ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*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 Chief Constable for Dyfed Powys Police 2. The National Police Chiefs' Council 3. Hywel Dda Health Board
1	**CORONER** I am Paul Jonathan Bennett, assistant coroner, for the coroner area of Pembrokeshire & Carmarthenshire
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 5th February 2015 I commenced an investigation into the death of Meirion James aged 53 years. The investigation concluded at the end of the inquest on 24th January 2019. The conclusion of the inquest was a narrative conclusion in accordance with the completed jury questionnaire which is appended to this report. The medical cause of death was 1a. Positional Asphyxia; 1b. due to restraint following acute behavioural disturbance; 2. Obesity.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been arrested for an assault on his mother and taken to Haverfordwest Police station. In the immediately preceding period, he had been detained under Section 136 of the Mental Health Act 1983, following a roadside incident, but that fact had not been adequately communicated to the Custody Staff at Aberystwyth Police Station nor the medical staff at Bronglais hospital where he was taken as (a) place(s) of safety. He was subsequently discharged without a mandatory mental health assessment when he proceeded to commit the assault on his mother. While he was at Haverfordwest Police station he became agitated and attempted to leave his cell. He was restrained by police officers during the course of which he became located in the prone position on the floor. He subsequently stopped breathing and despite attempts to resuscitate him, he died from positional asphyxia.

| 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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) Whether the content of police training in dealing with restraint should be addressed
(2) Whether the criteria for identifying the most appropriate place of safety and the responsibilities for transporting someone who is detained under Section 136 MHA 1983 should be reviewed
(3) Whether the content and frequency of police training on the status and responsibilities of an Appropriate Adult under the Police & Criminal Evidence Act should be reviewed. |
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| 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 1st 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 ███████████████
2. The Independent Office for Police Conduct;
3. CRG Medical Services;
4. Doctor ███████████

I have also sent it to the Police & Crime Commissioner for Dyfed Powys and the Welsh Ambulance Services NHS Trust who may find it useful or of interest.

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 | 4th March 2019.

[DATE]   [SIGNED BY CORONER] |