



REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The National Probation Service, FAO [REDACTED], Director General

1. CORONER

I am Ms N J Mundy for South Yorkshire East

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.

<http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>

<http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made>

3. INVESTIGATION and INQUEST

On 4 October 2019 I commenced an investigation into the death of Todd James Salter. The investigation concluded at the end of the inquest. The conclusion of the inquest was:

Suicide

1a Suspension by ligature

4. CIRCUMSTANCES OF THE DEATH

Mr Salter was released from prison on licence in July 2019. Upon his release there was confusion regarding which organisation had responsibility to assist him with housing leading to him residing with his family. This had a deleterious effect on Mr Salter's mental health as independent living was a key element of him being able to re-establish contact with his daughters. As time progressed Mr Salter's struggles with life increased, the spice habit he had in prison combined with life challenges led to him taking illicit drugs. Although Mr Salter wished to overcome his drug habit he and his family struggled to obtain support needed from the various agencies. Of note was that the Probation officer who had been assigned to Mr Salter stated in evidence that she did not know that an option available to her was to contact ASPIRE Drug and Alcohol Service for Doncaster. She further stated in evidence that she did not know that they could have referred Mr Salter for an assessment, could have sought advice from a Consultant psychiatrist and could have liaised with mental health services together with Mr Salter's mother. These were all crucial elements in providing Mr Salter with the support he clearly needed. As it was, the Probation officer was exploring options to have Mr Salter recalled but communication with Mr Salter as to her intentions in this regard were far from clear. By the 30th September 2019 he was at crisis point, left his mother's address, made his way to Doncaster police station where at some time between 02:41 a.m. and 07:15 a.m. on the 1st October 2019 Mr Salter hanged himself outside the police station.

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) The lack of knowledge of the Probation officer as to the services she could contact to obtain necessary mental health assessments. This would appear at the very least to suggest this gap in knowledge may be due to inadequate training.
- (2) Mr Salter being driven to desperate measures of committing criminal acts in an effort to be arrested or recalled in order to secure treatment and support; this appeared to be the way matters were moving forward without engaging with appropriate mental health services.
- (3) Generally poor engagement and collaborative working with both agencies and family alike.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [REDACTED], National Probation Service 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 13th July 2021. 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 Persons: [REDACTED], Messrs Browne Jacobson and Government Legal Department. 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.

18 May 2021

Signature


Ms N J Mundy LL.B (Hons) Senior Coroner for South Yorkshire East District