Leeds Community Healthcare
NHS Trust

White Rose Office Park
Building 3
Millshaw Park Lane
Leeds
LS11 0DL
Tel: 0113 220 8500
www.leedscommunityhealthcare.nhs.uk

Mr Oliver Longstaff
HM Area Coroner for West Yorkshire
His Majesty's Coroner's Office
Burgage Square
Wakefield
WF1 2TS

1 May 2025

By email: [redacted]

Dear Mr Longstaff

Re: Regulation 28 response: Inquest touching the death of Nicholas Oliver James Gedge

I write in response to your Regulation 28 report dated 11 March 2025 concerning the death of Mr Nicholas Oliver James Gedge. In advance of responding to the specific concerns raised in your report, may I begin on behalf of Leeds Community Healthcare NHS Trust ("the Trust") by conveying my deepest condolences to the family of Mr Gedge for their loss.
Your report that was issued to The Chief Constable, West Yorkshire Police and to Leeds Community Healthcare NHS Trust, raised the following concerns:

"From the point when the Detention Officer first entered Nicholas' cell to when CPR was commenced, 8 minutes and 12 seconds elapsed without CPR being given. Within that timeframe, two Detention Officers and a nurse were present in the cell after 75 seconds had passed.

On the evidence, there did not appear to be any shared understanding between the three people in the cell with Nicholas of the urgency of starting CPR on an unresponsive person. There did not appear to be a co-ordinated approach to assisting Nicholas, with the Detention Officers and the nurse not appearing to have defined roles which they understood and undertook.

It was not clear whether there were any protocols in place to define the respective roles of detention staff and medical staff attending a medical emergency in a cell. The passage of time before CPR was commenced gives rise to a concern either that the importance of early CPR was not

appreciated, or that the communication between detention and medical staff did not facilitate its prompt commencement."

These matters of concern have been given careful consideration by the Trust and I set out below the actions that have been agreed in response.

- At the time of the event, Health Care Professionals (HCP) employed by LCH received Life Support training on an annual basis. This included basic life support (affiliated to the Resus Council UK standards) and training on the automated external defibrillators and emergency bag contents including bag valve mask, nasal and Guedel airways, oxygen and emergency drugs.
- Since January 2024, (after this incident) the training session for LCH staff has been expanded to include the use of a further airway adjunct (i-gel) and reflective discussions around any clinical issues or themes (e.g. recently staff have experienced an increase in opiate overdoses in custody). This is in addition to introducing medical emergency / CPR scenarios to introduce elements of teamwork.

I would like to reassure you and Mr Gedge's family that the concerns raised in your Regulation 28 report have been listened to and reflected upon and in order to improve the timeliness and co-ordination of basic life support, the Trust will implement the following actions:

Concern	**Response**	**Timescale**
Lack of shared understanding and co-ordination between detention officers and healthcare professionals for starting CPR	• In addition to the organisational mandatory bespoke life support training, LCH will expand the scenario aspect of training to include simulation exercises in the custody suite environment with the aim of improving the co-ordination between LCH staff and detention officers in the event of emergency scenarios. • The service has added a photographic description of the contents of the emergency bag to aid the quick identification of items in an emergency.	Discussion to take with police by May 28th, 2025, with the aim of introducing joint scenarios in training by August 31st, 2025.
	• A working group consisting of LCH HCP's, led by a clinical team manager, has commenced to review the Death in Custody (DIC) procedure. • The service will ensure that they include 'coordination of response' in the investigation process of incidents where there has been a life-threatening response or a DIC.	The task group will conclude by August 31st, 2025.

	• The procedure will be agreed with the police to ensure the coordination of response in life threatening situations is robust. • LCH has conducted a reflective conversation with the staff involved in the incident and has incorporated their recommendations and suggestions for improvements into the CPR training. • The DIC review will also enhance the joint reflection process with all colleagues involved in the incident.	
Unclear if protocols in place to define roles and responsibilities in emergency	• All current LCH protocols are organisation specific and are agreed with the police.	

As a matter of clarification, Leeds Community Healthcare NHS Trust would also like to note that within the Regulation 28 report (page 1, section 4) it states:

“Nicholas was moved from the cell bench to the floor, and the nurse inserted an intraosseous needle at 1548 hours and an oxygen mask shortly thereafter.”

This was in fact not an intraosseous needle and it was the administration of Naloxone (medicine that rapidly reverses opioid overdose) as an intramuscular injection.

We hope the above actions taken by Leeds Community Healthcare has addressed the Coroner’s concerns, but should the Coroner have any further queries, please do not hesitate to contact Leeds Community Healthcare Trust.

Yours Sincerely,

[redacted]

Executive Director of Nursing and Allied Health Professionals
Leeds Community Healthcare NHS Trust