ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGERMON 20 KEI OKT TO TREVERT TOTOKE BEATING
	THIS REPORT IS BEING SENT TO:
	4. Made Ciles and Chief Countries of the
	Mark Gilmore, Chief Constable for West Yorkshire Police Force
1	CORONER
	I am Miss Melanie J Williamson, Assistant Coroner, for the coroner area of West
	Yorkshire (Eastern)
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. [HYPERLINKS]
	[TTT EXEMAG]
3	INVESTIGATION and INQUEST
	On the 40 th Onte to 2040 and the state of
	On the 19 th October 2012 an investigation was commenced into the death of David Robert Oldfield, aged 38 years. The investigation concluded at the end of the inquest on
	12 th March 2014. The medical cause of the Deceased's death was:-
	1(a) Shock and haemorrhage
	(b) Stab wounds to neck penetrating jugular vessels.
	The Jury returned a unanimous Open Conclusion.
4	CIRCUMSTANCES OF THE DEATH
	During the early hours of the 5 th October 2012 an incident took place at the Deceased's
	home address involving the Deceased and his partner. In the course of the said incident
	both the Deceased and his partner sustained significant injuries. Emergency services
	were alerted and attended at the scene shortly after 4am on the 5 th October 2012, including firearms officers with West Yorkshire Police Force who had been granted taser
	authority. Between 4.08am and 4.10am the Deceased was tasered after he had
	suffered fatal stab wounds to his internal and external jugular vessels on both sides of
	his neck, and extensive blood loss. The Deceased's condition deteriorated and he
	passed away at 4.24am on the 5 th October 2012 at 6 Poplar Square, Farsley, near
5	Leeds. CORONER'S CONCERNS
	SOLICITE SOLICE AND
	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) There is no evidence that the act of tasering the Deceased caused or contributed to
	his death; however, there is evidence that tasering can, in certain circumstances, cause
	serious injury and/or death to a person;
	(2) The tasering of a person by firearms officers should only take place in appropriate and justifiable circumstances, and a failure to do so unnecessarily increases the risk of a
	and justinable circumstances, and a failure to do so unnecessarily increases the risk of a

	loss of life; (3) On the basis of evidence adduced in the course of the Inquest it is unlikely that the events immediately preceding the tasering of the Deceased occurred in the manner stated by one or more of the attending firearms officers; (4) Therefore, it is of concern as to precisely what were the circumstances which preceded the act of tasering the Deceased, whether such was appropriate and justifiable in all the circumstances and, if not, whether similar circumstances could arise in the future.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 9 th May 2014. 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:- (1)
9	DATE 14 th March 2014 Melanie J Williamson Assistant Coroner