GRAEME HUGHES

HER MAJESTY'S
ACTING SENIOR CORONER

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Constable of South Wales Police & The Chief Executive of the College of Policing**
1	**CORONER** I am Graeme Hughes Acting Senior Coroner for **South Wales Central**
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 04/04/2019 I commenced an investigation into the death of Deborah Margaret LAMONT. The investigation concluded at the end of an inquest on 17th January 2020. How, when & where she came about her death were found as follows:- On 28.3.19 Deborah Margaret Lamont has travelled to the Village Hotel, Whitchurch. There, at some time after 9.40pm she has tied a ligature around her neck and suspended herself from an anchor point above the entrance door. She was found deceased by South Wales Police Officers just after 11pm. The evidence was sufficient to determine that she intended the consequences of her actions to be her own death. My conclusion was Suicide
4	**BRIEF CIRCUMSTANCES OF THE DEATH** SWP officers attended room 161 at the Village Hotel at approximately 23:05 on Thursday 28/03/19 in response to a report from Hotel staff, concerned for the guest Debbie Lamont (DL). Staff had been unable to get a response from Debbie and when opening the door to her room they believed that she was slumped behind the door and were unable to open the door further than a few inches. Upon officers arrival staff used a key card to open the door and it was noted that a white bed sheet was wrapped around the overhead fire door closer which was attached to something heavy behind the door and inside the room. Officers have at this point tried to remove the sheet however it was taut. Officers managed to slide inside the room and found Debbie slumped on her knees facing the bathroom with the bed sheet tied in a noose around her neck and suspending her slightly against the door. She was limp, cold to touch & pale. There were no obvious signs of a disturbance. Officers have commenced CPR chest compressions and rescue breaths and applied the defibrillator pads to her for around 10 minutes until Paramedics arrived. The defibrillator repeatedly advised no shock was

	advisable and to continue CPR. Eventually Paramedics arrived and continued with CPR for around 30 minutes eventually declaring ROLE at 23:43 hours. DL had experienced a suicidal episode earlier in the day in the hotel where response officers have attended. They have noticed that she was upset, sat with tights tied around her neck and superficial scratch's to her wrists. Paramedics attended and she spoke with the police control room Mental Health supervisor at the time. It was determined that she would be able to stay at the hotel as follow up mental health contact would be arranged.
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 will 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 Inquest focused upon the response of the emergency services - SWP, WAST & CTMUHB Mental Health Nurse, to the earlier suicidal episode. Evidence was received from amongst others, [redacted] of SWP, [redacted] – paramedic from WAST & Mental Health Nurse, [redacted] regarding their involvement with DL. [redacted] gave evidence as to his interpretation of s136 Mental Health Act 1983(MHA). In particular, whether he believed that the power to remove DL arose in the particular circumstances he was presented with on the evening of 28.3.19. In summary, his interpretation of s136 was that, even if he had been satisfied that DL was suffering from a mental disorder & in immediate need of care, or control, the power to detain would not have been available to him, due to the exclusion in s136(1A). His interpretation of that sub-section was that as DL had paid for the hotel room in which she was staying, that was a room in which she was *living.* Regard was had during the Inquest as to the Department of Health Guidance to the changes to the MHA 1983, published in October 2017. No specific guidance as to the classification of a hotel room for the purposes of whether that falls within the exception in s136 (1A) is provided. Whilst it is accepted, both by myself, & in the Guidance, as above, that there will always be some degree of discretion for a police officer to exercise in relation to the interpretation of whether a person is *living* in a hotel room, the evidence here was that DL had booked into the room for one night & had no more than a bare licence to occupy it (which would contrast with, for example, an individual or family temporarily *housed* in a hotel room by a local authority, or a care home resident occupying indefinitely a room in a care home). Hence, based upon the evidence I received, and my interpretation (in these particular circumstances) of whether a hotel room came within s136 (1A) MHA, I found it likely that [redacted] did have the power to remove DL to a place of safety My concern is that faced with a similar situation (albeit in circumstances were the officer did consider a person was suffering from mental disorder and requiring of immediate care, or control), an officer may reach the same conclusion as [redacted] determine the power to remove did not exist, and this may lead to a risk of death to that individual. I would emphasise that whilst I interpreted s136 MHA as likely to afford [redacted] the power to remove DL on the night in question, I found his assessment of DL to be a reasonable one, and that the grounds to remove her did not exist as she was not in immediate need of care, or control.

	(2) I consider that it is necessary for the police to consider their interpretation of whether a hotel room falls within the exception provided for by s136 (1A) MHA, and to provide clear guidance, and instruction to officers faced with exercising their powers under s136 MHA in circumstances were an individual presents with suffering from mental disorder, is requiring of immediate care or control and at that time is located in a hotel room.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 16th March 2020. 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 College of Policing, the Local Health Board Mental Health Team and the family who may find it useful or of interest. 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	20/01/2020 Signature  Graeme Hughes Acting Senior Coroner **South Wales Central**

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