ANNEX A

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. The Chief Constable, South Yorkshire Police Headquarters, Carbrook House, 5 Carbrook Hall Road, Sheffield, S9 2EH**
1	**CORONER** I am Alexandra Pountney, Assistant Coroner, for the coroner area of South Yorkshire (West District)
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 30 April 2020 an investigation was commenced into the death of Matthew Terrill. An inquest started on 19 February 2024 and concluded on 8 March 2024. The cause of death was: 1(a) Cardiorespiratory arrest. 1(b) Hypoxic ischemic brain injury. 1(c) Cocaine, [redacted] (synthetic cannabinoids), heroin, pregabalin, gabapentin and dihydrocodeine toxicity (with associated acute agitation), and ischemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** On 22 April 2020, Matthew Terrill was taken into custody at Shepcote Lane Custody Suite, Sheffield by officers from South Yorkshire Police who had arrested him in the community.

	At the time of his arrest, Matthew was intoxicated by drugs (including, Cocaine, [redacted] (synthetic cannabinoids), heroin, pregabalin, gabapentin and dihydrocodeine). An ambulance was called by officers in the community at 11.27am and cancelled at 11.43am. Matthew arrived at Shepcote Custody Suite at 11.56am. There is an attempted booking in procedure for Matthew between approximately 11.57am and 12.05pm, during which time Matthew was exhibiting behaviour of drug intoxication, possibly combined with acute mental health symptoms, and ultimately required restraint by officers. Matthew was restrained and escorted to a cell before he was assessed by healthcare professionals stationed at Shepcote Lane, of which there were two on shift and available. Healthcare professionals were unable to assess Matthew in his cell during the restraint by officers, which lasted for approximately 11 minutes. Matthew was then put on level 4 constant observations with two police officers (including the arresting officer) assigned to him. This period of observation lasted roughly between 12.16pm and 13.28pm, when it was noted that Matthew was no longer breathing. No further medical assessment was carried out during the period of observation. The evidence before the Court was that the officers assigned to constant observations had limited experience of carrying out the task and had not been briefed by the custody sergeant.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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. – **1. Lack of training in the First Aid or Personal Safety courses for police officers in relation to recognising the signs and symptoms of drug intoxication. Specifically, how to recognise a drug overdose or the ill-effects of drug intoxication, and when it is appropriate for a detainee to be taken to hospital.** I have been told that officers routinely come across persons who are intoxicated through drugs, and that officers are routinely expected to risk assess these persons and decide whether to transport to hospital or custody. Without proper guidance in place for the officers, I am concerned about the risk of future death to persons who are intoxicated by drugs and requiring hospital treatment. I note the circulation of the 'Patient or Prisoner' cards, but these do not include reference to intoxication by drugs. I note also that some training is given to trainee officers, but this does not specifically cover intoxication by drugs and, even if it did, I am concerned that training an officer once, at the beginning of their career,

leaves the door open to the development of bad practice and the fallibility of human memory.

2. **Lack of training in First Aid or Personal Safety courses for police officers in relation to recognising the signs and symptoms of mental health conditions and acute mental health crisis. Specifically, when this may be impacting upon the behaviour of the detained person and whether they require medical assistance from a hospital.**

   I have been told that officers are trained in methods of communication with persons who are suffering from mental health episodes, but not how to recognise the symptoms. There is training on ABD, and I am not concerned about the officers' ability to respond to persons with suicidal ideation. Accepting that police officers are not medical professionals, I am concerned that there is no guidance on recognition of symptoms of mental health conditions falling short of crisis (in particular the way in which this may affect behaviour) and appropriate management, then detained persons suffering from a mental health episode, or with pre-existing mental health conditions, may be at risk of future death.

3. **Lack of training in First Aid or Personal Safety courses for police officers in relation to the heightened risk of positional asphyxia and intoxication.**

   I have seen guidance from the College of Policing that there is a heightened risk of positional asphyxia in persons who are intoxicated. I am concerned that without some guidance and training, police officers will be unable to take steps to reduce the risk of positional asphyxia in intoxicated persons which may cause a risk of future death.

4. **Lack of refresher or mandatory annual training for police officers in relation to constant observations.**

   I am told that there is no specific mandatory training for police officers on constant observations, but that trainee police officers are now given training on constant supervision as part of their introduction to the custody suite. I have been told that there is an optional CPD module available to officers on constant observation training. I am concerned that police officers are being regularly asked to perform constant observations on detainees of the highest risk levels without any mandatory training or refresher training on the subject. Whilst the Custody Sergeant is tasked with providing a briefing to officers who are tasked with constant observations, I am concerned that there is no evidence of consistency in this task being completed to an appropriate standard or at all. There is a risk that in a busy custody suite, this briefing will be overlooked or omitted (and in fact that was the evidence in this case). There is no evidence to reassure me that this was a one-off incident, rather the evidence before me suggested that it was not. This gives rise to a risk of future death for detained persons on level 4 constant observation.

	5. Lack of refresher or mandatory annual training for police officers in relation to information to be passed to the custody officers during the booking in procedure. I am told that there is no specific mandatory training for police officers on the information expected of them at the custody suite desk during the booking in procedure, but that trainee police officers are now given training on constant supervision as part of their introduction to the custody suite. I am concerned that police officers are regularly handing over to custody officers without any mandatory training or refresher training on the subject, which leaves the information that they decide to pass over open to discretion. Training an officer once, at the beginning of their career, leaves the door open to the development of bad practice and the fallibility of human memory. This gives rise to a risk of future death for detained persons if pertinent information is omitted, for example health or intoxication information. **6. Lack of safety net for custody suit documentation, specifically the constant supervision forms.** I am told that whilst there has been a welcomed change to the format of the constant observation forms, there is no safety net for ensuring that these forms are handed over in a timely manner or by the custody sergeant. I am also told that there is no audit trail in place for checking that these forms are being signed by police or custody officers to ensure that the envisaged sergeant briefing is being given. I am concerned that there is a risk of future death to detained persons on level 4 constant supervision in circumstances where the sitting officers may not be experienced in the task, have not been trained, and are not consistently being briefed by the custody officers. **7. Jury concern – the design and format of the documentation, specifically the level 4 supervision form, was unclear and poorly structured.** This featured within the jury's narrative conclusion, and whilst I heard some evidence that certain elements of the form had changed. It is broadly similar in its new format to the copy that the jury were presented with.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 22 May 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 Interested Persons. 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 other person who I believe may find it useful or of interest. I have sent a copy to the College of Policing. 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.
9	 **27 March 2024** **Alexandra Pountney** **HM Assistant Coroner**