mg tablets of [REDACTED] and an unknown quantity of [REDACTED] mg of [REDACTED]. He clearly expressed suicidal ideation. Evidence was given at the inquest that the reason for the category 3 disposition was that the “conversation did not disclose any of the high risk drugs that enable a higher disposition. Under the NHS Pathways this is a category 3.”</p> <p>It is clear that no consideration was given to the number of tablets taken when deciding the relevant category for disposition. Concentration appears to be entirely on the type of drugs used.</p>                       |
| 11. | <p><b>COPIES AND PUBLICATION OF THIS REPORT</b></p> <p>I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.</p> <p>I also may send a copy of the report to any other person who I believe may find it useful or of interest.</p> <p>I can confirm I have sent the report to:<br/> Mother of Samuel Hand<br/> Father of Samuel Hand</p> <p>I also have a duty to send a copy of the report to the Chief Coroner.</p> <p>You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner’s <a href="#">PFD Publication Policy (2026)</a>. 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.</p> |
| 12. | <p><b>SIGNATURE</b></p> <p>[REDACTED]</p> <p><b>Anne PEMBER</b><br/> <b>Senior Coroner for</b><br/> <b>Northamptonshire</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |