



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. [REDACTED] – National Police Chief's Council (NPCC)2. [REDACTED] – Chief Executive Officer, College of Policing3. [REDACTED] – West Yorkshire Police
	<p>CORONER</p> <p>I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 15th March 2023, I commenced an investigation into the death of Anugrah Abraham ("Anu"). Anu died on the 4th March 2023 in Woodland near Red Rock Lane in Bury. He was 21 years old. The medical cause of death was confirmed as 1a) Hanging.</p> <p>I recorded a conclusion of Suicide recording the circumstances as follows: "The deceased was a serving West Yorkshire police officer. He had been on annual leave since the 16th February 2023. He was due to return to work on the 4th March 2023. The prospect of returning to work is likely to have been a source of distress to the deceased. On the 3rd March 2023 in the early afternoon he left his home address. There was nothing in his behaviour which gave rise to concerns from his family. At 22:50 hours when he had not returned home, Greater Manchester Police were contacted and he was reported missing. In the early morning of the 4th March 2023 the deceased was located in a wooded area near Red Rock Lane, Radcliffe. He had died as a result of hanging with the intention of ending his life."</p>
4	<p>CIRCUMSTANCES OF DEATH</p> <p>In 2021 Anu had joined West Yorkshire Police ("WYP") under the Police Constable Degree Apprenticeship programme ("PCDA"). This was in conjunction with Leeds Trinity University ("LTU"). At the time it was only possible to join the police if you already had a degree or undertook at degree alongside training to be a police officer. In 2021 the application programme was online and there was no face to face assessment. In addition, a decision had been taken by WYP Chief Officers to remove the in-force interviews.</p> <p>Of note, Anu had not achieved the grades required at A level to undertake a stand alone policing degree.</p> <p>Prior to commencing the PCDA there is no evidence of Anu having any issues with his mental health.</p> <p>The court heard from a large number of witnesses in respect of various aspects of the PCDA and how it operated in practice.</p>

I found as a matter of fact that :

- there should have been closer working between the Central Assessment Unit in WYP, in particular the student officer's assessor and the District Sgts who had day to day line management responsibilities for the officer.
- Anu had emerged from his 12 week training at Carr Gate on a development plan. This was not immediately known to his District Sgts and also raised concerns as to the decision to place officers onto patrol when they had failed to demonstrate the skills required of them.
- Anu was subject to what were described as "Stage 1 meetings in accordance with Regulation 13 of the Police Regulations 2003". Within WYP, use of regulation 13 had developed into a series of staged meetings. Anu was subject to a "stage1" meeting. It was not immediately clear where the process for implementing various stages of Regulation 13 emanated from. In Anu's case his District Sgts were not aware Anu was subject to such a review as this information was not shared with them.
- The lack of shared information between those tasked with the various aspects of Anu's management led to mixed, inconsistent messages to Anu as to how he was developing and performing.
- On the 24th September 2022 Anu was referred to Occupational Health ("ODU") the waiting time to be seen was three months. He was not seen until the 15th December 2022. The referral had been for a back injury but also his mental health. There was an inadequate assessment of his mental health and a lack of consideration of any adjustments required given his mental health issues were linked to his work and the PCDA.
- During this time he also accessed the Employee Assistance Programme and was referred to a counsellor. In October 2022 it was recorded that he was suffering from severe anxiety and severe depression. This was linked to the PCDA programme and his work. He reported having suicidal thoughts. This information provided to the counsellor was not shared with WYP.
- On the 4th January 2023 Anu had a lengthy meeting with one of his Sgts following which he attended a quarterly review. The serious concerns WYP had as to Anu's ability were not shared or reflected in the quarterly review.
- There was a lack of clarity and understanding as to what options were available to students if they wanted to leave the PCDA programme after 2 years but continue with the degree element. Evidence was contradictory as to whether there academic credits could be used to continue on a degree albeit they may have to fund any remaining years.
- On the 13th January 2023 Anu made direct contact with the OHU where it was acknowledged he appeared to be in "intense mental distress." Whilst he was spoken to again later that day, there was no plan documented that he would be seen or re-contacted by OHU, this appeared to be because Anu had made direct contact and it had not been a referral from a senior manager. Anu should have been offered a face to face appointment.
- On the 23rd January following further concerns about Anu's work he had a meeting with a District Sgt and was advised he was being placed on a further development plan. A subsequent email was sent to Anu by his Sgt setting out his development. During the course of this meeting Anu indicated he felt suicidal. An urgent referral was made to OHU. The subsequent email to Anu in no way was reflective of a caring approach to an individual who was expressing suicidal thoughts.
- Following this urgent referral to OHU an appointment was offered for April 2023. Anu should have been offered an urgent face to face appointment.

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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 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:-

National Police Chiefs Council and West Yorkshire Police

1. The court heard that most OHU referrals within police forces now relate to mental health issues as opposed to physical health issues. Despite this, there are no specialist Registered Mental Health nurses recruited into WYP OHU. Indeed the court heard the situation within WYP may be indicative of the national picture.

	<p>2. Following Anu's death there was no investigation into the quality of care afforded to him by the OHU within WYP. Hence at the time of the Inquest, there had been no reflection by practitioners as to the quality of care provided and no learning in respect of processes and procedures. It was accepted that following the Inquest there were matters which would be considered. The lack of investigation meant learning from deaths in order to prevent future deaths was not addressed.</p> <p>National Police Chiefs Council National Wellbeing service</p> <p>3. The court heard as to the increase in mental health issues amongst Police Officers nationally. Despite this, the question of what <i>imminent</i> adjustments should be made or considered once an officer discloses suicidal thoughts, was unclear. This is before an OHU appointment. In this case Anu's mental deterioration was reportedly directly linked to his role as a police officer. It is acknowledged that this is a difficult issue and there will be issues such as confidentiality to consider.</p> <p>College of Policing</p> <p>4. Whilst the court heard there are now different routes into policing and there is no longer a requirement to undertake a degree. The court heard from a significant number of officers who had undertaken the PCDA. Many of the witnesses told the court of the impact this route into policing had on them at the time, including the levels of stress they incurred. The PCDA does continue to operate.</p> <p>College of Policing and National Police Chiefs Council</p> <p>5. Ensuring there is a full understanding across Police forces as to the PCDA and the sharing of accurate information with all those involved in the management of student officers so there is clear documented records and understanding as to how a student officer is progressing and whether they are likely to become an efficient constable.</p> <p>6. Consideration of the Regulation 13 process for PCDA students and how this works in practice across forces.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe each of you respectively have 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 <u>12th March 2025</u>. 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 namely:-</p> <p>Family of Anugrah Abraham National Police Chiefs Council College of Policing West Yorkshire Police Leeds Trinity University</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. 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>Date: 14 January 2025</p> <p>Signed </p>