REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable of Nottinghamshire Police**
1	**CORONER** I am Nathanael Hartley, assistant coroner for the coroner area of Nottingham and Nottinghamshire.
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** On 29th April 2024 an inquest was opened into the death of Paul Ian Taylor, aged 58. The inquest concluded on 17th December 2024. I made a determination at inquest that he died as a result of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Paul Taylor had been under police investigation for offences that necessitated consideration of the Suicide Prevention and Risk Management of Suspects policy, Nottinghamshire Police document PS260, by the police. That policy was complied with. It was appropriate not to arrest Mr Taylor at the outset of the investigation, so he was voluntarily interviewed and he was released under investigation for a two year period. Within a fortnight of him being made aware that criminal charges had been authorised, he intentionally took a large quantity of prescription medication and was found deceased at his home address on 3 January 2024.
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. – When a suspect is arrested for offences requiring a referral to a mental health nurse, commonly referred to in Nottinghamshire as "Liaison and Diversion" the custody sergeant makes that referral automatically, which allows the opportunity for a suspect to obtain assistance from a healthcare professional, if they desire. In addition, there are welfare assessments conducted by the officer in charge of the investigation. In cases where a suspect is interviewed on a voluntary basis for relevant offences, the suspect is not dealt with at a custody suite and a referral to a mental health nurse is

	not automatic. In this latter scenario, only welfare assessments are completed by the officer in charge of the investigation without any involvement from healthcare services.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18 February, 2025. 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 Persons: 1. Paul's family. I have sent a copy of the report to the College of Policing as I believe they may find it useful or of interest. I am under a duty to send the Chief Coroner a copy of your response and all interested persons who, in my opinion, should receive it. I may also send a copy of your response to any 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. She may send a copy of this report to any person who she 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	**Dated: 24 December 2024**  **Nathanael Hartley** **HM Assistant Coroner** **For Nottingham and Nottinghamshire**