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:** **1 [redacted] Chief Constable Derbyshire Constabulary** **2 College of Policing**
1	**CORONER** I am Susan EVANS, Area 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 01 December 2021 I commenced an investigation into the death of Chad George ALLFORD aged 23. The investigation concluded at the end of the inquest on 24 October 2024. The conclusion of the inquest was that: On 27th October 2021 Chad Allford died at King's Mill Hospital. The cause of death is recorded as the effects of Cocaine. Police attended [redacted] in Alfreton following a planned operation involving the supply of class A drugs, in order to effect an arrest. After failed attempts to gain entry using keys and an enforcer, police officers gained access through an open door at the rear of the property. Following confrontation with a police officer Chad placed a package of Cocaine into his mouth. Police used various tactics in an attempt to retrieve the package and prevent injury or harm to Chad. A police officer called an ambulance, changing the incident from an arrest to a medical emergency as it was suspected that Chad had ingested a class A drug. Chad was assisted out of the property towards the drive where his health quickly declined. Chad started to convulse and was experiencing breathing difficulties. Chad was taken to King's Mill Hospital, where he later died at 18:21.
4	**CIRCUMSTANCES OF THE DEATH** See above
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) The evidence in this inquest focused, in part, on police officers' response to concealment of drugs in the mouth. The officers were part of a team, acting on intelligence, to make a drug offence arrest. None of the officers concerned had received prior training in this regard. They employed various methods to try and control Mr Allford and although each instructed Mr Allford to spit the drugs out, none of them warned him of the risks to his life of not

	doing so. It was not clear that officers understood the importance of communicating the dangers. Attempts were made by officers to open his mouth and sweep the drugs out of the mouth with their hands. A number of officers gave evidence that they were not aware of some of the risks inherent in placing their hands in someone's mouth, including the risk of packages entering the airway and therefore choking, and they were not aware of the relevant passages in the NPCC Personal Safety Manual or importantly, the principles relating to this contained within. This was not only the position in 2021 but remained the position at the time of the inquest. I am concerned that there is no standard provision for guidance or training for police officers in units tasked to make arrests for drug offences, to equip them to make informed decisions when faced with this situation. In the Personal Safety Manual (Module 12 pg 42), it is described as a 'common tactic used by some subjects during arrest to conceal controlled drugs in their mouths'.
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 December 19, 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 **Mr Allford's family** **Derbyshire Police Legal Services** I have also sent it to 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: 25/10/2024**

	 **Susan EVANS** **Area Coroner for** **Derby and Derbyshire**