IN THE SURREY CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Jan McLEAN A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

• Lynne Owens, Chief Constable of Surrey Police.

1 | CORONER

Richard Travers HM Coroner for Surrey

2 | CORONER'S LEGAL POWERS

I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

3 | INVESTIGATION and INQUEST

The inquest into the death of **Mr Jan McLean** was opened on the 20th August 2013 and was resumed on the 1st June 2015 with a jury. It was concluded on 16th June 2015.

The jury found that the cause of death was:

1a – Cocaine, Amphetamine and Butylone toxicity.

The jury concluded with a narrative and a short form conclusion of 'Drug related death.

Within their narrative conclusion the jury determined that Mr McLean swallowed an unknown quantity of unknown drugs whilst in the custody of police at a residential address in Guildford.

4 | CIRCUMSTANCES OF THE DEATH

On the 12th August 2013, Mr McLean visited a flat in Guildford where drugs were being used. Whilst at the flat police officers attended and Mr McLean was arrested as were the other two occupants of the flat. Mr McLean was subsequently placed into a police van and taken to Guildford police station were he was taken unwell. He was later taken by ambulance to the Royal Surrey County Hospital where, despite treatment, he died on the 14th August 2013.

During the course of the inquest evidence was heard that whilst still in

the flat one of the officers called the Force Control Room ('FCR') at Surrey Police HQ, to request a Police National Computer ('PNC') check on Mr McLean. The operator to whom the officer spoke told him that there were markers against Mr McLean's name for self-harm and drugs. It transpired that there were further details in relation to those markers on a separate page of the database, which set out a history of Mr McLean having previously swallowed class A drugs following arrest by the police. That information was not passed to the officer at the scene, who along with other officers agreed that he would have acted differently had he been aware of it.

Evidence was also heard that since this incident, additional / update training has been provided to all FCR operators as to the need to interrogate the full detail of any such markers and to relay that information to the person requesting it.

Further evidence was heard that officers on the street are now provided with their own Mobile Data Terminal (in the guise of a smart phone), which allows them to interrogate the PNC database for themselves, albeit that in certain parts of the County the telephone network was weak and a signal was not available.

However, there was no evidence that the type of training that had been provided to FCR operators regarding the importance of fully interrogating any warning markers on the PNC had also been provided to police officers.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters that gave rise to concerns that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken.

The MATTER OF CONCERN is:

Training

Consideration should be given to providing full and adequate training to all police officers of the need to interrogate fully all details relating to warning markers held on the PNC, whether by means of an MDT or by enquiry through the FCR.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

YOUR RESPONSE You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed. 8 **COPIES** I have sent a copy of this report to the following: Chief Constable of Surrey Police. 2. The other Interested Persons in the Inquest: a. Bhatt Murphy on behalf of Mr Michael McLean b. Slater & Gordon on behalf of c. Capsticks on behalf of SECAMB d. Berrymans on behalf of 3. The Chief Coroner Signed: Richard Travers

DATED this 22nd June 2015