Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chief Constable West Yorkshire Police**
1	**CORONER** I am Peter MERCHANT, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 15 February 2024 the death of Paul Andrew Alexander was reported to this jurisdiction. A forensic autopsy was conducted on 17 February 2024, and an investigation into the death was commenced. The investigation concluded at the end of the inquest between 13 and 15 May 2025. The medical cause of death was 1a cold water immersion. A narrative conclusion of the inquest was that: Paul Andrew Alexander had a long-standing history of mental illness since December 1989. In July 2022 a consultant psychiatrist following review changed his primary diagnosis to paranoid schizophrenia with a secondary diagnosis of mental and behavioural disturbance due to the use of cannabinoids. At the time of his death, he received oral medication of Haloperidol 8 mg per day. On 4 February 2024 at 00.12 hours a call was made to police expressing concerns for Paul's welfare. Under the Right Care Right Person framework, the call was redirected to the ambulance service who did not attend as they did not have a location for Paul. No emergency services were dispatched. This represented a missed opportunity. However, it is not possible to determine whether Paul's death would have been avoided given the likelihood is that his death occurred shortly after entering the water at Aspley Marina at around 04.43 hours on 4 February 2024.
4	**CIRCUMSTANCES OF THE DEATH** As identified above, Paul Alexander had a long-standing history of mental illness. At the time of his death, he was under the care of community mental health services who visited him regularly to monitor his compliance with taking his oral medication. The last contact prior to his death was on 29 January 2024 when his care coordinator visited Paul. No concerns were reported or noted. His care coordinator left Paul with a month's supply of Haloperidol. On 4 February 2024 at 00.12 hours a call was made to the police by a member of the public expressing concerns for Paul's welfare. Under the Right Care Right persons framework (RCRP) the call was redirected to the ambulance service who did not attend as the caller was unable to provide them with a location (contrary to information provided to the police in the initial call). The call was redirected back to the police. The caller became frustrated with being passed between the emergency services and terminated the call. No attempt was made to contact the caller again. As such no emergency services were dispatched. Subsequently, on 6 and 7 February 2024, following further calls to the police Paul was identified as a missing person, initially as a medium risk and then a high risk. On 14 February 2024, a body was discovered in the water at Aspley Marina, Huddersfield. This was subsequently identified as Paul.

	In the ensuing police investigation CCTV last identified Paul as being alive at around 04.43 hours on 4 February 2024 when he was seen running across a car park and down a flight of stairs towards the marina. He was not being chased and was observed on the CCTV to be behaving bizarrely. The conclusion was that he entered the water in the marina at that time and died as a consequence of cold-water immersion.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) In the course of the evidence, it became apparent the police had introduced RCRP in September 2023. RCRP is a police initiative arising out of a national agreement but to be implemented by individual police forces. Little or no consultation with other agencies had taken place prior to the implementation of RCRP in September 2023.Whilst I heard evidence that meetings with other agencies now do take place, the specifics of Paul's case and the broader issues it raises have not been discussed nor is there any understanding/ agreement in place as to how such a situation would now be addressed. As much as the court was advised was that if a similar situation arose today, there may be a discussion between operational managers in the respective police and ambulance call centres, but that this would be reliant upon the matter being brought to the attention of those respective managers by the call taker. The evidence from the RCRP lead at the ambulance service indicated the scenario that arose with Paul was not an isolated example. As such there appears to be a lacuna in how emergency services will respond to such a situation when it was accepted this was a call expressing concern for Paul's welfare.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action. I would invite the police, no doubt in conjunction with other agencies to consider the scenario to consider what steps could be taken to reduce the risk of deaths from such circumstances.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by July 18, 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 [redacted] I have also sent it to [redacted]

	[redacted] who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 25/05/2025**  **Peter MERCHANT** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**