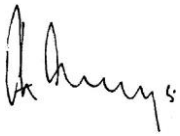
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Bedfordshire Police Chief Constable** **2 His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 10 June 2021 I commenced an investigation into the death of Sean Gerard DUIGNAN aged 44. The investigation concluded at the end of the inquest on 14 November 2022. The conclusion of the inquest was that: Sean Gerard Duignan was a well respected, well liked and universally helpful base sergeant at the Luton Airport Armed Policing Unit (South Base). On the 29th May 2021 he was arrested following reports of a vehicle being driven erratically and dangerously. A Bedfordshire Police sergeant visited him at his home to conduct what was initially to be a welfare check. Sean was intoxicated with alcohol and was arrested and taken into custody on suspicion of drink or drug driving. He remained in custody until the following afternoon when he was released under investigations. Multiple and serial enquiries were made by members of the custody and health care staff at Milton Keynes Police Custody suite to determine his mental health and to keep him safe. Those checks were repeated on release. They were continued by the police federation representatives and his close friend [redacted] All seemed well. The next day, a day off, Sean travelled to the Luton Airport Armed Policing Unit where the South Base armoury is located. The armoury security was lax and had been for a prolonged period. The computer system used for electronic access was repeatedly failing but seemingly no coherent approach was taken to remedy this. The back up master armoury key was kept in a PIN protected locked box, but the PIN number was universally known. Because of an error in the computerised system an officer was allocated single point access when she should not have been. She unwittingly let Sean, whose own access to the armoury had been restricted without his colleagues being informed, into the armoury. He took a hand gun and ammunition, entered the base gym and shot himself in the head.
4	**CIRCUMSTANCES OF THE DEATH** This report touches the death of police sergeant 5353 Sean DUIGNAN who was found deceased at Bedfordshire polices airport unit offices located on Percival way Luton from what is believed to be a self-inflicted gunshot wound. At about 09:15rs on Monday 31st May 2021 officers have been made aware of a concern for the wellbeing of PS DUIGNAN and they have been asked to make a search of the airport policing unit offices located at Percival Way Luton. Officers have conducted the search and have found PS DUIGNAN deceased on the floor of

	the gym which is located on the ground floor and next-door to the armoury, also on the ground beside him was a police side arm hand gun and two bullets. First aid has commenced and an ambulance has been called, paramedics have attended and continued treatment but unfortunately, he was declared deceased at 09:45hrs by paramedic [redacted] It should be noted the PS DUIGNAN was arrested on Saturday 29th May 2021 for the offence of drink driving and taken to Milton Keynes police station where the drink drive procedure was carried out,
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Sean Duignan was arrested on the 29th May 2021 and taken to Milton Keynes Police Station where he was detained and released under investigation the next day, Sunday 30th. That seems to have been a likely trigger for Sean to take his own life. The next day he was on leave and went to the Luton Airport Police base where the Southern Armoury was located. He was the Armed Response base sergeant. Sean entered the equipment room, where the manual override keys to the armoury were located in a locked box secured by a PIN. Officer [redacted] who were present in the equipment room said Sean appeared startled to find them there. He remained cheerful and engaged in cheeky banter [redacted] was of the view that Sean entered so that he could access the armoury key. Sean, discovering his access to the override key was blocked asked one of the officers to second him into the armoury. By chance, it was [redacted] who agreed and went with Sean to the armoury. She had been given single access by error following a Chronicle systems failure some time previously. Sean applied his armoury card to the reader and entered his PIN. It failed. [redacted] reasonably thought it was because Chronicle had failed again and used her card and PIN. Because she was allowed – incorrectly – single access, the door opened and she let Sean in where he retrieved a handgun and ammunition. Had [redacted] any other officer at base known that Sean's access had been restricted she would not, I am certain, have allowed him entry. There was a serious failure by senior management to effectively and safely manage the South Base Armoury. All the base officers who gave evidence before me told me the armoury system, which they referred to as Chronicle, repeatedly and randomly failed. These multiple failures were, according to [redacted] not communicated effectively to her. She agreed that she did not herself make any further detailed enquiry instead relying on her Operational Inspector to manage the issue and/or to feed back as appropriate. The computerised system controlling the access to the armoury at South Base included a

	number of different parts including the server, the software, the Chronicle system itself, the card readers etc. The system as a whole repeatedly failed. There was no effective ongoing monitoring of the system. CI Rowley Smith agreed that the system did not work properly and the monitoring system did not work properly. As part of a fail safe to ensure that officers who needed weapons could obtain them if the computerised system failed, an armoury override key was kept in a locked box, secured by a PIN, in the equipment room. All officers giving evidence before me agreed that the PIN number was common knowledge. The fact that the PIN number was common knowledge meant potentially that any one of the officers working at the base had unfettered access to the armoury [redacted] The fact that the access was not abused by the officers was due wholly to their trustworthiness and professionalism. On this occasion, Sean sought access to the armoury via the key but was thwarted by both PC [redacted] being present in the equipment room. Unfettered access to the armoury meant that rogue officers (of whom luckily there were none) could potentially have had access to weapons for the purposes of criminality, suicide (as in Sean's case) or homicide. Overall, I find the lax approach to safety and security in the South Base armoury by senior management, who were responsible, to be extraordinary. [redacted] agreed that the armoury was an unsafe environment. In the interval between Sean's death and the Inquest some 18 months later, I was not reassured that effective action had been taken to secure the armoury. Immediately post Inquest some reassurance was provided but gaps remained.
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 March 13, 2023. 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 • The family • Bedfordshire Police Chief Constable • Bedfordshire Police Federation • Thames Valley Police Chief Constable • The IOPC I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 16/01/2023**  **Sean CUMMINGS** **Assistant Coroner for** **Bedfordshire and Luton Coroner Service**