

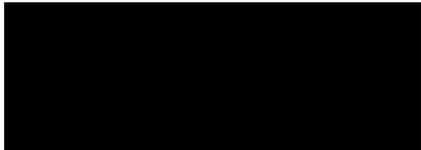


## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1 Chief Constable [REDACTED]</b> <b>Chair of the National Police Chiefs Council</b> <b>50 Broadway</b> <b>London</b> <b>SW1H0BL</b></p>
<b>1</b>	<p><b>CORONER</b></p> <p>I, Penelope Schofield, Senior Coroner for the Coroner area of West Sussex and Brighton and Hove</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 17 January 2025 I commenced an investigation into the death of Benjamin WEBSDALE (known as Ben) aged 50. The investigation concluded at the end of the inquest on 28 January 2026. The conclusion of the inquest was a narrative conclusion namely that:</p> <p>Ben died by suicide. Ben's mental health had first deteriorated following the suicide of a young person whom he had released from custody as the duty Custody Sergeant and Ben's subsequent attendance as a witness in his inquest proceedings. His mental health suffered further cumulative decline following a separate allegation of police misconduct and his subsequent arrest; the investigation was ongoing at the time of his death. Prior to these incidents, he did not have any mental health history.</p>
<b>4</b>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 16<sup>th</sup> January 2025 Ben [REDACTED] Ben was a serving Police officer at the time of his death and was the subject of a police misconduct investigation being investigated by the Independent Office police conduct. Papers having only been served upon him a few days before his death.</p>
<b>5</b>	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows: (brief summary of matters of concern)</p> <ol style="list-style-type: none"><li>1. Evidence was heard at the Inquest that there is no local or national recording of cases where police officers have died by suicide or who have attempted suicide whilst under police investigation for an offence of Police Misconduct. Without this information the Police service cannot identify if suicide is more prevalent amongst Police Officers and whether additional measures need to be put in place to support officers who are in this position.</li><li>2. Similarly I heard evidence that Police officers are repeatedly exposed to high levels of suicide incidents and trauma yet not all Police forces in England and Wales had implemented the recognised "STEP" campaign (Suicide Trauma Education</li></ol>



	Prevention).
<b>6</b>	<b>ACTION SHOULD BE TAKEN</b>  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.
<b>7</b>	<b>YOUR RESPONSE</b>  You are under a duty to respond to this report within 56 days of the date of this report, namely by April 14th, 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.
<b>8</b>	<b>COPIES and PUBLICATION</b>  I have sent a copy of my report to the Chief Coroner and to the following Interested Persons   <b>Sussex Police</b> <b>Independent Office for Police Conduct.</b>  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. They may send a copy of this report to any person who they believe 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.
<b>9</b>	Dated: 17/02/2026    Penelope SCHOFIELD Senior Coroner for West Sussex, Brighton and Hove