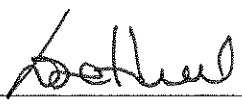
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable of West Midlands Police**
1	**CORONER** I am Louise Hunt, Senior Coroner, for the coroner area of Birmingham and Solihull
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 17th August 2010 an Inquest was opened touching the death of Lloyd Edward Butler. The Inquest concluded on 24 June 2014. The conclusion of the inquest was as per the attached record of inquest.
4	**CIRCUMSTANCES OF THE DEATH** Mr Butler was arrested for being drunk and incapable on the 4th August 2010 at 12.00 noon. He was taken to Stechford Police Station where he was detained in a "drunk cell". He was placed on level 3 observations by way of CCTV with 30 minute rousing. In view of his risk the rousing was decreased to every 15 minutes. The initial risk assessment of Mr Butler was undertaken visually as he passed the custody desk. At the time in question West Midlands Police had a policy in place whereby anyone arrested for drunk and incapable should be taken to hospital for further assessment. Over the course of the next 3 hours officers within the custody suite make jokes of the deceased condition, used personal mobile telephones, used the custody suite telephone for personal calls and used the intranet for personal use. Their language was crude and degrading using many swear words. Due to the distraction and banter, observations of Mr Butler were not constant and rousing was not timely nor in accordance with the West Midlands Police Policy. At 15.15 a nurse attended to Mr Butler to assess him. The nurse found Mr Butler on the floor on his back struggling to breathe. After a few minutes Mr Butler went into cardiac arrest and was conveyed to Birmingham Heartlands Hospital where he was pronounced dead shortly after arrival. The CCTV footage of Mr Butler's detention was played at the inquest. It is suggested that this is viewed by the Chief Constable in assisting to understand the concerns raised below.
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 professionalism and leadership in the custody suite was striking. There was no leadership by the custody sergeant and no control of the behaviour of any of the staff. Evidence heard at the inquest indicated this sort of banter and practice was common and continuing. Many detainees in the custody block are vulnerable, often have mental health difficulties and other social problems and may be in varying degrees of intoxication. The custody staff are responsible for those detainees and should carry this responsibility out in a professional and disciplined manner. (2) There was insufficient evidence at the inquest that any guidance or training had been conducted for custody staff regarding what was acceptable behaviour in a custody suite following the events in question. (3) There was evidence at the inquest that the CCTV footage of Mr Butler's time in custody was representative of the general approach and culture within custody suites in the West Midlands. West Midlands Police should consider how this culture might be addressed and changed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 20th August 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: [redacted] being represented by Irwin Mitchell Solicitors. The individual Police officers being represented by Slater and Gordon Solicitors [redacted] being represented by Thompsons Solicitors IPCC 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	**25th June 2014**  **[SIGNED BY CORONER]**