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:** **The chief constable, Essex Police**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 20 November 2017 I commenced an investigation into the death of Raymond Alan Knight The investigation concluded at the end of the inquest on 4 April 2019. The conclusion of the inquest was:- **At approximately 19.54pm on the 19 November 2017 Mr Raymond Alan Knight was stopped by police. After a search of his vehicle he was then arrested on suspicion of possession with the intent to supply illicit drugs at 20.15. He was transported to Grays Police Station custody suite and whilst waiting in the holding cell with police officers he collapsed. Emergency medical care was provided immediately and paramedics attended. Mr Knight was then taken by ambulance to hospital where he was pronounced dead. Toxicological analysis indicated high levels of cocaine in Mr Knight's blood.** **The death was drug related**
4	**CIRCUMSTANCES OF THE DEATH** See above
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. – The CCTV camera positioned in the holding area at Grays Police Station did not include, within its range, sight into the individual holding cells. As a result, there was no photographic record of exactly how Mr Knight was and what he was doing while he was in the holding area. It is essential to be able to see what is happening within the holding

	cells when a prisoner is detained within one of them. The court was told that a police officer would be required to be at the cell at all times but if, for any reason, there were to be no officer in attendance, a CCTV record of within the cell is essential. The introduction of discrete camera coverage of the holding areas may well prevent future deaths, of whatever cause, in those specific locations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 31 May 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 – **1. Taylor Haldane Barlex solicitors for [redacted]** **2. IOPC** **3. ITN solicitors for the family** **4. G4S** 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	**5 April 2019** **Caroline Beasley-Murray**