REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1. CORONER

I am Mr. Ian Potter, Area Coroner for Kent and Medway.

2. DATE OF REPORT

20 May 2026

3. 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. THIS REPORT IS BEING SENT TO

1. Chief Constable of Kent Police

You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 July 2026. I, the coroner, may extend the period if an appropriate application is made.

4. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary

5. SUMMARY OF CORONER'S CONCERN

The concerns relate to:

- Lack of policy / procedure for minimising suicide risk and safety-netting those released from police custody following an arrest for offences known to have significantly increased risks.
- No requirement for officers to receive ongoing / updated training regarding the conducting of welfare checks for those thought to be at risk of self-harm / suicide.

6. ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe you have the power to take such action.

7. INVESTIGATION and INQUEST

On 23 June 2025 an investigation was commenced into the death of [PM], aged 44 Years.

The investigation concluded at the end of the inquest on 13 May 2026. The conclusion of the inquest was 'Suicide'.

The deceased was last seen alive at his home address by a friend and a police officer at 21:36 on 18 June 2025, following concerns for his welfare. At about 19:20 on 19 June 2025, the deceased was found partially suspended [redacted]. An ambulance was called but sadly a paramedic verified the fact of death shortly thereafter. The deceased died as a result of the ligature around his neck, which was applied after he had taken a [redacted] overdose. He took those actions with the intention of ending his life.

I a Ligature Around The Neck

1b

1c

1d

II [redacted] Overdose

8. CIRCUMSTANCES OF THE DEATH

On the 18th June 2025 , Kent Police officers arrested the deceased on suspicion of an offence contrary to section 160 of the Criminal Justice Act 1988. A search of his home address was conducted under section 18(1) PACE and a number of electrical devices were seized. It was acknowledged that those arrested for this type of offence are at a significantly heightened risk of self-harm / suicide, particularly within the first 48 hours following release from police custody.

Police officers undertook a number of risk-assessments on him during his time in police custody and there was also an assessment by the Liaison and Diversion Service. No specific risks were noted.

Once released on bail (late afternoon / early evening of 18 June 2025), police officers understood the situation to be that he had no mobile devices and no home telephone, and he would therefore be unable to contact family members or support services, if he wished. He was advised that he was permitted to purchase another mobile telephone and that his service provider would be able to transfer his current number to a new phone. As it happens, but entirely unknown to police officers at the time, his work mobile telephone and laptop had not been seized. As such, he would have had the means to make contact with others had he wished to do so.

Family become concerned for his welfare on the evening of 18 June 2025. A friend attended his home address but initially got no response and therefore requested police to conduct a welfare check. This was undertaken and the police officer was satisfied that there was no immediate risk and that he had made plans for the following day.

In the early evening of 19 June 2025, he was found deceased inside his home address.

9. CORONER'S CONCERNS

During the course of the inquest I heard evidence 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. Part of the evidence in this inquest was that Kent Police does not have its own policy or standard operating procedure regarding the risk assessing and safety-netting of those arrested for this type of offence. I was directed to Operational Advice from the College of Policing (June 2019) entitled "Managing the risk of suicide for persons under investigation for online child sexual abuse and exploitation" ('the Advice'). It was confirmed that the Advice is available to officers on the Kent Police intranet. However, the nature of the Advice is such that some of it's content is not suitable for individual officers to make case-by-case assessments and decisions without there being an organisational level policy or procedure in place. While it is accepted, in the particular circumstances of this case, that parts of the Advice (e.g. paragraph 3.9) would not have altered the outcome, the concern remains regarding future risks to others.

2. 1heard evidence that, following initial basic training, officers at Kent Police are not required to undertake any face-to-face update or refresher training regarding welfare checks that they undertake regularly in the community. For the avoidance of doubt, I found that relevant officer undertaking the welfare check on the evening of 18 June 2025 was 'kind and compassionate' and did 'her best to conduct the welfare check'; however, it is not difficult to see that a lack of ongoing training raises risk in the future.

10. COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:

1. Family of the deceased

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026) Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

Signature