ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable, South Yorkshire Police Headquarters, Carbrook House, 5 Carbrook Hall Road, Sheffield S9 2EH**
1	**CORONER** I am Marilyn Whittle, Assistant Coroner, for the coroner area of South Yorkshire (West)
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 8 March 2024 an investigation was commenced into the death of Andrew Herrin Dodds. An inquest started on 6 November 2025 and concluded on 7 November 2025. The cause of death was: 1a [redacted] 1b [redacted] .
4	**CIRCUMSTANCES OF THE DEATH** Andrew Herrin Dodds was assessed by mental health services at Northern General Hospital on 10 August 2023 after expressing suicidal thoughts. He was discharged and referred to the alcohol care team, GP primary mental health team and provided with details of CRUSE, Andy's Man Club and IAPT. Andrew then self referred to the single point of access and was accepted for further crisis assessment. He was deemed high risk and reported a plan to end his own life. He was assessed at the Longley Centre and agreed to further assessment by the Home Treatment Team. On 16 August he attended the Longley Centre but left before he was seen. Sheffield Health and Social Care (SHSC) were concerned as they were unable to contact him and reported this to South Yorkshire Police. Andrew then later contacted SHSC and made an appointment to attend the next day. He did not attend the appointment the next day and his friend stated he had left that morning. SHSC contacted SYP as they

were unable to contact him. The Police were unable to contact Andrew and a missing persons report was created for Andrew on 17 August 2023.

SYP were unable to contact Andrew and contacted both his friend and his brother. On 19th August Andrew's brother contacted SYP to state he was at a hotel and he was located by Police at a hotel in Sheffield.

On 20 August Police were called to a hotel in Sheffield as Andrew was threatening to harm himself. The Police used their s136 Powers to take Andrew to a place of safety for a mental health assessment. SHSC were informed of this by SYP and that he was conveyed to the s136 at Rotherham, Swallownest Court as the s136 in Sheffield was full.

SYP handed over Andrew to Swallownest court and provided details to them. It is clear for the documentation form that next of kin details were not provided. Andrew's brother was informed he was at the s136 suite but then despite him being concerned for his bother received no further updates from SYP and was not informed to contact the s136 suite directly. He was under the impression that SYP would keep him updated.

SHSC tried to contact Swallownest Court for any update on the assessment and outcome but did not receive any. I was told they continued to be concerned for Andrew's welfare.

A mental health act assessment was undertaken that determined he did not require any medical recommendation, there was no evidence of mental illness that required admission or referral to secondary services. No next of kin information was available to them and so no information or communication was made with them either during or following the assessment. The outcome of the assessment was not communicated to SHSC or SYP. Andrew was provided with a taxi to take him to Sheffield Train Station as he stated he was going to stay with his brother.

At Sheffield Train Station he presented himself to the station manager requesting his laptop be given to the Police and stating that he was being followed by a gang from Germany. BTP Officers spoke to Andrew. I was informed that they undertook a PNC check which identified that he was known to mental health services and there was mention of him being suicidal. I was told it did not contain any information that he had recently been a missing person and that he had recently been detained under s136. There was no next of kin details. The BTP Officer emailed the South Yorkshire Police Force Control to check if they had any details about Andrew and he received an email in response which mentioned he believed he was being followed by gangs and had been a missing person a few days previously but this report was now closed. Due to the lack of information they did not contact mental health services for more information or contact next of kin to confirm that Andrew was stating he was making his way to them. They asked him if he felt suicidal and he answered no. I was told they had no reason to believe he was lying and had no reason to hold him therefore they allowed him to get on a train.

SHSC continued to try to contact Swallownest court for the outcome of the assessment and Andrew to no avail during this period due to their continuing concerns.

Unfortunately on the train Andrew took his own

	life. He was found by the train conductor when the train was pulling into Tamworth train station and despite being attended to he was pronounced deceased at the scene.
5	**<u>CORONER'S CONCERNS</u>** 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. – (1) Police did not pass over relevant details including next of kin to the s136 suite meaning next of kin could not be contacted. They also did not inform next of kin to contact the s136 directly and did not provide any further updates. This happened shortly after a shift change over so whether a full handover was provided between officers to allow this information to be given is not clear. (2) There was missing information on the PNC check which meant that Andrew was not flagged as recently being held under s136. The further email from force control also did not mention that he was recently detained under s136. I was told if this had been on the system BTP would have contacted mental health services for more information.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 12 January 2026. 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 Interested Persons. 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 other 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	**17 November 2025** **Marilyn Whittle, HM Assistant Coroner**