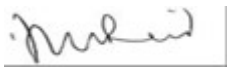
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted], Chief Constable, Dyfed-Powys Police.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the 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 [the details below are fictional]** On 1 June2022 I commenced an investigation and opened an inquest into the death of Matthew David Harris. The investigation concluded at the end of the inquest on 20 June 2023. The conclusion of the inquest was that Mr. Harris died as the result of suicide.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Harris come by his death?", the jury recorded as follows: *"*On 27.5.22 Matthew David Harris was found in his cell at HMP Long Lartin having suspended himself [redacted]. As a result of his injuries he died on 29.5.22 at the Alexandra Hospital, Redditch. Matthew David Harris had a background of mental health and substance misuse issues." Mr. Harris had been arrested on 13.5.22 by Dyfed-Powys Police on suspicion of murder, and was subsequently charged and remanded into custody at HMP Swansea on 16.5.22.
5	**<u>CORONER'S CONCERNS</u>** 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) Following his arrest, and before he was interviewed about the alleged offence of murder, Mr. Harris was assessed by a consultant forensic psychiatrist, [redacted]. Although [redacted] concluded that Mr. Harris was fit to be detained and fit to be interviewed, he did note possible symptoms of Post Traumatic Stress Disorder, likely due to some trauma in Mr. Harris' background, possible symptoms of a personality disorder, and "potentially a psychotic process, with potential underlying delusional beliefs";

	(2) During his police interview on 14.5.22, when describing his movements before the alleged murder had taken place, Mr. Harris told officers he had [redacted], intending to jump off in order to take his own life, but had decided against it because "I thought no, I've got to reveal all this first"; (3) Despite the fact that these comments revealed very recent suicidal ideation on Mr. Harris' part, no mention of them appears to have been made in any of the following documents: (a) The Person Escort Record (PER) and Suicide and Self-Harm (SASH) Warning forms which accompanied Mr. Harris from police custody at Haverfordwest Police Station to Haverfordwest Magistrates' Court on 16.5.22; (b) The PER and SASH Warning forms which accompanied Mr. Harris from Haverfordwest Magistrates' Court to HMP Swansea later that same day. (4) Although I was quite satisfied that the omission of these comments from the above documents made no difference to the sad outcome in this case, I am concerned that the failure by Dyfed-Powys Police officers to realise that such comments ought to be included on a PER and SASH Warning form, if repeated in future, may lead to a person in custody's risk of suicide and/or self-harm, being either underestimated, or ignored completely.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Constable of Dyfed-Powys Police 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 **16 August 2023.** 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: (a) Deighton Pierce Glynn solicitors (acting for Mr. Harris' family); (b) Government Legal Department (acting for HM Prison & Probation Service); (c) Practice Plus Group; (d) Midlands Partnership NHS Foundation Trust; (e) Swansea Bay University Health Board; (f) HM Chief Inspector of Prisons; (g) Independent Advisory Panel on Deaths in Custody. 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	**21 June 2023**  **David REID** **HM Senior Coroner for Worcestershire**