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 **THIS REPORT IS BEING SENT TO:** **1. Staffordshire Police as the police force in charge of the deceased at the time of his arrest and death.** **2. National Police Chiefs' Council as the association with power to issue advice and guidance to police forces nationally.** **3. G4S as the organisation responsible for the custody officers at the time of death and the holder of contracts for the provision of custody officers to police forces in several part of the country.** **4. Nestor Primecare who hold the contract for the provision of medical services to Staffordshire Police in respect of detainees in custody.** **5. Department of Health who will be taking responsibility in 2016 for the provision of medical services to police forces nationally in respect of detainees in custody.** **This report is being sent to the National Police Chiefs' Council, Nestor Primecare and the Department of Health under the provisions of Regulation 28(4)(c) and no response is required of them save for an acknowledgement that this report will find its way to an appropriate person within its organisation.**
1	**CORONER** I am Ian Stewart Smith, senior coroner, for the coroner area of Stoke-on-Trent & North Staffordshire.
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 16th November 2011 an Inquest was opened into the death of the deceased and concluded on 9th April 2015 after a 10 day hearing with a jury. The conclusion was a detailed narrative conclusion. The medical cause of death was 1a Methadone intoxication. 1b Alcohol withdrawal in a chronic alcoholic. II Fatty infiltration of the liver.
4	**CIRCUMSTANCES OF THE DEATH** On Saturday 2nd October 2011 the deceased was arrested on a no-bail warrant and taken to the Northern Area Custody Facility, Etruria, Stoke-on-Trent. He had a history of (former) heroin abuse, was receiving prescribed medication but he was also an admitted heavy abuser of alcohol, drinking over 10 cans of strong lager each day. He remained in custody, at times under close observation, for lengthy periods being viewed through a cell camera, was seen by four doctors on 6 separate occasions and received medication in the form of his prescribed methadone plus diazepam and chlordiazepoxide for alcohol withdrawal. He was found unresponsive in his cell shortly before 9.00pm on Sunday 3rd October 2011. Although attended upon by doctors there was evidence of poor or no communication between doctors and custody sergeants and frequent

	misunderstandings over the required level of observation. It was accepted that these failures did not materially cause or contribute to death and that some steps have been taken to correct failings. There is potential for failings to occur nationally. I recommend that the following be considered (see paragraph 5 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. That consideration be given to issuing guidance that whenever a detainee is attended upon by a medical practitioner there should be a verbal consultation between the medical practitioner and custody sergeant as to any issues of concern and the level of observations to be had for that detainee in addition to the medical practitioner making detailed notes on the detainee's custody medical record. 2. That consideration be given to the provision of joint training exercises for medical practitioners, custody sargeants and custody detention officers and assistants. 3. That training should provide targeted emphasis on the correct levels of observation. 4. That consideration should be given to eliminating the phrase 'continue observations at the current level' and require that doctors and custody sargeants specify the level of observation precisely. 5. That training should include targeted training on the risks and dangers of drug and alcohol abuse, including methadone intoxication and alcohol withdrawal, particularly if the detainee is likely to be in custody for upwards of 24 hours.
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 Friday 12th June 2015. 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 following:- 1. Chief Coroner, Regulation 28 Reports, Chief Coroner's Office, 11th Floor Thomas More Building, Royal Courts of Justice, The Strand, London, WC2A 2LL 2. [redacted] (father of the deceased), 3. [redacted] (mother of the deceasd) 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	[DATE] 15/4/2015	[SIGNED BY CORONER]