REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Chief Constable, Sussex Police
1	CORONER
	I am ROBERT SIMPSON, assistant coroner, for the coroner area of WEST SUSSEX
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 18 th December 2018 an investigation into the death of Mark Oliver George Mallinson, aged 30, was opened. The investigation concluded at the end of the inquest on the 4 th February 2020. The conclusion of the inquest was suicide.
4	CIRCUMSTANCES OF THE DEATH
	On the evening of the 2 nd December 2018 it was alleged that Mark Mallinson had breached the terms of a restraining order to which he was subject. Sussex Police initially sought to arrest Mark Mallinson.
	Over the following 4–5 hours Mark Mallinson made numerous threats to take his own life. As soon as Sussex Police were made aware of these threats Mark Mallinson was designated as a high risk missing person and dealt with accordingly.
	Mark Mallinson had telephone contact with a number of police officers during this period as well as significant telephone contact with family members whilst police officers were present. At some time between 03.20am and 04.24am on the 3 rd December 2018 Mark Mallinson committed suicide.
5	CORONER'S CONCERNS
	During the course of the inquest the evidence revealed a matter giving rise to a 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 MATTER OF CONCERN is as follows. –
	provided a statement about the training given to police officers in the area of suicide intervention. stated that he had created a training package for new recruits. This training is designed to give first responders pointers to save lives and to buy time.
	I received further information during the course of the inquest that most new recruits of Sussex Police in the last 12-18 months had received the training. However this training is not being rolled out to the remainder of the police force. The concern I have is that training specifically designed to save lives is not being provided to all front line staff.

ACTION SHOULD BE TAKEN
In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
YOUR RESPONSE
You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 rd April 2020. 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.
COPIES and PUBLICATION
I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely the family of Mark Mallinson and
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.
7 th February 2020
Robert Simpson, Assistant Coroner