**GRAEME D HUGHES**

**HIS MAJESTY'S SENIOR CORONER**

**SOUTH WALES CENTRAL CORONER AREA**

**CORONER'S OFFICE**
**THE OLD COURTHOUSE**
**COURTHOUSE STREET**
**PONTYPRIDD**
**CF37 1JW**

[redacted]

## 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>[redacted] **- The Chief Constable of South Wales Police** |
| 1 | **CORONER**<br><br>I am Graeme D Hughes, Senior 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>On 5 November 2019 I commenced an investigation into the death of John Henry WHITE. The investigation concluded at the end of the inquest on 20/10/2022.<br><br>The conclusion of the Jury was: -<br><br>We as a jury have come to the conclusion of suicide, to which a failure to release the ligature sooner<br><br>possibly contributed to chances of survival. |

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| | The medical Cause of Death was found to be:-<br><br>**1a Hypoxic Brain Injury**<br><br>**1b Hanging**<br><br>**1c**<br><br>**II** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>These were recorded as:-<br><br>On the 20th October 2019, John Henry White suspended himself [redacted] Police were in attendance. John was eventually released and transferred to the Royal Glamorgan Hospital where he died on 23rd October 2019.<br><br>The Inquest focused upon: -<br><br>A. How, and in what circumstances Mr White came about his death<br><br>B. The unavailability of issued equipment (primarily ligature cutters) to the response officers attending upon Mr White leading to an extended period of suspension by ligature.<br><br>The jury found that this omission to act to cut the ligature had possibly contributed to his death. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern.<br><br>In my opinion there is a risk that future deaths will occur unless action is taken.<br><br>In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>1. In June 2020 the Independent Office for Police Complaints recommended that all response vehicles be equipped with a ligature cutter or similar.<br><br>That recommendation was accepted by Chief Superintendent Clare Evans on behalf of South Wales Police in July 2020.<br><br>I received evidence from Chief Inspector [redacted] that in 2020 South Wales Police had determined to widen the scope of the recommendation to all frontline officers. She informed me that ligature cutters were delivered to the force in July 2022.<br><br>As at the 4th of October 2022, approximately 25% of those had been distributed to frontline officers. |



[redacted] [redacted]

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| | She was unable to assist the court with the timeline for the remaining distribution other than in relation to her own force division - a target date of the 22nd of October 2022.<br><br>She candidly accepted in her evidence that the incomplete distribution to all frontline officers at this time meant that the scenario faced by the response officers attending upon Mr White on the 20th of October 2019 was still patent & the opportunity to release a suspended individual currently dependent upon whether there had been distribution to the tasked response officers.<br><br>That is the concern that I have and wish you to consider and address.<br><br>2. A collateral concern, not directly causative of Mr White's death, arose during the inquest and which I also wish to bring to your attention.<br><br>This concerns the availability of bespoke training to response officers in relation to handling similar situations faced by the officers on the 20th of October 2019.<br><br>The three attending officers on 20.10.19 indicated that they had not received specific training (notwithstanding the evidence I received from retired Detective Chief inspector [redacted] that he had prepared a video for officers covering this type of scenario as part of mental health awareness training in 2017) to assist them in managing the scenario they faced.<br><br>Retired Detective Chief Inspector [redacted] indicated that he had delivered training that year to officers within the force for the purposes of cascading the same widely.<br><br>Given both the statistical and anecdotally evidenced increase in *mental health crisis* incidents (on occasions resulting in death) that your officers are required to attend, I believe that it would be of benefit to those officers who have not received this bespoke training, (as well, perhaps those who may benefit from refreshing their knowledge) for consideration to be given to reinstating the same and expediting its delivery widely – i.e. to all *frontline* staff.<br><br>I would stress that the two immediate response officers cannot be, nor indeed were, criticised in their individual interactions with Mr White on the 20th of October 2019. Indeed, and without the apparent benefit of the training, they interacted with Mr White in accordance with the approach advocated by retired Detective Chief inspector [redacted]. |
| 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 have 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 20th December 2022. 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. |



[redacted] [redacted]

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to Mr White's family, The College of Policing (for their consideration & wider dissemination) and (possibly former) Deputy Assistant Commissioner, [redacted] (who was seized of the IOPC's recommendation in 2021) 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 | 25 October 2022<br><br>**SIGNED:**  <br><br>H M Senior Coroner for South Wales Central Coroner Area |