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.** The Right Honourable Boris Johnson P.C. M.P., Secretary of State for Foreign and Commonwealth Affairs, House of Commons, London SW1A 0AA
1	**CORONER** I am M Jennifer Leeming, Senior Coroner for the Coroner Area of Manchester 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 the 9th November 2015 I commenced an investigation into the death of Antony Miles Abbott, aged 36 years born the 25th September 1979. The investigation concluded at the end of the Inquest on the 16th March 2017. The conclusion of the Jury at the Inquest was that Antony Miles Abbott had died of:- 1a Hanging The Jury further recorded the following conclusion:- Misadventure Antony's death was contributed to by neglect. The failure to implement the recommendations of the May 2015 report on the Benidorm Police Station Custody Office was a significant factor in Antony's death.
4	**CIRCUMSTANCES OF THE DEATH** The jury found that Antony was arrested on the 23rd October 2015 and taken to Benidorm Police Station, Benidorm, Spain where he was placed in a cell. Antony was observed following being placed in the cell for a period of 18 minutes. Antony was found with a soft loose ligature around his neck which was tied to the cell door. There was no CCTV Surveillance either directly within the cell or to the end of the corridor where the cell was located. There was also no audible means of attracting attention for example a buzzer within the cell. There was no observed officer presence for a period of 18 minutes as verified by the CCTV footage.

	There had been a report in May 2015, provided by the Police Trade Union Representative, which contained significant recommendations including an additional surveillance camera at the far end of the corridor, repairing the existing sound apparatus systems in the cells, modification of the cell doors (removing bars), the holding area to be repositioned. In addition, as a minimum that there should be manned surveillance of the cells at all times, until the recommendations had been implemented. At the time of Antony's death, there is no evidence that any of these recommendations had been implemented. There was evidence to support that Antony was planning for life in the future. During the course of the previous evening, that led to his death there is evidence that there was nothing in his demeanour to suggest that Antony wasn't looking forward to the future.
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: The Jury recorded the Matters of Concern which are described above in their Conclusion and in their findings as to the circumstances of the death. A copy of the Police Trade Union Federation Report to which the Jury refer is herewith together with a translated copy. In addition evidence was given at the Inquest that whilst Custody Officers in Spain must be trained to administer first aid to detained persons, that training does not include training in the administration of Cardio Pulmonary Resuscitation (CPR). These matters are reported in order that they can be brought to the attention of the relevant Authorities in Spain through the appropriate channels.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that you have the power to take such action as aforementioned.
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 18th May 2017. 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:- 1. [redacted] (Antony's Partner), [redacted] 2. [redacted] (Antony's Father), [redacted] 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	**Dated** **23rd March, 2017**	**Signed** **M Jennifer Leeming, HM Senior Coroner**