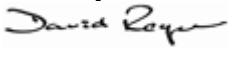
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Constable of South Wales Police**
1	**CORONER** I am David Regan, Assistant Coroner, for the coroner area of 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** A Coronial investigation was commenced on 27th October 2020 into the death of Leighton Alan Dickens. The Investigation concluded at the end of the inquest which I conducted with a jury on 18th – 28th September 2023. The conclusion was a narrative conclusion and the medical cause of death was 1 (a) pressure on the neck (incomplete or atypical hanging)
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as: - Leighton Dickens died by incomplete atypical hanging alone in his home address on 14th October 2020. The narrative conclusion which the Jury returned was: Leighton Dickens died by hanging himself in circumstances where his intention could not be ascertained. It is the juries understanding, that it was a

	missed opportunity on the part of the police not to detain Leighton Dickens at hospital until he had been assessed by a Mental Health Professional. The Inquest focused upon: - a. Mr Dickens' mental health condition and behaviour on the night of his death. b. The fact that police officers came upon him by the side of the road in an undressed state in the presence of his partner who was trying to convey him to hospital. c. His presentation and behaviour towards the officers before during and after arrival at hospital d. The decision by officers not to invoke their powers under s. 136 Mental Health Act and to leave Mr Dickens at hospital in circumstances in which they knew that he had not been subject to medical assessment and intended to leave. e. The limited sources of support available to assist or guide the officers.
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 the withdrawal of the mental health triage support provided to the police by mental health nurses, the medically qualified sources of urgent support available to police officers to assist them to safeguard the public are limited to the mental health crisis teams. (2) The crisis teams may not be readily available and deal with their own case load. (3) The alternative support available from a mental health tactical adviser, is not provided by a clinically qualified member of staff and does not have access to the PARIS mental health records system. (4) The intended replacement of the mental health triage support was to have been by the "111 press 2" service. This has not been put in to place and there is no current timescale for it to be put into place.

	(5) This leaves officers with limited sources of qualified mental health advice, with access to relevant clinical records, when responding to the risks posed by those suffering from mental health crisis within the community
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th November 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 family who may find it useful or of interest. Welsh Government, Medical Director of the Cwm Taf Morgannwg University Health Board, Medical Director of the Cardiff and Vale University Health Board, Medical Director of the Swansea Bay University Health Board. 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	**29th September 2023** **SIGNED:**  **D Regan** **Assistant Coroner**