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 National Institute for Health and Care Excellence**
1	**CORONER** I am Rachel Knight, Assistant Coroner, for the coroner area of South Wales Central.
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 11th July 2017 I commenced an investigation into the death of Jon David JAMES. The investigation concluded at the end of the inquest 23rd January 2020. The conclusion of the inquest jury was Narrative. The medical cause of death was found to be: 1a. Hypoxic/Ischaemic Brain Damage 1b. Cardiac arrest during restraint of a man suffering acute behavioural disturbance associated with long-term use of cocaine and anabolic steroids
4	**CIRCUMSTANCES OF THE DEATH** The narrative conclusion read as follows: On the 24th June 2017, police were called by concerned members of the public, to Preston Close, Llantrisant. It was a G1 rated call for assistance. Mr Jon David James had spent time in the Cross Keys pub the previous evening. He had drunk alcohol and had taken a high volume of cocaine. At 1:37 police arrive in the area. At 1:39:51 to 1:40:00 police are at the scene. Police saw Jon standing on a car and displaying erratic behaviour, but pleading for help. After a brief interaction between Jon and the police, he got down from the car but soon ran off. Police chased him into a nearby garden and a struggle started, which lasted approximately 16 minutes. Attempts were made to de-escalate the situation. Suddenly Jon became motionless. Police initially thought Jon was faking his motionless state, because a pulse was detected. However, recovery position was then put into place, while handcuffed, as a precautionary measure because pain tests were done with no reaction. The police were emotionally and physically exhausted. At 2:01 a pulse could not be found and Jon had had a cardiac arrest, CPR was started. At 2:11 an ambulance arrived at the scene. At 2:30 the ambulance arrived at Royal Glamorgan Hospital, but Jon never regained consciousness. Tests showed that Jon had taken heavy abuse amounts of cocaine before the incident as well as alcohol. Tests and history shows Jon was a chronic cocaine and anabolic steroid user. This lead to an enlarged heart, which had an effect upon his body and contributed to his death. Jon died on the 27th June 2017.

	The Inquest focused upon:- a. The circumstances in which Mr James came to lose consciousness; b. Mr James' drug use in the period leading up to the incident; c. During the period after the restraint/struggle had taken place, the actions of the police at the scene; and d. The response to Mr James showing signs of Acute Behavioural Disturbance
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. – 1. Extensive evidence was received from a Consultant Forensic Pathologist and an expert who is a lead trainer for South Wales Police. They were both of the firm opinion that the publication of NICE guidance on the subject of Acute Behavioural Disturbance would be of vital benefit in preventing future deaths. 2. ABD is clearly a complex topic, with understanding ever-increasing. There have been other PFD reports from coroners seeking to implement national training and guidance on ABD, primarily for frontline police, emergency call handlers and paramedics. However, it is only the paramountcy of NICE guidance that would place ABD at the forefront of the national agenda. Critically, such guidance would be of enormous practical use not only to medical professionals, but also to police and any others who find themselves in the difficult position of having to respond to any individual exhibiting signs of ABD in either public places or clinical settings. 3. There is no current NICE guidance dealing specifically with ABD, and the number of deaths related to it is rising.
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 16th April 2020. 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 family who may find it useful or of interest. [redacted], mother of Jon James [redacted] Chair of National Police Chiefs Council [redacted] Chair of the Board of The College of Policing [redacted], Consultant Forensic Pathologist, University Hospital of Wales, Cardiff [redacted] South Wales Police Headquarters, Bridgend 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	20th February 2020 **SIGNED:**  Rachel Knight, Assistant Coroner for **South Wales Central**