REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Constable, West Midlands Police** **Criminal Justice Mental Health Liaison Team, Midland's Partnership Trust**.
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner for the Black Country.
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 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 26 March 2023, I commenced an investigation into the death of Mr Parminder Singh Sanghera born on the 7 July 1980 who died on the 13 February 2023. The investigation concluded at the end of the inquest on 16 July 2024. The inquest was heard before myself sitting without a Jury and my conclusion at inquest was one of Suicide. The medical cause of Mr Sanghera's death was recorded as 1a) Compatible with a combination of drowning and [redacted]
4	1. At 5.23pm on 12 February 2023, a call was made to West Midlands Police to report a male running around naked in Wolverhampton. 2. Mr Parminder Sanghera was detained and arrested for outraging public decency. He had a head injury and displaying behaviour that concerned officers about his mental health and was taken to New Cross Hospital in Wolverhampton. 3. They arrived at hospital at 6.26pm and was discharged as fit for detention at 11.47pm after being treated. 4. Mr Sanghera was then taken to Oldbury custody suite where a risk assessment was undertaken, and his detention authorised at 12:34am on 13 February 2023. 5. Mr Sanghera was kept in custody throughout the night under level 3 observations and was seen by a Health Care Professional (HCP) during the night. 6. A decision was made to release Mr Sanghera without charge, and a pre-release risk assessment completed at 1.51pm on 13 February 2023, stated "no" for concerns about risk of suicide or self-harm following release.

	7. The custody records further stated that Mr Sanghera was suffering from behavioural issues and that he had been reviewed by L&D (Liaison and Diversion) and assessed for mental health issues the day before. He was not found to warrant a full Mental Health Act assessment the previous day. 8. Mr Sanghera was reported to be unwilling to leave and force was used to escort him from the cell and the custody suite by two police staff. 9. Transport arrangements were not deemed necessary, and it was stated that he was not showing signs of mental vulnerability. 10. External CCTV footage showed that after Mr Sanghera left custody at around 1.55pm. He stood outside the custody suite for a period. He then walked away from the custody suite and returned to the car park area numerous times. He was last seen on CCTV outside the custody suite at 3.52pm walking towards the canal towpath. 11. At 5.00pm a log was created that a male had been found deceased in the canal near to Oldbury custody suite. He was discovered face down with a [redacted]. An ambulance attended and sadly life was pronounced extinct at 6pm at the scene.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. During the course of the inquest, I heard evidence Mr Sanghera was deemed to be suffering from behavioural issues rather than a mental health crisis and no full Mental Health Act assessment took place either at New Cross Hospital or whilst in custody at Oldbury Police station. 2. The risk assessments performed in hospital and police custody identified no concerns of risk of suicide or self-harm from release. However, evidence at the inquest showed that he was suffering from a mental health crisis at the time. 3. My concern is that given the erratic behaviour he was displaying and his vulnerability, further consideration should have been given for a full mental health act assessment to take place before release. Therefore, you may wish to consider reviewing the arrangements and assessments required before discharge from hospital or being released from custody.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 October 2024. 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 Person, family of the deceased. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**Mr Zafar Siddique** **Senior Coroner** **Black Country Area** **12 August 2024**