REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. [redacted], Chief Constable, Greater Manchester Police, Central Park, Northampton Rd, Manchester M40 5BP. 2. [redacted], Chief Constable, South Yorkshire Police, Carbrook House, 5 Carbrook Hall Rd, Sheffield S9 2EG
1	**CORONER** I am Tanyka Rawden, Senior 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. 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 11 August 2023 I commenced an investigation into the death of Roger Gary Leadbeater aged 74. The investigation concluded at the end of the inquest on 22 January 2026. The conclusion of the inquest was unlawful killing.
4	**CIRCUMSTANCES OF THE DEATH** Roger died on 9 August 2023 due to multiple stab wounds inflicted by a patient who was detained in hospital under the Mental Health Act and who had absconded from escorted leave. The patient had been known to Mental Health Services since 2008 and had experienced psychosis and command hallucinations telling her to hurt others. She had previously killed animals and assaulted people, and she presented a risk to animals and people. During her last admission to hospital between October 2022 and August 2023, the patient was violent to staff. She absconded nine times, attempted to abscond fifteen times, and failed to return from leave three times. Despite handovers between police forces and between the police and the Trust not being clearly recorded, there was evidence of the patient using drugs, carrying weapons and making threats to harm people during her periods of absence. On 7 August 2023 the patient's care was transferred to a new inpatient Consultant Psychiatrist and Responsible Clinician. During a thirty-minute board round meeting that morning a period of escorted leave was authorised. This decision was made without clear documentation of the reasons for the decision, without consideration of a detailed risk assessment, and outside of the policies which stated that leave after a suspension should be reviewed face to face at the next Multi-Disciplinary Team Meeting.

	The patient absconded whilst on escorted leave and two days later her actions brought about Roger's death.
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. – During the inquest evidence was given by both South Yorkshire Police and Greater Manchester Police that hand overs between police forces, and between Greater Manchester Police and the Greater Manchester Mental Health NHS Foundation Trust were inadequate and not clearly recorded. This resulted in the Greater Manchester Mental Health NHS Foundation Trust being unaware of, or unclear about, significant risk factors such as the patient assaulting others, making threats to harm others, using drugs and carrying weapons during her periods of absence. This impacted on their subsequent decision to grant the patient leave, including the granting of leave for the final time, two days before Roger died. The inquest heard that handover forms were being developed by both forces and policy changes were planned to support the new form, but this process had not been completed. The evidence provided to the Court on 7 January 2026 was that, as in August 2023, the content and quality of hand overs still relied on individual officers acting without guidance or documentation. On 22 January 2026 the Court was told both police forces now have a hand over form, but both forces have not updated the relevant policies to support its implementation or audit its use. I am concerned that without a robust handover process in place, key information about those detained under the Mental Health Act and being transported by police will not be appropriately communicated. This is turn may affect risk assessments and decisions around patients being granted leave.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 20 March 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 following Interested Persons: • The family of Roger Gary Leadbeater via their legal representative. • Greater Manchester Mental Health Trust Foundation Trust. I have also sent it to:

	• Home Office Direct Communications Unit, 2 Marsham Street, London, SW1P 4DF. • Royal College of Policing, College of Policing, Leamington Road, Ryton-on-Dunsmore, Coventry, CV8 3EN. • The National Police Chiefs' Council, 50 Broadway, London, SW1H 0BL. • Association of Police and Crime Commissioners, Lower Ground, 5-8 The Sanctuary, Westminster, London SW1P 3JS. who may find it useful or of interest. 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. 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	[redacted] 23 January 2026