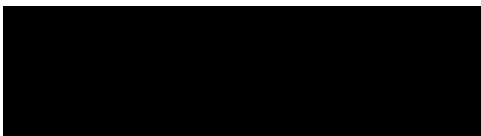


**REPORT TO PREVENT FUTURE DEATHS  
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**

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| 1. | <p><b>CORONER</b></p> <p>I am James Bennett, His Majesty's Senior Coroner for Herefordshire.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 2. | <p><b>DATE OF REPORT</b></p> <p>20/07/26</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 3. | <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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 4. | <p><b>THIS REPORT IS BEING SENT TO</b></p> <p>1. Chief Executive Officer, <b>College of Policing</b>.<br/>2. Chair, <b>National Police Chiefs' Council</b>.</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14/09/2026. I, the Coroner, may extend the period if an appropriate application is made.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 5. | <p><b>YOUR RESPONSE</b></p> <p>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.</p> <p>I have a duty to send a copy of your response to the Chief Coroner.</p> <p>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.</p> <p>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.</p> <p>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages: <a href="#">Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary</a>.</p> |
| 6. | <p><b>SUMMARY OF CORONER'S CONCERN</b></p> <p>Police Search Advisors (PoSAs) are crucial to high risk missing person enquires. The inability of police forces to provide 24/7 365 day coverage of PoSA responsibilities is being impeded by: (1) insufficient provision of training places, and (2) the number of training places made available does not appear to prioritise those forces in most urgent need of PoSAs or those that cannot fulfil 24/7 365 day coverage.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

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| 7. | <p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 8. | <p><b>INVESTIGATION AND INQUEST</b></p> <p>On 12 February 2026 I commenced an investigation into the death of Alan Hirst aged 19 years. The investigation concluded at an inquest held on 15 July 2026.</p> <p><b>The medical cause of death was confirmed at post-mortem examination as:</b><br/>1a. Immersion in Water.</p> <p><b>How, when and where the death occurred is as follows:</b><br/>On the evening 5 February 2026 Alan had been with friends in Leintwardine, Herefordshire. Around 23:00hrs he left on a bicycle in the direction of home. The bike had no lights but it was understood he was using his mobile phone for illumination. Last activity on his mobile phone and a credible sighting was around 23:15-23:30hrs. Upon realising he was missing his family contacted the police at 21:45hrs on 6 February. The police commenced active missing person enquiries. On 8 February he was located deceased in flood water around the A4110 near Adforton, near the location of his last known mobile phone activity and the credible sighting. Post mortem examination found no evidence of any traumatic injury or typical evidence of drowning. It is most likely his death was caused by cardiac arrest upon sudden immersion in cold water and he was deceased prior to being reported missing.</p> <p><b>The conclusion was:</b><br/>Death was the consequence of immersion in cold flood water. The available evidence does not reveal how Alan came to enter the water.</p>                                                                                                                                                                                                                                                                                                                 |
| 9. | <p><b>CIRCUMSTANCES OF DEATH</b></p> <p>In addition to ‘how, when, and where’ above, on the specific issue of the role of the PolSA:</p> <p>During a period of severe flooding West Mercia Police could not provide 24/7 PolSA coverage due to a shortage of PolSAs. When Alan was reported missing by his family on the evening of 6 February the duty PolSA determined the flood water around the last known location should not be searched, in part due to not having all the facts, and in part due to the risk posed by darkness and very cold conditions. Upon finishing his shift early morning on 7 February he commenced rest days aware there was no PolSA coverage from 7 February. Through good will he provided his contact details to the officers leading the missing person enquiry but was not contacted. The evidence demonstrated that had a PolSA been on duty on 7 February they would have reviewed the decision not to search the flood water. The following day, on 8 February the investigation team decided to search the flood water around Alan’s last known location and he was found within 20 minutes.</p> <p>Generally, I heard evidence from a West Mercia Police PolSA and the Head of Force Operations. West Mercia Police currently has nine PolSAs which is insufficient to cover PolSA responsibilities 24/7 365 days a year. Individual police forces have no control over the number of training places offered by the single authorised provider of the course (Police National Search Centre). It is not guaranteed all attendees will pass the demanding course. Police forces then have to wait for further offers of training places. It follows there is no quick fix and potentially West Mercia Police will persistently be unable to recruit a sufficient number of</p> |

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|     | <p>PolSAs. There was no evidence that the Police National Search Centre takes into account urgent need.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 10. | <p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:</p> <ol style="list-style-type: none"> <li>1. PolSAs are crucial to high risk missing person enquires. The inability of police forces to provide 24/7 365 day coverage of PolSA responsibilities is being impeded by: (1) insufficient provision of training places, and (2) the number of training places made available does not appear to prioritise those forces in most urgent need of PolSAs or those that cannot fulfil 24/7 365 day coverage.</li> </ol> <p>I have served this PFD report on the College of Policing as they are responsible for the Police National Search Centre.</p> <p>I have served this PFD report on the National Police Chiefs' Council as they have responsibility for coordination and collaboration of national operational response which may be relevant to what action can be taken.</p> |
| 11. | <p><b>COPIES AND PUBLICATION OF THIS REPORT</b></p> <p>I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.</p> <p>I also may send a copy of the report to any other person who I believe may find it useful or of interest.</p> <p>I can confirm I have sent the report to:</p> <ol style="list-style-type: none"> <li>1. Alan's Family.</li> <li>2. Head of Force Operations, West Mercia Police.</li> </ol> <p>I also have a duty to send a copy of the report to the Chief Coroner.</p> <p>You may make representations to me, the Coroner, about the publication of the contents of this report in line with Chief Coroner's <a href="#">PFD Publication Policy (2026)</a>. 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.</p>                                                                                                                                                                                                                    |
| 12. | <p><b>SIGNATURE</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |