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:** **1.** [redacted], Chief Executive Officer of the College of Policing **2.** Chief Constable [redacted], Chair of the National Police Chiefs Council **3.** Niche Technology/Niche RMS **4.** [redacted], Chief Executive Officer of the Maritime and Coastguard Agency **5.** National Strategic Board of the National Police Air Service **6.** [redacted], Chief Executive Officer of RNLI **7.** [redacted]erty, Managing Director of the Association of Ambulance Chief Executives **8.** [redacted], Chair of the National Fire Chiefs Council **9.** [redacted] Chief Executive Officer of NHS England **10.** Chief Constable [redacted], Dorset Police **11.** [redacted], Chief Fire Officer Dorset & Wiltshire Fire & Rescue Service **12.** [redacted], Chief Executive Officer of South West Ambulance Service NHS FT
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 11th August 2020, an investigation was commenced into the death of Ivan Rumenov Ignatov, born on the 10th February 1996. The investigation concluded at the end of the Inquest on the 26th May 2023. The Medical Cause of Death was: Ia Drowning The conclusion of the Inquest was a narrative conclusion that Ivan Rumenov Ignatov died as a consequence of drowning in open water, in circumstances where his intentions for entering the water remain unclear.

4	**CIRCUMSTANCES OF THE DEATH** At around 21.15 hours on the 19th July 2020 Ivan Rumenov Ignatov was seen to enter the driver's seat of a motor vehicle parked on Easton Square, Portland attempting to take the vehicle. There was a tussle where Ivan received injuries and he fled on foot, knocking on the doors of residents nearby asking for help, displaying agitated behaviour. At approximately 22.00 hours he was seen by police officers, and he ran off from them on foot into a nearby quarry. At approximately 22.13 hours he was seen to enter and exit the water at Church Ope Cove, Portland fully clothed, displaying odd behaviour. At around 22.21 hours he was located walking on the cliffs and coastline of Portland, Dorset. He was acting erratically and seen stumbling along the rocky terrain. He was followed by the national police helicopter and police officers on the ground in an attempt to safeguard him. At 22.48 hours he entered the waters of the English Channel, north of Durdle pier and swam away from shore a distance of approximately 20 to 50 meters. At approximately 23.03 hours he went underneath the water and did not resurface. He was found deceased in the water south of Durdle Pier, Portland on the 31st July 2020.
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. During the inquest evidence was heard that: i. At approximately 19.35 hours on the 18th July 2020, Ivan, a Bulgarian international with a history of mental health illness, who spoke limited English and had never been arrested before, was arrested for the offence of domestic related assault and taken to Weymouth Police station where he was interviewed and released on bail at approximately 18.00 hours on 19th July 2020. He was released without an address to reside at, although an offer had been made by the custody sergeant for police officers to take him to his home address, where the victim lived, to collect his belongings and then take him to a place he could temporarily stay, such as a hotel. Whilst waiting for the officers to arrive to take him, Ivan left the Police station of his own accord and made his way to Portland, Dorset where he then attempted to take a motor vehicle as outlined in the circumstances above in section 4. During his time in police custody, it was identified by the custody sergeants that Ivan required a face to face assessment by the mental health practitioner. This did not happen. Further at approximately 09.00 hours on the 19th July he was seen to place an item around his neck which was interpreted by the custody sergeant as being an act of self-harm. At this time his risk of harm was assessed as low as his clothing had been replaced by rip stop clothing.

ii. When detained at the Police station it was not recorded anywhere on the custody record or associated Niche paperwork that this was Ivan's first time in police custody. There is no set question for this on the risk assessments within the custody log system held on Niche. In the College of Policing Authorised Professional Practice Guidance (APP guidance) on detention and custody risk assessment, the fact that it is the first time a person has been arrested or detained may indicate an increased risk. It is therefore important this is recorded somewhere. Other factors that appear in the list contained in the APP guidance which may increase the risk to a suspect were present with Ivan but were not highlighted or collated in the police records and which would assist with risk assessments.

Further in the Niche occurrence log when an entry is placed entitled "Primary Investigation" where there are 15 different sections to be completed, number 2 deals with the suspect. This does not however cover anything concerning the risk to the suspect themselves. There is no where other than on the custody risk assessment where officers managing the case can record the risks to the suspect themselves, unless they record this as a free type entry on the custody record or the Niche occurrence log.

Information gathering and collating can therefore be missed and key information around a suspect's risk may not be highlighted in a clear, easily accessible location. When a person is released from police custody, the investigating officer and the custody sergeant submit reports for the bail application to be considered by the duty Detective Inspector to approve. In this case, key information about Ivan's risk, such as the placing of the clothing around his neck, and unusual behaviour during the police interview, were not all collated and recorded in one place where all the information was easily accessible.

iii. In the APP Ggidance on detention and custody risk assessment there is no specific guidance on what may fall into the category of low, medium or high risk when a person is being assessed by a custody sergeant. In comparison when grading a missing person there is more specific guidance in the current APP guidance on missing persons.

iv. There is no formal guidance given to custody sergeants or police officers as to what to do when a detainee has no place to reside upon release from police custody.

v. Upon his release from police custody, Ivan was given leaflets, such as the mental health safety netting advice leaflet detailing the mental health services he could access. These were given in English and placed with his property which was given to him upon his release from custody. They were not translated or explained to him. In Dorset these leaflets are now able to be produced in the language of the detainee or in an

understandable format for those who may have difficulties with reading, however this is likely to be a national problem.

vi. A number of emergency services and search and rescue services were involved in the events on the 19th July after Ian had tried to take the motor vehicle. These were Dorset Police, National Police Air Service (NPAS) His Majesty's Coastguard (HMCG) & the RNLI. The police radio was accessible by Dorset Police and NPAS as a channel of communication and HMCG and RNLI are able to communicate via VHF radio but there is no direct communication between all services, for example for NPAS and HMCG to directly communicate, they go via the police command centre. This can lead to a misunderstanding of what is going on, on the ground. In this case it was the belief of the NPAS Tactical Flight Operator (TFO), who was aware that there was a risk to Ivan's life from about 22.15 hours, and also the Force Incident Manager (FIM) in the police command centre, that a lifeboat had been launched, when in fact it had not. They therefore believed one was on route when it was not. If they had been aware that it was not on route this would have allowed for further communications or direct requests to be made between agencies, and other actions being taken. I was told in the evidence that there is work ongoing around an emergency services channel for communications, but this would not include search and rescue agencies and I have been told this is taking a considerable period of time to develop.

There appears to be from the evidence a lack of understanding between emergency services and search and rescue teams about the work each other undertakes, the language and terms they use, and the tasks they undertake.

2. I have concerns with regard to the following:

i. There is not sufficient clarity in the identifying, collating and recording of factors which may increase a person's risk on the Niche system that Dorset Police, and other forces nationally, use and as a result information could be missed which is vital to a person's risk assessment and their risk to themselves or others.

ii. There is not sufficient guidance given to custody sergeants on a national basis of how to assess a person's risk.

iii. There is no guidance, that I am aware of, which addresses what should be done by police forces, and particularly custody sergeants, when a person is to be released without an address to reside at and I would request consideration is given to such guidance being provided.

iv. There is a lack of knowledge and/or understanding amongst emergency services and search and rescue services, especially around terminology, process and communication for them to be

	ensure they can work together when an incident arises without confusion or misunderstanding arising. I would request that consideration is given to further national and local training or guidance across emergency and search and rescue services to ensure communication can be facilitated without delay, and ensure terms and processes are understood to avoid any doubt of what action is being taken when an incident is ongoing. v. Leaflets given to detainees when released from police custody are not always accessible due to language or literacy barriers and I would request that consideration is given nationally by NHS England and all Police Forces to ensure that any documentation detainees, especially any providing help and assistance, is accessible to them.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 3rd August 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: (1) Ivan's family (2) DHUFT (3) Castle Rock Group Medical Services (4) Chief Constable of Dorset Police (5) HMCG (6) NPAS (7) RNLI 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	**Dated** **8th June 2023**	**Signed**  **Rachael C Griffin**