



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:</p> <p>1. Professional Standards Department, West Yorkshire Police, Laburnum Road, Wakefield WF1 3QP 2. Independent Office for Police Conduct (IOPC), PO Box 473, Sale, M33 0BW</p>
1	<p>CORONER</p> <p>I am Oliver Robert Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern).</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 29/08/2024 I commenced an investigation into the death of Martin Ian Stubbs, aged 50. The investigation concluded at the end of the Inquest on 24/10/2024. The conclusion of the Inquest was that Mr Stubbs' death was a suicide by hanging. He had hanged himself at his home address on 26/08/2024 and left notes to his family indicative of an intention to end his life. The medical cause of death was 1a) Hanging.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Stubbs was a serving Police Officer. On 29/11/2022, nine days after receiving a long service and good conduct award at a formal ceremony in Wakefield, he was arrested by officers from West Yorkshire Police Professional Standards Department and bailed. He was suspended from duty. He remained suspended and on bail until his death. He had sought medical advice and assistance because of the mental strain of being suspended for so long, and a note recovered from the scene stated his belief that West Yorkshire Police had contributed to his death.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>Mr Stubbs' father (a former officer himself and still a civilian police employee) expressed his firm belief that the length of time he had been suspended from duty had played a significant part in</p>

	<p>his son's decision to take his life. It is a concern that someone subject to an internal disciplinary process has a legitimate expectation that that process will be dealt with expeditiously in the interests of all parties, and that that legitimate expectation was not met in Mr Stubbs' case. Mr Stubbs' family do not understand whether the delay in concluding the process reflects resource issues or an institutionalised practice of allowing such matters to drift without proactive management to bring them to a conclusion. Anecdotally, Mr Stubbs' family are aware of other long outstanding internal disciplinary proceedings and fear other families may have to go through an experience similar to theirs.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13/12/2024. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> <p>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.</p>
9	<p>Signed:</p> <p>Oliver Longstaff Area Coroner West Yorkshire (E)</p> <p>Date: 25/10/2024</p>