Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Constable, Heddlu Gwent
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **14 /12/2019** I commenced an investigation into the death of **John Allan TUCKER DOB: 2/6/1975.** The investigation concluded at the end of the inquest on: **3/11/2020** The conclusion of the inquest was recorded as: **Natural Causes** The medical cause of death was: **1a) Congestive cardiac failure** **1b) Cardiomegaly and ischaemic heart disease** **1c) Coronary Artery Disease (operated)** **2. Drugs (methadone and cocaine) and alcohol intake.**
4	**CIRCUMSTANCES OF THE DEATH** John Tucker had a medical history of significant cardiac disease. This was in part caused by hypercholesterolaemia (abnormally high cholesterol levels in the blood) which caused plaque to be laid down in the arteries that supply blood to the heart. There was also a family history of coronary artery disease. As a result John did suffer from occlusion of the arteries and suffered a heart attack which resulted in the need for him to undergo surgery and in 2018 he underwent a coronary artery bypass grafting of all 4 coronary arties.

	John was thrown life-line by this surgery but due to his underlying predisposition of high cholesterol and diabetes, the coronary disease would return if he did not change his lifestyle. This included taking drugs and alcohol. John was under supervision by the MOSOVO team and was apparently last seen alive by [redacted], a member of the team on 10th June 2019. I am satisfied that John was alive when seen by [redacted] and I did not consider there was any evidence of respiratory distress (as suggested by the family). However, during questioning [redacted] was asked about John's condition and whether she would be able to recognise and manage signs of respiratory distress. [redacted] confirmed she had received first aid training but could not confirm that she would recognise respiratory distress or know how to manage such a problem. DS [redacted] also gave evidence in relation to the police investigation and to confirm there was no evidence of third party involvement in John's death. In relation to training, DS [redacted] also confirmed that officers are given training in basic life support but she could also not confirm that she could recognise or manage treat respiratory distress. There was no evidence of any flaw or omission in care afforded to John by Gwent Police and no evidence, as aforementioned, that John was suffering from respiratory distress at the time. This was a line of argument advanced by the family.
5	**CORONER'S CONCERNS** During the course of the inquest, 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 information from [redacted] of the MOSOVO team and DS [redacted] raised some concerns about the nature and extent of basic life support and first aid training provided to the different staff employed by Gwent police who of course may be in regular contact with people who are unwell or injured giving rise to respiratory problems.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. <u>I should be grateful if the following information be provided to me</u>: Confirmation regarding the nature and extent of basic life support training provided to police employees; officers and civilian staff, particularly in relation to the recognition and management of respiratory distress.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 13th January 2021. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • The family of Mr John Allan TUCKER 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 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	**DATE 19/11/2020** Signed CSaunders Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**