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:** [redacted]
1	**CORONER** I am Clare Bailey HM Senior Coroner for Teesside & Hartlepool Coroner's Service
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 18 February 2020 I commenced an investigation into the death of Michael Lee DALKIN aged 22. The investigation concluded at the end of the inquest on 30 April 2024. The conclusion of the inquest was that: Michael Lee DALKIN Suffered with hypoplastic left heart syndrome. On the evening of 26/12/2019, he was socialising in Stockton town centre. He consumed alcohol and illicit substances. In the early hours of 27/12/2019, he was inside Goldie's Bar. Two off duty door supervisors believed he was going to cause injuries with a glass. One of the off duty door supervisors removed the glass from him and moved him to the floor. They transported him outside the bar by carrying him by his limbs. They placed him on the floor outside the bar. Their actions were inconsistent with SIA training but reasonable and proportionate in the circumstances. Michael Lee DALKIN died in an Ambulance on Stockton High Street on 27/12/2019 due to a combination of his congenital heart defect, ingestion of alcohol and drugs and stress caused by the interaction with the off duty door supervisors.
4	**CIRCUMSTANCES OF THE DEATH** Mr Dalkin was socialising in Goldies bar, Stockton High Street in the late hours of 26.12.19 and early hours of 27.12.19. Two off-duty door supervisors were in the venue. They observed Mr Dalkin in a group of people who were arguing between themselves. They saw him walk to the bar and pick up an empty glass. Mr Dalkin placed the empty glass behind his back and started to walk back to the group with whom he had been arguing. Both off-duty door supervisors formed the impression that he was going to use the glass as a weapon. One of the men removed the glass from him. Mr Dalkin threatened the man with injury, so he was moved to the floor and escorted out of the premises. Outside of the venue Mr Dalkin collapsed and was attended to by the emergency services. He died in the ambulance. Evidence was given at the Inquest about the door supervisors employed and in used at Goldies bar on 26/27 December 2019. Evidence was given by the owner and designated premises supervisor [redacted] as to improvements made however his evidence lacked credibility. Evidence was provided by other witnesses who were former door supervisors at Goldies and Che Bar (adjacent bars both owned by [redacted]). I determined that on 26/27 December 2019 the door supervisors were made up of one SIA registered door supervisor who was acting as a door supervisor, an unlicensed door supervisor acting as a door supervisor, the SIA registered designated premises supervisor who said he left the premises at approx. 21:00 on 26.12.19 and another man who was SIA registered but carried out the role of the manager and did not act as a door supervisor.

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: (brief summary of matters of concern) 1. The use on an unlicensed door supervisor. 2. The use of the SIA registered designated premises supervisor as a part time door supervisor. 3. The use of an SIA registered manager who was not carrying out the role of a door supervisor but was held out to be a door supervisor. 4. Completion of SIA registers with information that did not reflect the real number of operational and effective door supervisors
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by June 27, 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], SIA, Cleveland Police Licensing 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: 2 May 2024** **Clare Bailey** **HM Senior Coroner for Teesside & Hartlepool Coroner's Service**