MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Constable South Yorkshire Police

1. CORONER

I am Ms N J Mundy, Senior Coroner, for South Yorkshire, East District

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On the 16th May 2023 I commenced an investigation into the death of Peter Alfred Kelly. The investigation concluded at the end of the inquest on the 16th November 2023 . The conclusion of the inquest was:

4. CIRCUMSTANCES OF THE DEATH

Mr Kelly was taken into police custody on the evening of the 25th April 2023 following an assault whilst inebriated. He was placed in a cell, observed through the night and in the morning deemed fit enough for interview. The interview proceeded after which a decision was made that there was no legal basis upon which he could be detained further from an investigative point of view and thus arrangements were made for his release from custody.

The custody officer releasing Mr Kelly and who completed the Pre Release Risk Assessment noted that Mr Kelly stated to have mental health issues which were treated with sertraline. There is a question on that form which states "how are you feeling now" but this was left blank. In evidence the officer stated that he considered Mr Kelly's demeanour to be jovial, he caused no difficulties whilst in police custody, he did not feel that he was in crisis and felt that he was fit for release. However, whilst giving evidence he expanded on these comments by stating that he believed that Mr Kelly should have been seen by a health professional while in custody, he referred to having a Liaison and Diversion team and that he felt that the opportunity for them to assess was missed. He indicated that Mr Kelly had been dealt with "very fast" in custody that day and he assumed Mr Kelly was let out "too quick" he suggested that South Yorkshire Police missed an opportunity and that there are procedures in place and thus he feels that the organisation let Mr Kelly down, potentially. He informed me that the Liaison and Diversion team would check their own computers to see who they

wanted to assess and then come down and assess them and he speculated that the team may not have got round to him because he was released too quickly. Furthermore, he considered that the reference to depression and self harm on the assessments that took place in custody should have triggered a review by a mental health professional. .
The Inquest was suspended pending obtaining further information and resumed where evidence was provided from both the Liaison and Diversion team and in relation a professional standards referral. Accepted the evidence provided by the LND team which was essentially that the computer records they have access to merely list those that are in police custody, their name and the reason for their arrest and does not include any detail regarding mental health. There is space for officers to put LND in the margin which means that an assessment is being requested. However, many requests for assessment are made by those working in the custody suite contacting the LND directly by phone to express any concerns and to ask for an assessment.

Following this risk assessment Mr Kelly was released on the morning of the 26th April. Mr Kelly was found hanged at 07:45 on the 27th April and it was believed he had been dead for some time.

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 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. -

1. Failure of a custody sergeant to understand the processes for involving Liaison and Diversion team.

2. Lack of knowledge regarding the information that is available to the liaison and diversion team on the police connect system and the facility for police officers to enter LND on that system as a flag.

3. Failure to properly complete the Pre Release risk assessment and failure to understand the importance of the question asking an individual how they are feeling at the point of release.

4. A lack of understanding as to the triggers which may lead to contact with LND not just during a person's time whilst held in custody but at the point of release.

5. It appears that there is a training need for those working within the custody suite to understand how the system works with LND and the importance of adequately addressing those who are potentially vulnerable with regard to their mental health at the point of discharge.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you, Lauren Poultney 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 the **9th February 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: [redacted].

I am also under a duty to send the Chief Coroner a copy of your response.

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.

15 December 2023

Ms N J Mundy, LL.B (hons)

for South Yorkshire East