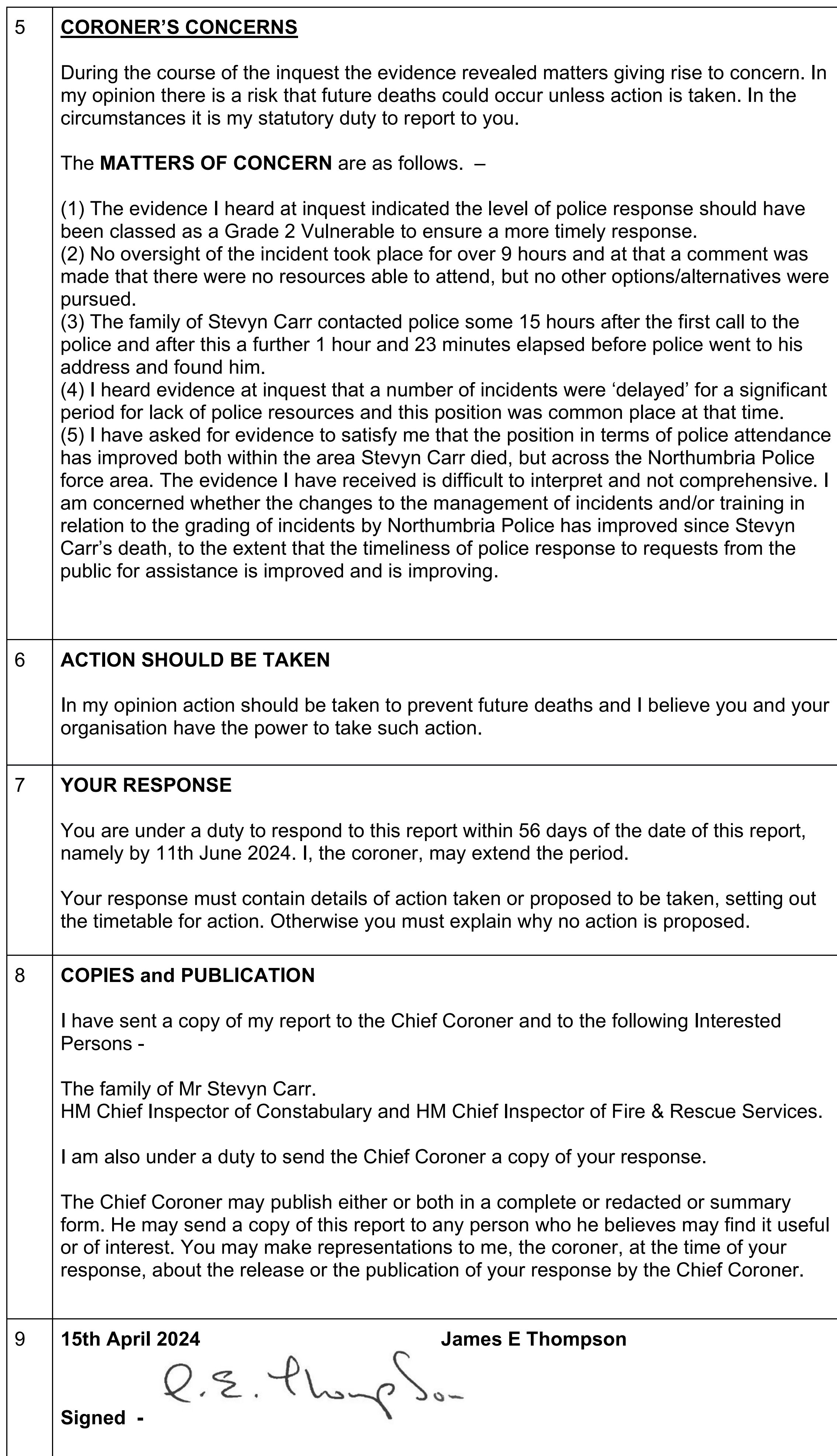
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] - Chief Constable - Northumbria Police**
1	**CORONER** I am James Thompson, Assistant Coroner, for the coroner area of Gateshead & South Tyneside
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 22nd November 2021 I commenced an investigation into the death of Stevyn CARR, 34 years old. The investigation concluded at the end of the inquest on 6th March 2024. The conclusion of the inquest was Drug & Alcohol Related. The medical cause of death was; 1a Cardiac Arrhythmia 1b Chronic Excess Alcohol Consumption and Use Of Amphetamine I found at inquest, Stevyn Carr died on 16th November 2021 at 17 Lytchfeld, Leam Lane, Gateshead from a cardiac arrhythmia caused by the toxic effects of him voluntarily consuming a quality of alcohol and amphetamines at some point prior to his death. His intention in doing so was not to end his life.
4	**CIRCUMSTANCES OF THE DEATH** Stevyn Carr contacted Northumbria Police on the evening of 15th November 2021 at 7.22pm. His contact with police call handlers and emergency operators was difficult to understand, due to on balance to his intoxication. He did ask for 'Help' and he was told police would attend. The calls to police were assessed a Grade 2 response - normally within an hour. No police attended until they entered Stevyn Carr's address at 12.02pm on 16th November after members of his family contacted the police at 10.38am to express their concerns for him. He was discovered dead when police entered his home. On the evidence heard it was not possible to ascertain whether earlier police attendance would have altered the outcome. From the first call to police to his discovery by police a period of 16 hours 40 minutes elapsed.



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) The evidence I heard at inquest indicated the level of police response should have been classed as a Grade 2 Vulnerable to ensure a more timely response. (2) No oversight of the incident took place for over 9 hours and at that a comment was made that there were no resources able to attend, but no other options/alternatives were pursued. (3) The family of Stevyn Carr contacted police some 15 hours after the first call to the police and after this a further 1 hour and 23 minutes elapsed before police went to his address and found him. (4) I heard evidence at inquest that a number of incidents were 'delayed' for a significant period for lack of police resources and this position was common place at that time. (5) I have asked for evidence to satisfy me that the position in terms of police attendance has improved both within the area Stevyn Carr died, but across the Northumbria Police force area. The evidence I have received is difficult to interpret and not comprehensive. I am concerned whether the changes to the management of incidents and/or training in relation to the grading of incidents by Northumbria Police has improved since Stevyn Carr's death, to the extent that the timeliness of police response to requests from the public for assistance is improved and is improving.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 11th June 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 - The family of Mr Stevyn Carr. HM Chief Inspector of Constabulary and HM Chief Inspector of Fire & Rescue Services. 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	**15th April 2024** **James E Thompson** **Signed -** J. E. Thompson