Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Southampton City Council…
2 Chief Constable of Hampshire

1 CORONER

I am Grahame Antony SHORT, Senior Coroner for the area of SOUTHAMPTON AND NEW FOREST

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 12/05/2017 I commenced an investigation into the death of Jason Marshall GREGORY aged 44. The investigation concluded at the end of the inquest on 18 February 2019. The conclusion of the inquest was:
Jason Gregory died due to the fact that he was restrained in an inappropriate manner after behaving aggressively in a public place whilst being intoxicated. There was a delay before he received the urgent medical treatment he required during which time he suffered irreversible hypoxic brain damage.

The medical cause of death was:
I a Combined and Delayed Effects of Exertion, Excitement, Restraint, Neck Compression and Drug Intoxication (Cocaine and Alcohol)
I b
I c

II

4 CIRCUMSTANCES OF THE DEATH

At about 00.04 on 6 May 2017 Jason Gregory was in Vernon Walk Southampton when he became involved in a disturbance near a night club, as a result of which he was physically restrained by at least two door security staff. During the incident he was struggling and tried to resist and so he was held by an arm hold around his neck for part of the time. His heart is likely to have suffered ventricular fibrillation and then cardiac arrest as a consequence of the restraint, his own exertion and excitement. Other contributory factors for the state of ventricular fibrillation were his intoxication with cocaine and alcohol.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: I heard evidence that door security staff called Southampton Citywatch (Whisky 1) just after midnight on 6 May 2017 by radio reporting a serious disturbance and requesting urgent police attendance at the scene, but this was refused and were told that a call should be made to emergency services using the 999 service. I am concerned that if there is an emergency or serious situation in Southampton known to Citywatch staff by reason of their monitoring or reports received, this fact is not being relayed to Hampshire Police in a timely way and so there is a risk that there will be delays in police officers attending and members of the public are at risk of death or serious injury as a consequence.
It is unclear to licenced security staff how they should call for assistance from the police when dealing with time critical situations at busy times.

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 18 April 2019. 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: [redacted] Synergy Security (UK) Limited, [redacted] and Security Industry Authority.

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

Grahame Antony SHORT
Senior Coroner for
SOUTHAMPTON AND NEW FOREST
Dated: 21 February 2019