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: - The CEO, HCRG Care Services Ltd, The Health Business and technical Park Heath Road Runcorn WA7 4QX Rt Hon Alex Chalk MP, the Secretary of State for Justice Ministry of Justice 102 Petty France London SW1H 9AJ Rt Hon Victoria Atkins MP, the Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU [redacted]
1	**CORONER** I am Peter Nieto, senior coroner for the coroner area of Derby and Derbyshire
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 07 September 2020 I commenced an investigation into the death of Mark PRYOR aged 46. The investigation concluded at the end of the inquest on 01 February 2024. The conclusion of the jury was: - *Mr Pryor suffered an alcohol withdrawal related seizure whilst detained in police custody which caused cardiorespiratory arrest and death. There were deficiencies in the health care professionals' assessment and treatment of Mr Pryor's alcohol withdrawal which probably made a more than minimal contribution to his death.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Pryor died at the emergency department of the Royal Derby Hospital on 5th September 2020, shortly after being taken there from police custody where he had gone into cardiorespiratory arrest due to alcohol withdrawal. He had a long-term history of drug and

	alcohol misuse and was alcohol dependent. He had been arrested and detained in police custody on 4th September. Mr Pryor was seen in police custody by Health Care Professionals (HCP's) due to his documented opiate misuse, methadone usage and alcohol dependency. Mr Pryor was attended on four separate occasions by two different HCP's whilst in custody. He was recognised to be dependent on alcohol and when he began to exhibit symptoms of withdrawal a HCP began a course of alcohol withdrawal medication to reduce the symptoms and guard against possible alcohol withdrawal related seizure. The inquest jury returned the following conclusion: - *'Mr Pryor suffered an alcohol withdrawal related seizure whilst detained in police custody which caused cardiorespiratory arrest and death. There were deficiencies in the health care professionals' assessment and treatment of Mr Pryor's alcohol withdrawal which probably made a more than minimal contribution to his death'.* The jury recorded the following findings: - *'The HCP assessments were not of a reasonable standard due to the following reasons:* *- Assessments provided were substantially shorter than the recognised accepted practice and consistently shorter than would have been required to properly assess Mr Pryor effectively. In addition to this the time between assessments was too long, particularly after the critical dose of the withdrawal medication was administered, to ascertain the effectiveness.* *- Assessments were lacking in consistent information i.e. BP, pulse, heart rate and history. Previous assessments were not referenced prior to each visit, changes in vital signs were not acted upon.* *- Assessment records were inadequate and lacking in detail.* *There was a point at which an increase in the withdrawal medication dose should have been considered when Mr Pryor's BP and pulse were not taken and found to be elevated. …..* *Although not demonstrably contributory to Mr Pryor's death, the jury records the following matters:* *There were inadequacies in the training and induction provided to the lesser experienced HCP who attended Mr Pryor.* *It is also clear that the lesser experienced HCP did not have suitable experience and skills to work as an HCP'.* The lesser experienced HCP had previously worked as a mental health nurse.
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: I am concerned that Health Care Professionals (HCPs) may not be receiving sufficient and adequate training to enable them to practice effectively or safely in police custody suites. This is based on the evidence and findings in Mr Pryor's inquest and my understanding that the training provided by HCRG may be very similar to that given by other providers of HCP police custody services nationally.

Clinical assessment and treatment is provided to police custody detainees by HCPs with the support of an on-call doctor. Typically there will be one HCP per shift. Nationally, HCP services are provided by a number of independent providers under contract to individual police forces. Professionals eligible to be recruited as HCPs (as taken from HCRG personal specification) are registered nurses (general or mental health), or paramedics with a minimum of two years post-qualification with NMC or HCPC registration and '*nursing experience in the following: A&E, ITU, EAU, SAU, Nurse Practitioner, Practice Nurse, EAU, SAU (other nursing backgrounds will be considered)'.*

Current training provided to newly appointed HCPs (by HCRG) consists of shadowing shifts with an experienced HCP, potentially for up to six or eight shifts; a two-day induction course; a medication related course of less than a day which includes a pass or fail test. There is also formal supervision and a three-month probationary period.

The two-day induction course covers the following topics: -

Day 1
Overview of the role of HCPs in custody; Consent, confidentiality and ethics – covering topics including the relevant laws, regulations and regulatory issues, the importance and limitations of concept, assessing capacity, nature of the HCPs dual responsibility and how it affects disclosure of sensitive information. and importance of record keeping; Fitness to detain – covering topics including the need to assess detainees for injuries, illnesses, and drug and alcohol problems, formulating a care plan in custody to manage risk and identifying those who are not fit to detain who may need alternative support; Fitness to interview / charge/ transfer / release – covering topics including a recap on assessing capacity and assessing, safeguards to prevent the risk of involuntary/false confessions, overview of illnesses that might be worsened by interview and factors to consider when assessing detainees' fitness to release; Drugs and alcohol is police custody – covering topics including examination features of alcohol and/ or opiate intoxication, examination features of alcohol or opiate withdrawal, key assessment details in the detainee with alcohol dependence, treatment of alcohol / opiate withdrawal in police custody; Mental health in custody - covering topics including the relevant sections of the Mental Health Act, the overlap of learning difficulties with mental health in police custody, the role of liaison and diversion (L&D) teams and the approved mental health professional (AMHP) and when to refer to specialist services; Mental state examination (MSE) – covering topics including purpose of MSE, format of MSE, communicating MSE findings and risk assessments.

Day 2
Forensic science and samples – covering topics including understanding Locard's Principle, which offences may trigger sample requests, taking non intimate and intimate samples and relevant procedural steps; Traffic Medicine – covering relevant procedures under the Road Traffic Act; Restraint, TASER and irritant sprays – covering an overview of different types of restraint and when a detainee may need hospital following restraint; Documentation of injury – covering how to take history for injuries, how to describe, document and classify injuries; Statement writing – covering topics including overview on preparing a witness statement, format of a witness statement and information required to complete a statement and importance of good clinical notation on the assessment forms provided in custody.

I have reproduced the summary of training, which was given in evidence at the inquest, to illustrate that there are obviously a very extensive number of topics which are listed to be covered.

I find it difficult to see that necessary training can be given within the specified time to equip a paramedic or nurse who is fresh to the custody setting to practice effectively and safely. The inquest heard evidence from the more experienced HCP that when she started, with a different provider some eight years prior, she had six weeks classroom-based training before she commenced full duties as an HCP. The inquest also heard that The Faculty of Forensic & Legal Medicine recommends a five-day induction course for HCPs.

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. **NB** – I am unclear where ministerial responsibility may lie regarding health care provision in police custody and hence I am sending this report to the MoJ and the Dept for Health and Social Care so that the relevant department/s will provide a response.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd April 2024. 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: [redacted] (son) Derbyshire Police Constabulary Independent Office of Police Conduct (IOPC) [redacted] [redacted] I have also sent it to: - Chief Cons. [redacted], Chair, National Police Chiefs' Council, 50 Broadway, London, SW1H 0BL [redacted], President, The Faculty of Forensic & Legal Medicine 11 St Andrews Place London NW1 4LE 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: 6th February 2024**  **Peter Nieto** **Senior coroner for** **Derby and Derbyshire**