	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted], West Mercia Police, Hindlip Hall, Worcester WR3 8SP 2) [redacted], Chief Executive, Wychavon District Council, Civic Centre, Queen Elizabeth Drive, Pershore, Worcestershire WR10 1PT
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5 April 2023 I commenced an investigation and opened an inquest into the death of Donna Louise SMITH (dob 06.02.1975). The investigation concluded at the end of the inquest on 7 May 2024. The conclusion of the inquest was that Ms. Smith's death was alcohol-related.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Ms. Smith come by her death?", I recorded as follows: *"On the morning of 4.3.23 Donna Smith was found unresponsive in Worcester City Centre. She was taken to Worcestershire Royal Hospital where, a short time later, she was confirmed deceased. She died as the result of acute alcohol intoxication."* Ms. Smith had first been spotted on a Worcester city centre CCTV camera (operated by an employee of Wychavon District Council) at 0654hrs on the morning of 4.3.23, lying in a flower bed outside the Maggs Day Centre, Deansway. She remained there for the next two hours or so, at which point the CCTV operator became concerned for her wellbeing and contacted the West Mercia Police control room. In that call over Airwaves radio, the CCTV operator stated that Ms. Smith had not moved at all for several minutes and "might be subject to hypothermia". The communications officer to whom he spoke replied "that would need to go to the ambulance service", at which point the call ended. In fact, neither party made a call to the ambulance service, as each had assumed that the other would be making the call. The communications officer stated in evidence to the inquest that although she felt she was being clear at the time, she appreciated that the words she used "could have been ambiguous". In the end, a concerned member of the public found Ms. Smith, and made a call to the ambulance service some 20 minutes later. Paramedics attended, provided Advanced Life Support, and took Ms. Smith to Worcestershire Royal Hospital, where she died later that morning.

	The cause of death established at inquest was: 1a acute alcohol (ethanol) intoxication; 2 hepatic steatosis, left ventricular hypertrophy. Given the evidence which I heard at the inquest, I could not conclude, on the balance of probabilities, that a timely phone call to the ambulance service by either the CCTV operator or the police communications officer would in fact have led to a different outcome in this case.
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) I heard evidence at the inquest that there was at the time of these events, and there remains now, a complete lack of formalised written policies, procedures or guidance governing the relationship between those operating CCTV cameras in Worcestershire (as Wychavon District Council do in respect of Worcester city centre CCTV cameras) and West Mercia Police; (2) At the inquest I found as a matter of fact that the failure by either the CCTV operator or the police communications officer to call the ambulance service immediately after their call over Airwaves, and their lack of understanding over whose responsibility it was to make such a call, arose substantially because of this lack of formal written guidance; (3) Furthermore, I heard evidence that despite Ms. Smith's death having occurred over 12 months ago, a draft Memorandum of Understanding between West Mercia Police and those operating CCTV cameras in Worcestershire had not yet been completed or formalised, but rather was still "being drawn up". For all of the above reasons, I am concerned that unless action is taken to formalise the relationship between those operating CCTV cameras in Worcestershire and West Mercia Police, and to provide proper guidance setting out their respective responsibilities in situations such as this, there is a risk that other deaths may occur in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you, as the Temporary Chief Constable of West Mercia Police and the Chief Executive of Wychavon District Council, 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 **3 July 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 [redacted], Ms. Smith's father. 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	**8 May 2024**  **David REID** **HM Senior Coroner for Worcestershire**