

«AuthorisingUserFullName» «AuthorisingUserAppointment» County of Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS		
	THIS REPORT IS BEING SENT TO:		
	1. The Chief Constable of Lincolnshire		
	2.		
1.	CORONER		
	I am Paul Cooper, Assistant Coroner for the Coroner area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.		
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made		
3.	INVESTIGATION and INQUEST		
	On 09/01/2020 I commenced an investigation into the death of Levi Craig Don Petitt, aged 19 on 23 rd December 2019. The investigation concluded at the end of the inquest on 30 th June 2021. The conclusion of the inquest was that Levi died as a result of Suicide, the medical cause of death being: 1a. Asphyxia 1b. Hanging 1c. 2.		
4.	CIRCUMSTANCES OF THE DEATH		
	1.A 999 report was received on 8 th December 2019 by Lincolnshire police that Levi had suicidal ideations 2.PC located Levi ,spoke to him and made sure he was safe before departure referring him.		
	to agencies that could assist relying upon Levi to take the initiative.		
	3.PC did not refer by PNN, complete a mental health proforma or refer the matter to anyone else in authority		
	4.PC readily accepted he thought Levi would follow up on his referrals and used his discretion on the night.		
	5.The family disagreed on medical grounds.		
	6.4 days later Levi committed suicide.		
5.	CORONER'S CONCERNS		



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	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)	PC was not aware of the Lincolnshire Police Concern for Welfare Policy Document PD238	
	(11)	PC admitted he used his discretion in dealing with the deceased and did not make a PNN ,complete a mental welfare proforma report, or reported the incident to any other officer on the night	
	(111)	when asked did not know what happened to the mental health proforma when completed	
	(IV)	Procedures appear to be in place to deal with such incidents. Please explain what training your officers receive to deal with such circumstances and are you satisfied your officers are sufficiently aware of the said policy document and act upon it.	
	(IV)		
	(V)		
6.	ACTION SHOULD BE TAKEN		
		y opinion action should be taken to prevent future deaths and I believe your organisation has bower to take such action.	
7.	YOU	JR RESPONSE	
		are under a duty to respond to this report within 56 days of the date of this report, namely by 2/2020. I, the coroner, may extend the period.	
		r response must contain details of action taken or proposed to be taken, setting out the table for action. Otherwise you must explain why no action is proposed.	
8.	COF	PIES and PUBLICATION	
	I ha	ve sent a copy of my report to the Chief Coroner and to the following Interested Persons	
		(a) Lincolnshire Police (b)	
	Iam	also under a duty to send the Chief Coroner a copy of your response.	
	sen	Chief Coroner may publish either or both in a complete or redacted or summary form. He may d a copy of this report to any person who he believes may find it useful or of interest. You may be representations to me, the Coroner, at the time of your response, about the release or the lication of your response by the Chief Coroner.	
	Date	e: «AuthorisedDateShort»	
	«Au	thorisingUserSignature»	



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and S. Corpe