	REGULATION 28 REPORTS TO PREVENT FUTURE DEATHS
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** On 12th August 2019 an inquest into the death of Mr Ian McDonald Taylor was opened. He died on 30th June 2019 in King's College Hospital, London. (159801) The inquest was concluded on 19th May 2022, heard before me with a narrative conclusion delivered by a jury.
4	**CIRCUMSTANCES OF THE DEATH** The medical cause of death was 1a Cardiac Arrest 1b Acute asthma, COPD, situational stress, ischaemic heart disease II Dehydration The narrative recorded that on 29th June, he had a physical altercation around 17.55 after which he lay on the pavement breathing heavily, that he was handcuffed and arrested (for prior assault) and an ambulance was called by police as he had difficulty breathing (but the service was exceptionally busy and his category did not qualify for highest priority ambulance). He had a cardiac arrest at 18.32 and an ambulance crew then attended promptly and after CPR he was transferred to hospital where he died at 22.10.

5. **The FIRST REPORT IS BEING SENT TO:**

1. [redacted], Director General IOPC, Independent Office for Police Conduct, 10 South Colonnade, Canary Wharf, London E14 4PU

2. [redacted], (Acting) Commissioner of Police of the Metropolis, Metropolitan Police Service, Victoria Embankment, London SW1A 2JL

THE CORONER'S MATTER OF CONCERN

The current fitness of PC [redacted] to serve as a police officer

Evidence was heard in court from officers in person and from body worn footage (BWV). It included:
18.18 PC [redacted] recalls discussing with colleagues it might be better to put him in their car where it was cooler. PC [redacted] hears Mr Taylor say *I'm going to die. Stand me up now.* Mr Taylor was lying down and had to be helped to stand up. PC [redacted] and PC [redacted] had just returned. PC [redacted] reassured him that he was not going to die and told the court that initially Mr Taylor did not support his own weight. He said that they had to support him walking to the car. On PC [redacted] BWV Mr Taylor may say something like *I'm fading* and then *I'm going to die now.*

Whilst PC [redacted] was away from Mr [redacted] he accepts that he is heard shortly after 18.14 stating to his sergeant on the radio "*He's currently on the floor playing the whole poor me poor me; he's going to have to go to hospital though as a matter of course.*" And at 18.24:
"He's saying he has chest pains he cant breathe blah blah; it's a load of nonsense but there we go"

He said in court that he formed these views as Mr Taylor seemed iller than he would expect from the nature of the previous altercation. He denied he thought Mr Taylor was faking. He claims to have made a continual risk assessment, but there is no record or evidence of that. He said that his views were influenced by a previous incident in which a man sprang to violence from previous calmness. They were not his final conclusion. There was no evidence as to his forming a different conclusion in the following 8 minutes before the cardiac arrest.

In court he was asked if he had learnt any lessons from the incident and he did not acknowledge he had. He was asked if he would do anything different in future, he made excuses for his comments and he said that he would be more sensitive in future. He was not able to answer a question about what considerations should be made to form the view somebody did not need hospital. He did not accept that he had made an inadequate risk assessment. He did not accept that such comments could have or might in future contribute to death by indicating a lack of urgency to a sergeant not at the scene. He was given an opportunity to make any other comment and could not bring himself to apologize to the family.

There was no evidence heard in court of the content or effect of supervision of the officer after the incident or whether training or attitudinal deficits had been identified and addressed. The family are concerned as to whether the officer should be suspended pending further investigations, and I disclsose that merely as a measure of their level of concern about public safety, as it is inappropriate for me to make any such recommendation.

ACTION SHOULD BE TAKEN

Given the evidence heard in court before the family and members of the press, it is in the public interest that statutory bodies consider whether further investigations or reports are warranted to give reassurance to the public about the fitness of this officer to serve by

1. The IOPC, not only on the basis of conduct at the scene, but the evidence of his attitude, insight and extent of learning in court.

2. The Metropolitan Police Service as to his supervision after the incident, assessment of training needs and provision of any further training.

6.	**The SECOND REPORT IS BEING SENT TO:** 1. The Rt. Hon Sajid Javid, Secretary of State for Health and Social Care, The Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU 2. [redacted], President of The Royal College of Emergency Medicine, Octavia House, 54 Ayres Street, London, SE1 1EU. **THE CORONER'S MATTER OF CONCERN** Mr Taylor was in police detention in a public place and was known to be a sufferer of both COPD and asthma, required to take a regular combination of inhalers and had a history of emergency admission to hospital with life threatening asthma. He repeatedly asked urgently for his inhaler, which he said was in his pocket and that he needed it and that he felt he was going to die. Police did not find it (although a broken inhaler found later at the scene might have been his). If he had been in a custody suite he would have had access to a custody nurse or medical practitioner who could have prescribed it. Because of wholly exceptional demands on the ambulance service, a paramedic was not available until after he had sufferred a cardio-respiratory arrest, from which he did not survive. A consultant paramedic and London Ambulance Service Director was asked about the feasibility of an inhaler device being available to police to offer to known asthmatics in exceptional circumstances when medical help was not available, such as is now in place in schools. He said that there were many difficulties: The difficulties included the adequacy of assemment of need by non medically trained persons on the scene, the difficulties of remote assessment, the threshold for confirmation of the person in distress being an established asthmatic, avoiding giving it to those with non asthmatic causes of breathlessness, and police training. Neverthless he said that lives might be saved and it should be looked at. Advice was given to the court that such a proposal would need legislative change.

	ACTION SHOULD BE TAKEN The Royal College of Emergency Medicine and The Deaprtment of Health are asked to consider whether a feasibility study is indicated to see if statutory change is advisable.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday, August 5th 2022. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted] and [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following interested persons: [redacted] and [redacted] Solicitors for the family [redacted] [redacted] for the Metropolitan Police Serivce (MPS) [redacted] for the London Ambulance Service (LAS) [redacted] I am also copying it to [redacted] from the Independent Office of Police Compalints (IOPC) and [redacted] Senior Paramedic (LAS), for information as they have an interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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	**[DATE]** **[SIGNED BY CORONER]**  **8th June 2022** **A N G Harris, Senior Coroner**