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 College of Policing** **2 National Police Chiefs Council**
1	**CORONER** I am David LEWIS, Assistant Coroner for the coroner area of Liverpool and Wirral
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 20 July 2022 I commenced an investigation into the death of Robert John EVANS aged 59. The investigation concluded at the end of the inquest on 04 February 2025. The conclusion of the inquest was that: The Deceased died from a combination of drug use and underlying pneumonia. Fractures to his ribs, fibula and larynx contributed more that minimally to his death. It is more likely that these fractures resulted from force used by police officers when he was detained for the purpose of a drug search five days earlier. The force used was not reasonable and proportionate in the circumstances. The Deceased declined offers of medical assistance, from officers and from his family.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was found dead at his home address at [redacted], Liverpool on 3rd July 2022. His death was due to a combination of drug use (Heroin, Diazepam and Cocaine) and underlying established pneumonia. He had sustained fractures to his fibula, five ribs on the right side of his chest and his larynx. These fractures contributed more than minimally to his death, by reducing his mobility and adding to his difficulty in breathing normally, thus likely exacerbating his underlying pneumonia. On 28th June 2022 the Deceased had been in contact with officers from Merseyside Police, when he was detained for the purposes of a search under the Misuse of Drugs Act 1971. Some of the officers used force in the course of his detention, which probably caused the fractures to the fibula, ribs and larynx. The force used was not reasonable and proportionate. The officers offered the Deceased the opportunity for medical assessment but he declined it. The Deceased was returned to his home address later the same day and remained there until his death. In the intervening period he complained to his family of being in pain, for which he self-medicated, but he declined suggestions that he should seek medical advice. Officers suspected that the Deceased had swallowed something previously concealed in his mouth at the time of detention but didn't pick up or fully convey to other officers on the urgency of a potentially life threatening condition. At post mortem a package containing drugs was found inside the Deceased's colon. It is unlikely that this package was the reason for the drugs found in the sample of blood analysed as part of the post mortem toxicology. There was reasonable suspicion that the Deceased ingested drugs, however this information was not relayed to all officers in attendance despite there being life-threatening

	consequences. Furthermore, upon handover to the Deceased's family, the potential drug ingestion was not communicated to them, which did not allow the family to facilitate appropriate medical care.
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 Deceased was observed by officers conducting what they suspected to be a drug deal. Within minutes, he was detained in the street for the purposes of a search under S.23 of the Misuse of Drugs Act 1971. At this time, he was seen/suspected by officers to have swallowed something, which they believed might be drugs. He denied it. Nothing was found on an external search other than Methadone, which had been prescribed to his partner. He could have been arrested for this, but was not. The Deceased sustained a significant injury to his leg at the scene (which was found on the post- mortem examination to be a fractured fibula), due to a blow from a police baton. He was asked if he wanted medical attention, but said not. He was taken to a nearby police station for a strip search. Again, nothing was found. Officers then took the Deceased back to his home address and left him there, with members of his family in attendance. Little more than an hour elapsed between the officers' first and last contact with the Deceased that day. Post mortem examination found a package containing drugs in the Deceased's colon, but it could not be established whether this had been swallowed (at the time of the detention or otherwise) or inserted per rectum at some time. The court heard that College of Policing Guidance for Custody Officers and Detention Officers provides that "…If officers know or suspect that a detainee has swallowed or packed drugs…they must treat the person as being in need of urgent medical attention and transfer then straight to hospital". However: (a) a person detained for a search under the Misuse of Drugs Act does not come to the attention of a Custody or Detention Officer, unless arrested; (b) there is no guidance (known to the court) to assist officers involved in such a search as to what they should do; (c) there is seemingly no power for officers to convey to hospital somebody detained under these provisions (but not arrested), if that is against their wishes. The upshot seems to be that, whilst the risk arising from swallowing a package containing drugs is the same in each case, there is a material difference between how different types of detainee are managed, depending upon whether an arrest has taken place. Officers told the court that if somebody declines an offer of medical attention they simply monitor their condition, for signs of any change or deterioration. However, even if that is effective and adequate, any monitoring inevitably ends when the individual is released from detention. In this case that was little more than an hour after the suspected swallowing event. When he was returned home, officers gave no advice to the Deceased or his family about the need for continued monitoring. There appears to be no guidance directed towards them as to what advice should be given. One officer said that nothing could be said to the family (about the need to keep him under close watch, because of the risk), because that would breach the individual's right to privacy. It occurs to me that a person suspected of involvement in a drugs deal (even if nothing is found on a search) might well be keen to avoid further attention from the police and/or medical services as quickly as possible, for fear of something being found that might incriminate them. I am concerned that a person detained for the purposes of a search under the Misuse of Drugs Act, who is then suspected of having swallowed drugs, might be exposed to a risk of death (or other significant harm) if they do not receive the sort of medical attention which the guidance to Custody and Detention Officers considers an 'urgent' requirement, and/or if they are not given appropriate guidance on their release from detention. I am further

	concerned that officers are not given guidance or training in how to address this risk, by means of communication or otherwise.
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 April 29, 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 **Family (via their legal representatives)** **Merseyside Police Officers (via their legal representatives)** **Merseyside Police** **Independent Office for Police Conduct** 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. They may send a copy of this report to any person who they believe 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: 04/03/2025** David Lewis **David LEWIS** **Assistant Coroner for** **Liverpool and Wirral**