REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** MPS [redacted] College of Policing [redacted]
1	**CORONER** I am Paul Rogers, HM Assistant Coroner, for the Coroner Area of Inner West London
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 the 21st March, 22nd March and 23rd March 2023 evidence was heard touching the death of Daniel LYLE. He died on 20th March 2020 aged 46 years. **Medical Cause of Death** I (a) Multiple Injuries **How, when, where Daniel LYLE came by his death:** At about 0820 on 20th March 2020 Daniel Lyle who suffered from paranoid psychosis had a psychotic episode in the garden area outside Morgan House, Tachbrook Street, London SW1 During the course of this episode he climbed approximately 30 feet up into a tree. Police officers tried to engage him in efforts to encourage him to come down safely from the tree, but he did not come down. During his time in the tree he displayed paranoid and delusional beliefs. Whilst moving within the tree Daniel fell striking his head on the hard surface beneath the tree causing serious head and chest injuries. Despite efforts by police, fire brigade, ambulance and helicopter medical personnel to resuscitate him, Daniel died from his injuries in the garden area outside Morgan House, Tachbrook Street London. **Conclusion of the Coroner as to the death:** Accident
4	**Circumstances of the death:** Extensive evidence was heard by the court in the form of written and oral evidence, and I was able to view the body worn video evidence of police officers who attended a call to police about Daniel's behaviour that day.

	Of particular significance for the purpose of this report are the following matters: (1) Daniel suffered from paranoid psychosis and had done for many years. (2) Part of the features of his psychosis were delusional beliefs. (3) On 20th March 2020 Daniel climbed high into a tree – over 25-30 feet above the ground whilst expressing delusional and psychotic beliefs that dead people were in the estate refuse bins. (4) Police officers attended and tried to encourage Daniel to come down from the tree for his safety. (5) He was approached and spoken to by more than one police officer until one officer PC [redacted] took over communication. (6) Other officers remained present but tried to keep a distance away and did not try to interfere with the one officer communicating with Daniel. (7) PC [redacted] the officer communicating with Daniel informed the court that he had received some training from the Metropolitan Police service in relation to dealing with those with mental health issues, and had received other training in different forces. He told me that he had pieced together information on how to deal with someone displaying mental health issues as a "patchwork" over 15 years. He told me that training on the presentation of symptoms and strategies to deal with those in mental health crisis would be something he would value. He said that whilst he did have some training and there was overlap in officer safety training, he would value individual training specifically on symptoms, presentation and strategies to de-escalate situations involving those displaying mental health difficulties such as psychotic and other distressed behaviour. (8) Daniel underwent an acute psychotic episode beginning before he entered the tree and whilst he was in the tree. Whilst moving within the tree Daniel fell sustaining fatal injuries. (9) Inspector [redacted] is the Central Mental Health and Adult Safeguarding team lead which sits within the Continuous Policing Improvement Command. [redacted] told me of initiatives and training developments addressing mental health within policing. [redacted] accepted that bespoke refresher training for frontline officers in helping to deal with those suffering mental health episodes was in the process of being developed by the MPS. [redacted] referred me to initiatives by the MPS Western Area Mental Health Team which had an element of training about the signs of mental ill-health and learning disorders, and general communication in a mental health crisis, and also referred to a one day course rolled out in 2018-19 for officers on mental health issues.
5	**Matters of Concern:** (1) Whilst recognising that police officers cannot be doctors or nurses nor should they be, it is a concern that training for officers whether initial or refresher is not sufficiently focused on: (a) an understanding of the symptoms and presentation of mental health conditions; (b) possible practical strategies informed by mental health professionals and those suffering such conditions as will enable officers to optimise their decision making under the national decision making model.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: The Family of Daniel Lyle [redacted] [redacted] (MPS) [redacted] IOPC - [redacted] LAS - [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	**23 May 2023**  **Paul Rogers** **HM Assistant Coroner Inner West London** **Inner West London Coroner's Court** **33 Tachbrook Street** **London SW1P 2ED**