John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Constable. North Wales Police, Glan Y Don, Abergele Road, Colwyn Bay LL29 8AW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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.
3	**INVESTIGATION and INQUEST** On the 7th of June 2016 I commenced an investigation into the death of Joshua James Alexander Hamill (DOB 23.7.91, DOD 5.6.2016). The investigation concluded at the end of the inquest on the 30th of November 2017 and a jury recorded a conclusion Misadventure with the cause of death being 1(a) Cerebral Anoxia with Oedema (b) Suspension 2. ADHD
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was known to the Mental Health Team of Northamptonshire Healthcare, NHS Foundation Trust and had been known to self-harm on a number of previous occasions. In the early hours of the 5th of June 2016 his girlfriend raised a "Concern for Safety" with North Wales Police indicating that he was threatening to kill himself. Officers attended and re-categorised the matter as a domestic incident, focussing their attention on the welfare of his girlfriend. They left the Deceased alone shortly after 01.00 and he was subsequently found at Flint Castle later that morning where he had died as a result of hanging.
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 will 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. That the current training afforded to police officers in North Wales was ineffective in ensuring that they were able to accurately identify mental health issues in persons they were attending. 2. That when an event was opened as a "Concern for Safety" it was closed down as domestic incident without there being a recorded resolution as to safety and welfare of the person originally at risk of harm.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 30th January 2018 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 Person – The Family of the Deceased 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. He may send a copy of this report to any person who he 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	Dated 5th December 2017 Signature Senior Coroner for North Wales (East and Central)

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