

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 Rose FARMER, Area Coroner, for the coroner area of Gwent.
2	DATE OF REPORT 16 July 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.
4	THIS REPORT IS BEING SENT TO 1. Chief Executive Officer of the College of Policing You are under a duty to respond to this report within 56 days of the date of this report, namely by September 10, 2026. I, the coroner, may extend the period if an appropriate application is made.
5	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 <i>Non-responses to Prevention of Future Death (PFD) reports – Courts and Tribunals Judiciary</i> .
6	SUMMARY OF CORONER'S CONCERN I am concerned that current College of Policing training does not include recognised environmental and demographic factors associated with ABD and ABD fatalities. Awareness of such factors may assist officers in identifying a potential ABD presentation at an earlier stage, before severe physiological deterioration occurs. Earlier recognition is likely to facilitate earlier medical intervention and improve the prospect of recovery.

	Unless action is taken, there is a risk that future deaths may occur.
7	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 each of you have the power to take such action.
8	INVESTIGATION AND INQUEST On 08 August 2024 I commenced an investigation into the death of Gareth Richard WILLIAMS aged 34. A 2 week long Jury Inquest started on 30 June 2025. The Jury decided the medical cause of death was: 1a [REDACTED] toxicity in a male with Acute Behavioural Disturbance. The Jury gave a narrative conclusion: “Prior to the 31st of July 2024, Gareth took an unknown quantity of [REDACTED]. This resulted in him developing symptoms in keeping with acute behavioural disturbance. On the 31st of July 2024, Gareth barricaded himself in his bedroom and started breaking glass. Gareth's condition started to deteriorate. The ambulance service were updated and arrived at 04:24. The priority was to transfer Gareth to hospital. The ambulance departed at 04:58, at 05:11 whilst enroute to hospital Gareth went into cardiac arrest. Cardiopulmonary resuscitation was commenced and Gareth was conveyed to hospital where clinicians continued to attempt to revive Gareth. Sadly, they were unsuccessful and Gareth passed away at the The Grange University Hospital, Cwmbran at 06:14 hours on the 31st of July 2024.”
9	CIRCUMSTANCES OF DEATH At approximately 00:15 hours on 31 July 2024, Gareth Richard Williams made a 999 call reporting that unknown individuals were attempting to force entry into the property where he lived with his grandmother. Police officers attended within 15 minutes and conducted searches of the address. No evidence of attempted entry was found. During the 999 call, Gareth had also reported hearing fireworks being discharged within the property, although the call handler did not hear any such disturbance. The attending officers described Gareth as appearing paranoid. He was shirtless and sweating, it was a warm summer evening. Gareth was able to communicate, follow instructions but remained concerned about people breaking in even after searches were conducted by officers and reassurance and safety advice given. Gareth informed officers that he had taken [REDACTED]. The officers, did not consider that he was presenting with Acute Behavioural Disturbance (ABD) and left the address. From 02:47 hours, Gwent Police received further calls from Gareth reporting that individuals were attempting to break into the property and were within the

	property. Officers attended for a second time, arriving at approximately 03:34 hours. On this occasion Gareth had barricaded himself inside a small box room within the property and had smashed a window and was agitated and distressed. The attending officers quickly recognised that Gareth was exhibiting symptoms consistent with ABD and requested an ambulance. However, during the relatively short period before he could be transferred to definitive medical care, Gareth's condition deteriorated rapidly. Whilst being conveyed to hospital he suffered a cardiac arrest and despite prolonged CPR died at hospital. The jury decided that Gareth died as a result of cocaine toxicity in a male with Acute Behavioural Disturbance. The Court was provided with evidence that: • ABD appears to be more common when the weather is warm and humid and that deaths occur more commonly during the summer months; and • Fatalities associated with ABD typically occur in men in their mid-thirties who have a history of stimulant drug misuse. Both of those features were present in this case. However, the evidence at inquest was that the police officers who dealt with Gareth on 31 July 2024 were unaware of these factors despite them being in a multi agency local pathway for dealing with suspected cases of ABD which Gwent Police had signed up to. The Court further heard evidence that these environmental and demographic factors do not form part of the College of Policing's training relating to ABD.
10	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: The Chief Executive Officer of the College of Policing I should be grateful if the following action is taken: To review the College of Policing's ABD training and consider incorporating recognised environmental and demographic factors associated with ABD and fatal ABD presentations. Awareness of such factors may assist officers in considering a potential ABD presentation in the early stages before it progresses to a severe and life-threatening medical emergency, increasing opportunities for timely healthcare intervention and improving the prospect of recovery. I am concerned that, unless action is taken, future deaths may occur.
11	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: • Family members and NOK of deceased • Gwent Police 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.
12	SIGNATURE Rose FARMER, Area Coroner for Gwent