**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Chief Constable, South Wales Police**<br><br>**Chief Executive, College of Policing** |
| 1 | **CORONER**<br><br>I am Graeme Hughes, Area Coroner, for the coroner area of South Wales Central |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>I commenced an investigation on the 6th March 2018 into the death of Matthew William Lewis. The investigation concluded at the end of the inquest on 11th February 2019. The conclusion was "Suicide" and the medical cause of death was 1a. Hanging |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>I attach a copy of the record of Inquest.<br><br>The Inquest focused upon:-<br><br>a. The events of 27.2.18 leading to, & of Mr Lewis's hanging, the South Wales Police response to the incident, & the emergency medical treatment he received.<br><br>b. The clarity, appropriateness & any causative impact of the instructions given by the South Wales Police call handler to the *willing* rescuers [redacted] (who reported the finding of Mr Lewis hanging). I attach a copy of the transcription of the call which was played during the Inquest. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>*(1)* Both [redacted] in their evidence expressed confusion as to the instructions that were passed to them by the call handler. In particular, whether they should approach Mr Lewis and attempt to cut him down or refrain from |

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| | doing so *in the interests of scene preservation*<br>(2) The subsequent evidence of the Officer in Charge, [redacted] was to the effect that his primary role as a police officer was the preservation of life. The initial instructions of the Call handler here appeared inconsistent with that expressed overriding duty<br>(3) In any hanging episode, time is very much of the essence following suspension. Whilst it could not be determined on the evidence the exact time that that occurred on 27.2.18, medical evidence received at the Inquest indicated that death/irreversible brain injury would likely occur, no later than 5 minutes post suspension. With such a narrow "rescue window", the clarity of instructions to *willing* rescuers appears paramount. Whilst it was found on the evidence that the actions of the call handler were neither directly, nor indirectly causative of Mr Lewis' death, there is a risk that in the future, a repeat of confusing/inconsistent call handler instructions may lead to delay & potentially contribute to the prospects of an unsuccessful rescue<br>(4) Guidance to/training for call handlers as to how to deal with such scenarios would seem desirable/mandated |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **10th April 2019**. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to [redacted] partner [redacted] who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **13th February 2019** **SIGNED:**<br><br>**HM Area Coroner** |