REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable, South Yorkshire Police**
1	**CORONER** Christopher Peter Dorries, senior coroner for the coroner area of South Yorkshire (West)
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 8th May 2013 I commenced an investigation into the death of Neil Budziszewski (aged 43). The investigation concluded at the end of the inquest on 13th February 2015. The conclusion of the inquest was that Mr Budziszewski had died of heart disease but the jury also found • that Mr Budziszewski had been displaying symptoms consistent with Acute Alcohol Withdrawal Syndrome from approx. 1am on the night of his detention • that a doctor should have been asked see Mr Budziszewski whilst in custody • it was *possible* that Acute Alcohol Withdrawal Syndrome had been a contributory factor in the death.
4	**CIRCUMSTANCES OF THE DEATH** Neil Budziszewski was arrested for an offence of theft early in the afternoon of 2nd May 2013. He was taken to Ecclesfield Police Station in a state of intoxication. He was then taken briefly to the Charge Office detention facility at Bridge Street for identification purposes before being returned to Ecclesfield. Later in the day Mr Budziszewski was interviewed, admitted the theft and was charged. As he had no address he was detained to be produced before court the following morning. However, when officers went to the cell to transfer him to the GeoAmey vehicle he was found to be dead. In the course of the inquest it became clear, and was accepted, that there had been a very significant number of failures to follow appropriate and necessary procedure given the information that had become clear. In particular there were numerous failures to communicate information between shifts, whether in writing or orally, and a failure to recognise that a doctor (who was already in the custody area) should have been asked to see Mr Budziszewski. There was also a failure to recognise that Acute Alcohol Withdrawal Syndrome can endanger life or, where this was appreciated, to act on this knowledge. Some, but not all, of these failures had already been identified by the IPCC investigation into Mr Budziszewski's death and/or an independent review of the custody procedures.

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) When Mr Budziszewski was first presented to the Ecclesfield afternoon shift custody sergeant he accepted custody without opening a custody record or completing a risk assessment. Whilst it is accepted that Mr Budziszewski was in drink at the time and un-cooperative there appears to have been no thought given to a risk assessment. (2) The afternoon custody sergeant failed to complete a Prison Escort Form for a transfer to Bridge Street (for LiveScan identification) in breach of guidance. Similarly, whilst the receiving custody sergeant at Bridge Street commenced a custody record and completed a risk assessment, he also failed to complete a Prison Escort Form for the transfer back. (3) The risk assessment completion at Bridge Street did not include asking Mr Budziszewski if he wanted to see a doctor, if he was on medication or if he was in contact with a medical service. Nor did it document that Mr Budziszewski should be checked every 30 minutes. (4) The custody sergeant at Bridge Street gave evidence that he was unable to conduct a full risk assessment because of Mr Budziszewski 's lack of compliance. However, no arrangement was made for the risk assessment to be reconsidered at a time when Mr Budziszewski was more compliant (which happened quite shortly thereafter). This officer recognised that an alcoholic who was approaching sobriety is someone who needs to be seen by a health care professional. (5) When Mr Budziszewski was returned to Ecclesfield Police Station, the afternoon custody sergeant failed to complete his own risk assessment or query issues arising from the risk assessment undertaken at Bridge Street. It is likely that the escorting officers could have added a great deal of knowledge for the custody sergeant about what had been said by Mr Budziszewski at Bridge Street. (6) The afternoon custody sergeant at Ecclesfield failed to place Mr Budziszewski on 30 minute rousing checks in breach of PACE Code C (paragraph 9.3). Indeed, there was no annotation on the custody record of the level of checks required (7) The afternoon custody sergeant recognised guidance that a doctor would normally be asked to attend for an alcoholic detainee, but failed to record on the custody record or risk assessment that Mr Budziszewski should be considered for an assessment later on. (8) The afternoon civilian detention officer believed that Mr Budziszewski had been taken off rousing checks by 8pm because he had been in custody some five hours and rousing 'was no longer necessary'. This seems to be a commonly made informal decision with no record made. (9) This detention officer felt that he had not been trained on the risks for alcoholics when they are sobering but was aware that they were susceptible to fits and sickness etc., because he had been told by one of the MEDACS nurses some time before. He recognises that this is important information that he had not been

	trained on.
	(10) There was no consideration given at that time to calling a health care professional, notwithstanding the information gained which included that Mr Budziszewski was an alcoholic and was a prescribed methadone user. The view seems to have been taken that the medical provider would simply refuse to see a detainee until they were no longer in drink. This carries considerable dangers if the detained person's condition was not actually caused by drink but by a head injury or hypoglycaemic state etc.
	(11) The inspectors review at 9pm indicates that Mr Budziszewski took medication for his alcoholism (which was not strictly correct, he took Tamazepam to assist him to sleep) and states that the inspector had informed the custody staff of this. That is incorrect, the inspector's evidence was that he was to return later on and inform the custody staff who were busy at the time but he never did so.
	(12) The reviewing inspector had no training in his task, he was simply given the job because he was an available shift inspector at the police station.
	(13) A significant amount of the handwriting on the custody record (notably including that by the reviewing inspector) was illegible. Yet nobody sought clarification of what had been written.
	(14) There was unnecessary confusion between the reviewing inspector and the afternoon civilian detention officer as to whether the deceased would be assessed by a health care professional. No referral took place.
	(15) The afternoon custody sergeant told the IPCC investigators that he did not think his custody suite training was fit for purpose. He claimed that this had already been raised by another custody sergeant but was not aware of anything happening about it.
	(16) The handover from the afternoon custody sergeant to night custody sergeant did not include information about Mr Budziszewski being prescribed Methadone, that he was an alcoholic, or that he was on 30 minute checks. This was accepted not to be a full and effective handover.
	(17) PACE requires a health professional to be called if the detainee is dependent on alcohol or drugs. This did not take place.
	(18) The oncoming (night) custody sergeant failed to review the custody record or risk assessment when he came on duty.
	(19) The night custody sergeant brought a young pet dog into the custody suite with him, which he accepted was wholly unprofessional. Whilst there is no evidence that this proved a distraction detrimental to the prisoner on this occasion, that might differ should this conduct be repeated by others.
	(20) Shortly after 3am if was noted by the night custody sergeant that the sound of retching could be heard from one of the cells. Investigation by the night detention officer showed this to be Mr Budziszewski. This caused his custody record to be reviewed (for the first time) and earlier notation concerning dependence on alcohol and the use of drugs was apparent. No action was taken to refer Mr Budziszewski for medical review even though the doctor was visiting another prisoner in the custody area at the time. No record of this incident was made in the custody record.
	(21) It is accepted that Mr Budziszewski was asked at this stage if he wanted to see a doctor and demurred. However, expert evidence was given that this was unwise

	and the doctor should have been asked to engage with the prisoner as this was likely to have resulted in co-operation. (22) No note was made in the custody record of the decision to place the prisoner back on 30 minute checks after the retching episode so that later officers would be aware. (23) The Prisoner Escort Form for the forthcoming transfer to the Magistrates Court was completed during the night shift. This makes no reference to the risks which were by now known. Expert evidence indicated that the risk of acute alcohol withdrawal syndrome was increasing as time went by rather than decreasing. (24) The night shift civilian detention officer made false entries of having carried out cell checks on the deceased at 0335 and 0430. On the first occasion it was written that Mr Budziszewski was asleep and breathing regularly but in fact this entry (written later) was made on the *assumption* that a visit must have been made at around that time and that is what would have been found. (25) Towards the end of the night shift the custody sergeant informed the civilian detention officer that he could go, thus leaving the custody sergeant alone. Although only a few minutes were involved, this; a) could have placed the custody sergeant at severe personal risk. b) may well have prevented the custody sergeant dealing swiftly and appropriately with an issue such as a prisoner collapsed in the cell (i.e. reluctance to open the cell in case the prisoner was faking an illness, resulting in a delay until other persons could be brought in from other areas of the police station). (26) The handover from the night custody sergeant to the morning custody sergeant was incomplete. Whilst CCTV makes plain that Mr Budziszewski was described as an alcoholic, there was no reference to the retching episode or the change in observations. In consequence of this latter point Mr Budziszewski was inadvertently changed back from 30 minute checks to 60 minutes without any consideration of needs. (27) Further, the custody record had been incorrectly marked during the night that Mr Budziszewski had been referred to a doctor which would at least be initially misleading to the morning shift although there was obviously no paperwork from a doctor. (28) The morning custody sergeant only reviewed the risk assessment around three hours after coming on duty, claiming that he only then noticed that Mr Budziszewski was an alcoholic. He told the court that this concerned him because for an alcoholic the checks would have been different and a doctor would have been required. In fact, the CCTV makes clear that the oncoming sergeant was told that Mr Budziszewski was an alcoholic on two occasions but he failed to take the actions that he himself described as necessary. (29) Expert evidence was given that acute alcohol withdrawal syndrome is associated with a high risk of death if not managed properly. The early symptoms such as shaking or retching (both displayed by Mr Budziszewski) indicate a rather lower risk but that could grow with time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **19th May 2015**. I 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 a copy has also been sent to Mr Budziszewski's brother. I have also sent a copy to the ACPO lead for safe custody, the IPCC and the Police Federation (who represented two officers at the inquest) each of whom who may find it useful or of interest. 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	**23 March 2015** **CP Dorries**