	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **2.** [redacted]
1	**CORONER** I am Jacqueline Devonish, area 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 6 March 2020 I commenced an investigation into the death of Andrew Gibbins, 54. The investigation concluded at the end of the inquest on 1 December 2020. The conclusion of the inquest was that he died from multiple skull and rib fracture with pneumohaemothorax due to a road traffic collision and that he had taken his own life.
4	**CIRCUMSTANCES OF THE DEATH** On 15.01.2020 Mr Gibbins who had a long history of mental health informal admissions ran into the path of a lorry on the A14 Westbound. Eye witnesses confirmed that his actions were deliberate. His injuries were incompatible with life. Recognition of Life Extinct (ROLE) at 20:50 hours. Mr Gibbins had been unescorted awaiting test results on Acute Assessment Unit (AAU). He had expressed to a security guard that he was feeling suicidal and that was why he was under Wedgewood unit. He appeared withdrawn but this information did not reach Wedgewood or the Staff Nurse.
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. – (1) The Hospital Security Guard guided Andrew Gibbins back to AAU looking lost and confused (following a cigarette break) when in a general way saying that he was feeling suicidal and that that had been the reason why he was under the care of Wedgewood. There were no immediate concerns for him, but the Security Guard had been concerned enough to ask for the Wedgewood staff member escort when he returned to AAU. Andrew's presentation had not been reported to any clinician at either AAU or Wedgwood.
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 18 February 2021. 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 am also under a duty to send the Chief Coroner a copy of your response. 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	**17 December 2020** Jacqueline Devonish