IN THE WEST YORKSHIRE (EASTERN) CORONER AREA

HM AREA CORONER OLIVER LONGSTAFF

IN THE MATTER OF NICHOLAS OLIVER JAMES GEDGE

REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1.** The Chief Constable, West Yorkshire Police **2.** Leeds Community Healthcare NHS Trust
1	**CORONER** I am Oliver Robert Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern).
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 2022 I commenced an investigation into the death of Nicholas Oliver James Gedge ("Nicholas") The investigation concluded at the end of the Inquest on 07/03/2025. The conclusion of the Inquest was that Nicholas' death was due to natural causes, the medical cause of his death being 1a) Out of Hospital Cardiac Arrest; 1b) Dilated Cardiomyopathy; 2) Chronic Substance Misuse (Cocaine, Heroin), Thrombosis of Pulmonary Vasculature, Pulmonary Granulomas (from injection of illicit drugs)
4	**CIRCUMSTANCES OF THE DEATH** Nicholas had been arrested and detained in the custody Suite at Elland Road Police Station, Leeds, overnight on 13th-14th November 2022. On 14th November he was remanded in custody pending being put before a court on 15th November. During the afternoon of 14th November, Nicholas was provided with a hot drink and a snack bar in his cell. AT 1507 hours he was observed by his in-cell CCTV (which was not regularly monitored) to pull his blanket over his head and shortly thereafter to become motionless. A Detention Officer looked through the observation panel in Nicholas' cell door at 1522 hours and observed him to be breathing. At 1544 hours, Nicholas was found to be unresponsive by another Detention Officer who had entered his cell as part of a final check before handing over to the late shift. Another Detention Officer and a Healthcare Professional (a nurse) attended the cell. 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. The nurse continued to attempt to rouse Nicholas and applied defibrillator pads to him at 1551 hours. CPR was commenced at 1552 hours. Ambulance staff arrived at 1556 hours and Nicholas was taken from the cell to hospital at 1626 hours. He was pronounced deceased in the Rssus area of the Emergency Department at Leeds General Infirmary at 1656 hours. His

	heart had remained in asystole or pulseless electrical activity from the point of his being discovered unresponsive in his cell.
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) 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. (2) 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 Nichoals, with the Detention Officers and the nurse not appearing to have defined roles which they understood and undertook. (3) 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or 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 06/05/2025. 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] (Nicholas' sister), Leeds Teaching Hospitals NHS Trust, Independent Office for Police Conduct. 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	Signed:  OLIVER LONGSTAFF Area Coroner West Yorkshire (E) Date: 11 March 2025