	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Constable, Greater Manchester Police
1	**CORONER** I am Joanne Kearsley, Area Coroner for the Coroner Area of Manchester South.
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 17th July 2012 I commenced an investigation into the death of Billy Paul Thomas Salton, date of birth 04.01.1993. The investigation concluded at the end of the inquest on 27th November 2013. The conclusion of the Inquest was that the deceased died as a result of 1a) Hypoxic Ischaemic Encephalopathy 1b) Cardiac Arrest 1c) Epilepsy, and a short form conclusion of natural causes was recorded.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was an epileptic whose compliance with his medication was, at times, variable. On the 5th July 2012 he presented at Cheadle Police Station where he was detained by Greater Manchester Police. He was noted by the Custody Staff to be an epileptic who was not in receipt of any of his medication. Due to his medical condition he was placed in a CCTV cell although there were no instructions given to any officers as to how long or when the CCTV should be monitored. Medical advice was therefore sought from MEDACS. The deceased was visited and examined by [redacted] He was found to be fit to be detained; no medication was prescribed for him at this stage. In his evidence [redacted] indicated that he did ask Mr Salton about when his last fit was, the time before that and when he was last in hospital. However he did not record any answers given on the documentation. He was not in a position to be able to verify Mr

Salton's prescription with his GP to the time and therefore he did not issue any medication. He did not enquire as to how long Billy was going to be in custody and assumed he was being placed before the court in the morning. He did not therefore set a time for enquiries to be made in the morning with the deceased's GP about his medication.

Shortly after this examination Billy had a seizure in his cell; this was un-witnessed at the time but has been seen subsequently on the CCTV footage.

On the morning of the 5th July the deceased indicated to the police and his legal representative that he did not feel well and thought he might have had an epileptic seizure and that he needed his medication. The police therefore requested a further medical assessment. The deceased was visited on this occasion by Nurse from Medacs. Nurse could not access the handwritten contemporaneous notes made previously by Dr This assessment could not be completed as the deceased ceased co-operating and left the medical room when Nurse informed him he could not prescribe medication.

Nurse completed the detained person's medical form indicating that the assessment had been completed and the deceased was fit to be detained, interviewed and transferred. No further enquiries were made to try and verify his prescribed medication. On handwritten notes made by Nurse nothing was noted on the detained person's medical records that the police should try and obtain medication from Mr Salton's home address. None of the police officers on duty recalled Nurse passing this information on to them.

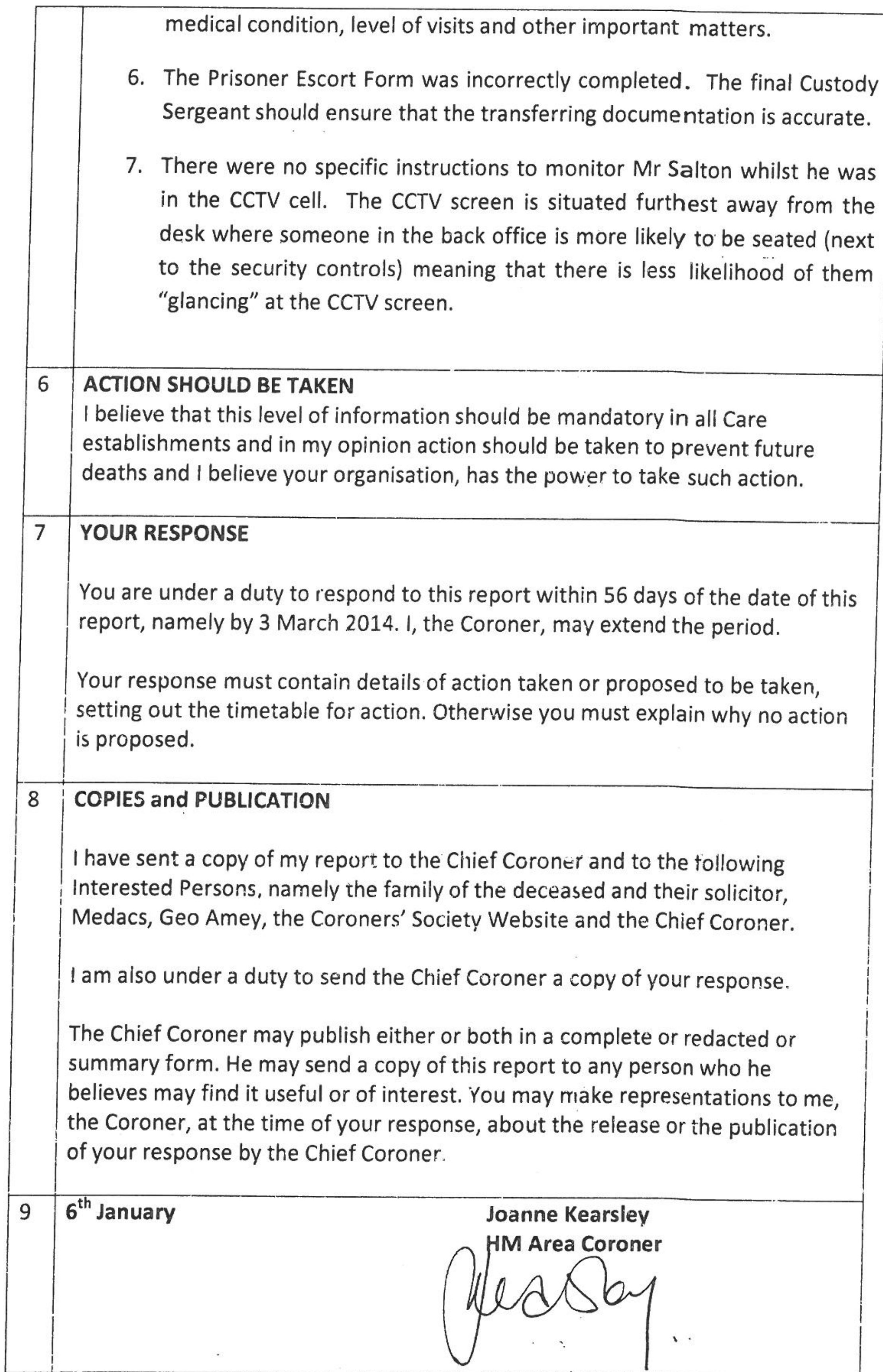
His GP details were subsequently obtained by his legal representatives who had re-attended at the police station for the interview. The police verified and obtained his medication. A third medical request was then made for the medication to be administered.

Nurse attended in order to administer the medication. She did not read through all the entries made on the previous Detained Persons Medical Forms. As she was asked to attend simply to administer medication she did not carry out an assessment of Mr Salton. However she then completed a Detained Persons Medical Form indicating that the deceased was fit to be detained, interviewed and transferred. The deceased was then prescribed his first dose of medication.

Mr Salton remained in custody overnight. His second dose of prescribed medications was administered at approximately 6pm. At approximately 8.40am the deceased had a second un-witnessed seizure in his cell.

Staff from GEO AMEY attended at the police station to transfer Mr Salton to Court. They had sight of his Prisoner Escort Form (PER) and the Detained Persons Medical Forms (Form 708) which accompanied him. It was noted by the GEO AMEY staff that these indicated that Billy was fit to be detained, interviewed and transferred. It was also noted that he was an epileptic. The forms were not read thoroughly and in her evidence the escorting officer indicated that she was unsure that Billy might have had a seizure whilst in custody, what his level of observations might have been or that he had been placed in a CCTV cell.

	At Stockport Magistrates' Court there was a delay in being able to deal with Billy in Court. Billy was seen by his legal representatives and at that stage Billy indicated that he felt OK. He was in a cell waiting to be called to Court. The last recorded cell check was at 11.56am, (recorded as 12.05 on the computer print out). Approximately 15 minutes later Billy was found collapsed in the cell. CPR was performed and he was taken to Stepping Hill Hospital where he died.
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. During the course of the evidence I heard that Mr Salton had remained in custody overnight and was not progressed as quickly as he could have been whilst in custody as there was no-one available to interview him. This is as a result of GMP policy on how people are progressed through custody. The Prisoner Processing Unit is not staffed overnight which leads to people being in custody longer than they should be and bringing GMP "up against the requirements of the Police and Criminal Evidence Act." GMP cannot indicate how many people may have been detained in custody longer than they should have been under their new policy. 2. There was a lack of understanding amongst the custody staff and staff from other agencies as to the level of observations Mr Salton was on and why he was on those observations. It is important that everyone who has care of someone in custody understands what the observations have been, what they should be, when they are to be carried out, whether rousing is required and why the observations are set as they are – i.e. what the medical condition/ concern is. 3. When the deceased is visited and checked all such visits should be accurately recorded on the custody record. 4. Risk assessments carried out whilst in police custody should be recorded when they are done. If there are no changes to a risk assessment then this should be recorded and any rationale noted. 5. Handovers between Custody Sergeants were ineffective and there was no handover between the Civilian Detention Staff. Important information was missed or lost in translation. Proper handovers should take place as to a detained person's condition, risk assessment, any



	medical condition, level of visits and other important matters. 6. The Prisoner Escort Form was incorrectly completed. The final Custody Sergeant should ensure that the transferring documentation is accurate. 7. There were no specific instructions to monitor Mr Salton whilst he was in the CCTV cell. The CCTV screen is situated furthest away from the desk where someone in the back office is more likely to be seated (next to the security controls) meaning that there is less likelihood of them "glancing" at the CCTV screen.
6	**ACTION SHOULD BE TAKEN** I believe that this level of information should be mandatory in all Care establishments and in my opinion action should be taken to prevent future deaths and I believe your organisation, has 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 3 March 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, namely the family of the deceased and their solicitor, Medacs, Geo Amey, the Coroners' Society Website and the Chief Coroner. 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	**6th January** **Joanne Kearsley** **HM Area Coroner**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive Officer, MEDACS
1	**CORONER** I am Joanne Kearsley, Area Coroner for the Coroner Area of Manchester South.
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 17th July 2012 I commenced an investigation into the death of Billy Paul Thomas Salton, date of birth 04.01.1993. The investigation concluded at the end of the inquest on 27th November 2013. The conclusion of the Inquest was that the deceased died as a result of 1a) Hypoxic Ischaemic Encephalopathy 1b) Cardiac Arrest 1c) Epilepsy, and a short form conclusion of natural causes was recorded.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was an epileptic whose compliance with his medication was, at times, variable. On the 5th July 2012 he presented at Cheadle Police Station where he was detained by Greater Manchester Police. He was noted by the Custody Staff to be an epileptic who was not in receipt of any of his medication. Due to his medical condition he was placed in a CCTV cell although there were no instructions given to any officers as to how long or when the CCTV should be monitored. Medical advice was therefore sought from MEDACS. The deceased was visited and examined by [redacted] He was found to be fit to be detained; no medication was prescribed for him at this stage. In his evidence [redacted] indicated that he did ask Mr Salton about when his last fit was, the time before that and when he was last in hospital. However he did not record any answers given on the documentation. He was not in a position to be able to verify Mr

Salton's prescription with his GP to the time and therefore he did not issue any medication. He did not enquire as to how long Billy was going to be in custody and assumed he was being placed before the court in the morning. He did not therefore set a time for enquiries to be made in the morning with the deceased's GP about his medication.

Shortly after this examination Billy had a seizure in his cell; this was un-witnessed at the time but has been seen subsequently on the CCTV footage.

On the morning of the 5th July the deceased indicated to the police and his legal representative that he did not feel well and thought he might have had an epileptic seizure and that he needed his medication. The police therefore requested a further medical assessment. The deceased was visited on this occasion by Nurse [redacted] from Medacs. Nurse [redacted] could not access the handwritten contemporaneous notes made previously by Dr [redacted] This assessment could not be completed as the deceased ceased co-operating and left the medical room when Nurse [redacted] informed him he could not prescribe medication.

Nurse [redacted] completed the detained person's medical form indicating that the assessment had been completed and the deceased was fit to be detained, interviewed and transferred. No further enquiries were made to try and verify his prescribed medication. On handwritten notes made by Nurse [redacted] nothing was noted on the detained person's medical records that the police should try and obtain medication from Mr Salton's home address. None of the police officers on duty recalled Nurse [redacted] passing this information on to them.

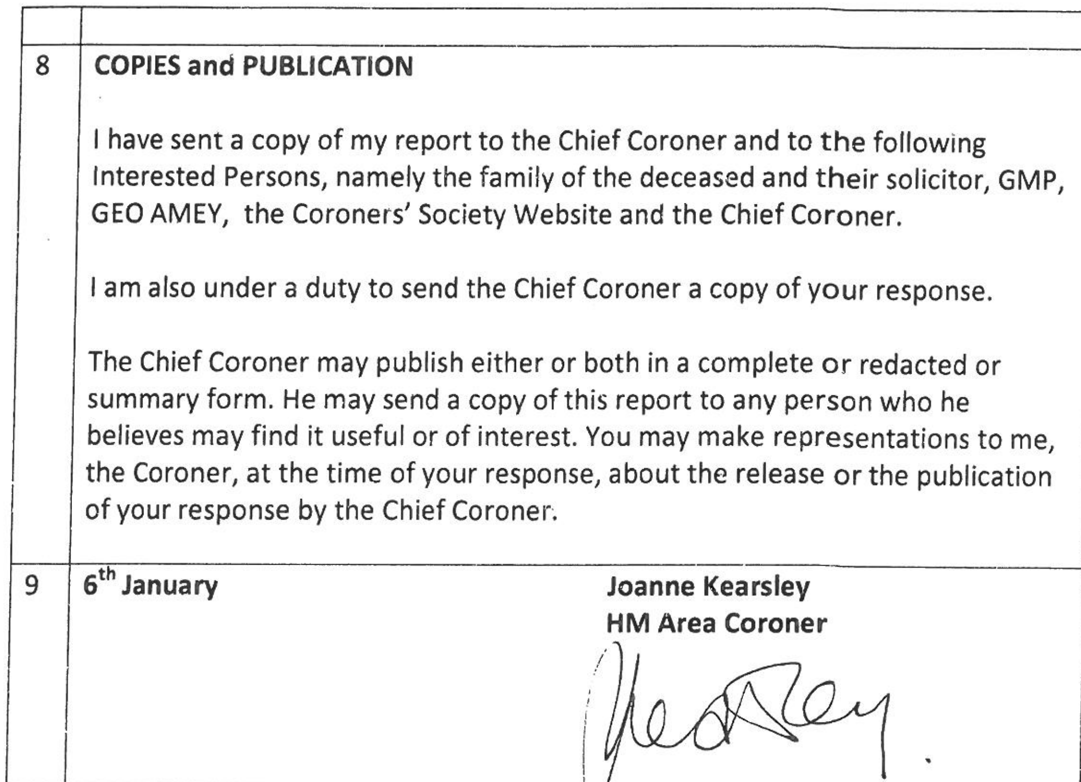
His GP details were subsequently obtained by his legal representatives who had re-attended at the police station for the interview. The police verified and obtained his medication. A third medical request was then made for the medication to be administered.

Nurse [redacted] attended in order to administer the medication. She did not read through all the entries made on the previous Detained Persons Medical Forms. As she was asked to attend simply to administer medication she did not carry out an assessment of Mr Salton. However she then completed a Detained Persons Medical Form indicating that the deceased was fit to be detained, interviewed and transferred. The deceased was then prescribed his first dose of medication.

Mr Salton remained in custody overnight. His second dose of prescribed medications was administered at approximately 6pm. At approximately 8.40am the deceased had a second un-witnessed seizure in his cell.

Staff from GEO AMEY attended at the police station to transfer Mr Salton to Court. They had sight of his Prisoner Escort Form (PER) and the Detained Persons Medical Forms (Form 708) which accompanied him. It was noted by the GEO AMEY staff that these indicated that Billy was fit to be detained, interviewed and transferred. It was also noted that he was an epileptic. The forms were not read thoroughly and in her evidence the escorting officer indicated that she was unsure that Billy might have had a seizure whilst in custody, what his level of observations might have been or that he had been placed in a CCTV cell.

	At Stockport Magistrates' Court there was a delay in being able to deal with Billy in Court. Billy was seen by his legal representatives and at that stage Billy indicated that he felt OK. He was in a cell waiting to be called to Court. The last recorded cell check was at 11.56am, (recorded as 12.05 on the computer print out). Approximately 15 minutes later Billy was found collapsed in the cell. CPR was performed and he was taken to Stepping Hill Hospital where he died.
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. MEDACS should ensure that all staff are fully aware of the content of any MEDACS policies or protocols, where these can be located in the police station and if necessary receive any required training on the same (the Court heard that [redacted] was not aware of the MEDACS Epilepsy Policy). 2. MEDACS should receive a verbal report from Custody Staff and as much information as possible as to the detained person's medical condition. Even if they are there solely to administer medication MEDACS staff should read any previous medical notes from the same stay in custody. 3. All staff are reminded of the need to record information on the MEDACS Assessment Form including completing a Care Plan. Such a form should be completed accurately including any negative answers to questions asked. 4. If a doctor or nurse is unable to complete a medical assessment or is not assessing an individual then this should be explained and any potentially misleading information should not be recorded.
6	**ACTION SHOULD BE TAKEN** I believe that this level of information should be mandatory in all Care establishments and in my opinion action should be taken to prevent future deaths and I believe your organisation, has 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 3 March 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, namely the family of the deceased and their solicitor, GMP, GEO AMEY, the Coroners' Society Website and the Chief Coroner. 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	**6th January** **Joanne Kearsley** **HM Area Coroner**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive Officer, GEO AMEY
1	**CORONER** I am Joanne Kearsley, Area Coroner for the Coroner Area of Manchester South.
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 17th July 2012 I commenced an investigation into the death of Billy Paul Thomas Salton, date of birth 04.01.1993. The investigation concluded at the end of the inquest on 27th November 2013. The conclusion of the Inquest was that the deceased died as a result of 1a) Hypoxic Ischaemic Encephalopathy 1b) Cardiac Arrest 1c) Epilepsy, and a short form conclusion of natural causes was recorded.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was an epileptic whose compliance with his medication was, at times, variable. On the 5th July 2012 he presented at Cheadle Police Station where he was detained by Greater Manchester Police. He was noted by the Custody Staff to be an epileptic who was not in receipt of any of his medication. Due to his medical condition he was placed in a CCTV cell although there were no instructions given to any officers as to how long or when the CCTV should be monitored. Medical advice was therefore sought from MEDACS. The deceased was visited and examined by Dr Morris. He was found to be fit to be detained; no medication was prescribed for him at this stage. In his evidence Dr Morris indicated that he did ask Mr Salton about when his last fit was, the time before that and when he was last in hospital. However he did not record any answers given on the documentation. He was not in a position to be able to verify Mr

Salton's prescription with his GP to the time and therefore he did not issue any medication. He did not enquire as to how long Billy was going to be in custody and assumed he was being placed before the court in the morning. He did not therefore set a time for enquiries to be made in the morning with the deceased's GP about his medication.

Shortly after this examination Billy had a seizure in his cell; this was un-witnessed at the time but has been seen subsequently on the CCTV footage.

On the morning of the 5th July the deceased indicated to the police and his legal representative that he did not feel well and thought he might have had an epileptic seizure and that he needed his medication. The police therefore requested a further medical assessment. The deceased was visited on this occasion by Nurse Kalhoro from Medacs. Nurse Kalhoro could not access the handwritten contemporaneous notes made previously by Dr Morris. This assessment could not be completed as the deceased ceased co-operating and left the medical room when Nurse Kalhoro informed him he could not prescribe medication.

Nurse Kalhoro completed the detained person's medical form indicating that the assessment had been completed and the deceased was fit to be detained, interviewed and transferred. No further enquiries were made to try and verify his prescribed medication. On handwritten notes made by Nurse Kalhoro nothing was noted on the detained person's medical records that the police should try and obtain medication from Mr Salton's home address. None of the police officers on duty recalled Nurse Kalhoro passing this information on to them.

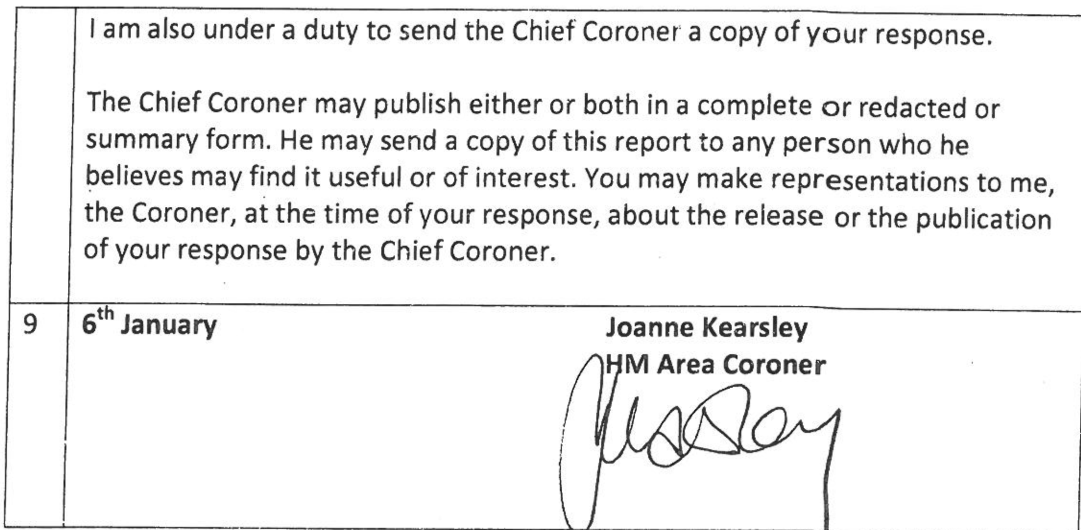
His GP details were subsequently obtained by his legal representatives who had re-attended at the police station for the interview. The police verified and obtained his medication. A third medical request was then made for the medication to be administered.

Nurse Whittaker attended in order to administer the medication. She did not read through all the entries made on the previous Detained Persons Medical Forms. As she was asked to attend simply to administer medication she did not carry out an assessment of Mr Salton. However she then completed a Detained Persons Medical Form indicating that the deceased was fit to be detained, interviewed and transferred. The deceased was then prescribed his first dose of medication.

Mr Salton remained in custody overnight. His second dose of prescribed medications was administered at approximately 6pm. At approximately 8.40am the deceased had a second un-witnessed seizure in his cell.

Staff from GEO AMEY attended at the police station to transfer Mr Salton to Court. They had sight of his Prisoner Escort Form (PER) and the Detained Persons Medical Forms (Form 708) which accompanied him. It was noted by the GEO AMEY staff that these indicated that Billy was fit to be detained, interviewed and transferred. It was also noted that he was an epileptic. The forms were not read thoroughly and in her evidence the escorting officer indicated that she was unsure that Billy might have had a seizure whilst in custody, what his level of observations might have been or that he had been placed in a CCTV cell.

	At Stockport Magistrates' Court there was a delay in being able to deal with Billy in Court. Billy was seen by his legal representatives and at that stage Billy indicated that he felt OK. He was in a cell waiting to be called to Court. The last recorded cell check was at 11.56am, (recorded as 12.05 on the computer print out). Approximately 15 minutes later Billy was found collapsed in the cell. CPR was performed and he was taken to Stepping Hill Hospital where he died.
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. Staff should be reminded of the levels of observation (cell checks) required on detained persons whilst in their custody. 2. Staff should be reminded that all cell checks should be accurately documented. 3. GEO AMEY should ensure that their staff have knowledge of and fully read any documentation available when collecting a detained person. This is especially true of any medical information and if there is a medical reason why someone is on a certain level / type of observation that this is replicated whilst in the custody of GEO AMEY.
6	**ACTION SHOULD BE TAKEN** I believe that this level of information should be mandatory in all Care establishments and in my opinion action should be taken to prevent future deaths and I believe your organisation, has 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 3 March 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, namely the family of the deceased and their solicitor, GMP, MEDACS, the Coroners' Society Website and the Chief Coroner.



	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	**6th January** **Joanne Kearsley** **HM Area Coroner**