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. [redacted] **Chief Medical Officer, St James's University Hospital, Leeds Teaching Hospitals NHS Trust, Department of Corporate Services Division, Beckett Street, Leeds LS9 7TF** 2. **Acting Chief Constable, [redacted] West Yorkshire Police Headquarters, P O Box 9, Wakefield, WF1 3QP**
1	**CORONER** I am David Hinchliff, Senior Coroner for the coroner area of West Yorkshire (Eastern)
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 12th May 2014 I commenced an investigation into the death of Adam RICE aged 46 years. The investigation concluded at the end of the inquest on 16th February 2016. The Jury recorded a Narrative Conclusion a copy of which is attached hereto.
4	**CIRCUMSTANCES OF THE DEATH** • On Saturday 10th May 2014, a member of the public contacted West Yorkshire Police to report that Adam RICE was asleep in a skateboard park in Leeds. • Police Officers took Mr RICE to Leeds General Infirmary. He later left the hospital before being fully assessed by hospital staff. • On Sunday 11th May 2014 a member of the public again saw Adam RICE asleep in the same park. On that occasion he was taken to Leeds General Infirmary by ambulance. • Hospital staff informed West Yorkshire Police that Adam RICE was being disruptive and uncooperative and they had concerns for his mental capacity. • Once he was deemed to have mental capacity he discharged himself from hospital without a CT head scan which was deemed necessary. • The Police were unaware that Adam RICE had self-discharged against medical advice. • Adam RICE was arrested on a non-bail warrant and was taken to Elland Road Police Station where he was detained. • During his detention he exhibited signs of alcohol withdrawal. • He subsequently collapsed and died in his cell on the morning of Monday 12th May 2014. • There was little communication between hospital staff and the Police at the time of his arrest. Had West Yorkshire Police known he had discharged himself against medical advice they may have changed the risk assessment and care plan or alternatively not accepted him into custody.

	• Adam RICE'S health was not good due to his lifestyle and the fact that he was of no fixed abode and he may have been suffering with symptoms of alcohol withdrawal. • When in Custody the standard of care varied depending on who conducted cell checks. • There were Custody staff shortages. • Staff were expected to conduct welfare checks together with control room duties in what was then an unfamiliar environment. • There was no working practice for Detention Officers to conduct formal handovers between shifts. In some instances information put on the Custody record was inaccurate and vague. • The Police and Criminal Evidence Act Rouse and Response Criteria was not fully understood or implemented. Some of the checks did not comply with the requirements of Police and Criminal Evidence Act - Code C Annexe H. • There was a lack of understanding of the observation levels even at the rank of Custody Sergeant. • A Detention Officer did not pay attention to the CCTV screen. He was unaware of his role. He behaved in an immature and unprofessional manner and left duty before the allotted time.
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. – A) As regards the Leeds Teaching Hospitals NHS Trust:- 1. When a patient self-discharges against medical advice and it is known or it is highly likely that the Police will immediately thereafter become involved and it can be foreseen that the patient will be taken into Custody. 2. Then the Clinician(s) involved should inform the Police that the person has self-discharged against advice and should give brief details of any desired and outstanding investigations or treatment (eg. Reference to a possible head injury would suffice and the desire to carry out a CT head scan). This I suggest would not breach patient confidentiality. B) As regards the West Yorkshire Police:- 1. To ensure that Custody staff to which I mean Police Officers of all ranks, Civilian Detention Officers and Nursing staff have a full and comprehensive knowledge of the Police and Criminal Evidence Act and the relevant Codes of Practice and the relevant provisions of the College of Policing Authorised Professional Practice Provisions in respect of Detention and Custody and Custody Management Planning. 2. That West Yorkshire Police only recruit Custody staff of the highest calibre to carry out this vital role involving some of the most vulnerable members of society. 3a To ensure that there are adequate staffing levels of all ranks and grades to fulfil this vital role particularly during periods of high demand when it is known that Custody facilities will be extremely busy and in particular on Fridays, Saturdays and Sundays. 3b To ensure that they have a bank of staff who might ordinarily be engaged in other duties but who are trained and have experience in Custody work who can be drafted in at short notice during such periods of high demand when it becomes obvious that the existing staff cannot cope with the demands being placed upon them.

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 Thursday 28th April 2016. 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:- Police and Crimes Commissioner, [redacted] Independent Police Complaints Commission and to Her Majesty's Inspectorate of Constabulary. 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: 3rd **March 2016** Signed: