

## **Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1 Chief Executive, East Midlands Ambulance Service</b></p> <p><b>2 Chief Constable for Nottingham and Nottinghamshire Police</b></p> <p><b>3 College of Policing</b></p> <p><b>4 Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust</b></p> <p><b>5 Secretary of State for Health and Social Care</b></p>
<b>1</b>	<p><b>CORONER</b></p> <p>I am Ms Alexandra Pountney, Assistant Coroner for the coroner's area of South Yorkshire (West) (sitting in Nottingham and Nottinghamshire coroner's area).</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION AND INQUEST</b></p> <p>An investigation into the death of Kaine Regan FLETCHER was opened on 28 September 2022, and the final inquest hearing is currently being heard by me, sitting with a jury. The final inquest hearing started on 30 June 2025 and concluded on 25 July 2025.</p>

#### 4 CIRCUMSTANCES OF THE DEATH

Kaine was a 26-year-old male with a diagnosis of Paranoid Personality Disorder and a history of substance misuse.

On 2 July 2022, Kaine called the police via 999 making threats to kill, if the police did not attend to him at his mum's address. A double-crewed, marked police vehicle attended Kaine and arrived at 16:00. On arrival, the response officers formed the view that Kaine was suffering an acute episode of mental illness, and that they may need to exercise their s.136 MHA 1983 powers to detain him. Kaine told the officers that he had recently used cocaine. The officers requested assistance from the Street Triage Team, a team formed through collaboration between Nottinghamshire Police and Nottinghamshire Healthcare NHS Foundation Trust, who duly attended to assess Kaine arriving at 17:04. The Street Triage Team comprised of one police officer and one community psychiatric nurse, travelling together in a marked police car. Kaine was assessed by the community psychiatric nurse not to require a Mental Health Act Assessment, and so the police did not exercise their s.136 powers. Rather, having had his physical health checked by paramedics between approximately 17:27 and 17:42, he was conveyed by marked police car back to his residential dwelling at the YMCA in Hucknall. The police incident log confirmed that Kaine was at the property by 19:46.

On 3 July 2022, at 00:04 and 00:16, respectively, two 999 calls were made by a member of Kaine's family to EMAS due to a concern that he may have attempted to take his own life and, by the later call, that he was uncontactable by phone. EMAS advised the family member that the incident had been logged as a Category 3 response, and that there was an 8 hour wait for an ambulance.

At 00:33 a member of Kaine's family called the police to report their concerns. A police resource was allocated to the incident, and two response officers in a marked police vehicle arrived at the YMCA at 01:55 to conduct a 'safe and well check'. Those officers quickly formed the view that Kaine was suffering an acute episode of mental illness and that he had taken illicit substances, namely cocaine and nitrous oxide. To begin with, Kaine is amenable to attending hospital voluntarily for a Mental Health Act Assessment. He followed the police officers out of the building and got into their marked police car. The situation changed rapidly and within seconds of being inside the vehicle, Kaine vocalised his belief that the officers are not really police. The officers showed Kaine their ID, but the situation persisted and one of the officers detained Kaine using her s.136 powers; handcuffs are applied. This happened at around 02:34. More units were requested and arrived at the scene. Kaine began to resist the detention, and there was then a period

	<p>of approximately half an hour where Kaine was being restrained by officers. The restraint continued as officers attempted to gain effective control of Kaine so that they could convey him to a place of safety by police vehicle.</p> <p>During the period of restraint, Kaine’s physical condition deteriorated, and at 03:03 EMAS are called when the police recognise that he was displaying symptoms of Acute Behavioural Disorder. The incident was then deemed a medical emergency.</p> <p>EMAS arrived on scene at 03:18. Kaine was pre-alerted to the Queens Medical Centre Resuscitation Department and conveyed there by ambulance. He arrived at 03:47.</p> <p>Despite the best efforts of the medical teams at QMC, Kaine had developed rhabdomyolysis and went into multi-system organ failure, which culminated in an unsurvivable cardiac arrest. Kaine died at 09:46 on 3 July 2022.</p> <p>The cause of death provided by the Home Office Pathologist is: 1(a) the physiological effects of exertion following a period of restraint, combined with cocaine and other substances.</p>
5	<p><b>CORONER’S CONCERNS</b></p> <p>During the course of the inquest I heard evidence 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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:</p> <p>This PFD should be read in conjunction with the PFD that I issued mid-inquest, dated 17 July 2025.</p> <ol style="list-style-type: none"> <li>1. <b><u>Lack of joint agency policy/cross-sector working on Acute Behavioural Disorder/Disturbance</u></b></li> </ol> <p>In September 2022, the Royal College of Psychiatrists issued a <a href="#">position statement</a> on Acute Behavioural Disturbance and Excited Delirium. The RCP recommended that:</p>

- A cross-sector working group should be convened to develop an interim consensus on ‘ABD’, with active involvement of patients and carers, to agree terminology, key principles for professional guidance, and priorities for further research.
- This group should include representatives from police, custodial, ambulance, emergency medicine, mental health, and the judicial and coronial system. Support from relevant government departments would help ensure consistency across services.
- Further research should be urgently commissioned, including detailed investigation into how racial bias plays into the application of terminology such as ‘ABD’.
- Members of the cross-sector working group should collaborate on the development and delivery of training materials for staff working across public services
- All services should seek to improve standardised collection of disaggregated data on presentations and outcomes, and to conduct regular multi-disciplinary reviews to support high-quality research on this topic.

I have heard evidence that in Nottingham and Nottinghamshire, no such cross-sector working is in place or joint agency policy is in place. I have also heard that there is no knowledge of such cross-sector working or joint agency policy in place within the East Midlands generally, or nationally. The consequence of this is that there is no joined up thinking, procedure or policy, between front-line services who are regularly dealing with cases of ABD. That lack of collaborative working between services gives rise to a risk of future death for persons who develop ABD both in the community or in custody. People at risk of developing ABD often also fall into categories of vulnerability, such as suffering with a mental health disorder or using illicit substances. To my mind, this increases the risk of future death in the absence of any collaboration. I am concerned that this appears to be a national issue.

## **2. Lack of agreed joint agency policy between EMAS and the police on s.136 MHA 1983 detentions**

I issued a PFD on 17 July 2025, part way through the final inquest hearing, to raise my concern over the apparent confusion with both the police and EMAS as to the applicable joint agency policy dealing with s.136 MHA 1983 detention and conveyance.

Since that PFD was issued, the evidence has developed and the position at the end of the inquest was as follows:

- The police confirmed that the document titled “*Nottingham and Nottinghamshire Multi-Agency Policy & Procedure Review Group Memorandum of Understanding: Joint Agency, sections 135 and 136 Mental Health Act 1983 Procedures*” has been ratified within their organisation and continues to remain the relevant joint-agency policy for s.136 detention and conveyance. This policy has been implemented for the police since its inception.

- EMAS cannot confirm whether the above policy has been ratified in its current version within the organisation. They have confirmed that an employee at EMAS signed off on the 2021 version, but that this information was never disseminated within the organisation because the finalised version of the policy remained within that employee's email inbox. The consequence appears to be that EMAS has never implemented this policy, rather they have been working to an internal policy for Mental Health Conveyance that contains different working standards.

Acknowledging that there is no confusion for the police as to the relevant policy, and that they do consider that it has been implemented, I remain concerned. My concerns can now properly be formulated as follows:

- There is no joined up thinking between agencies on the local policy for s.136 MHA 1983 detention and conveyance. For a policy to be effective, all purported parties to that policy need to know it applies to them.
- Internal disorganisation within EMAS has culminated in a situation where, even after a period of investigation between 17 July – 25 July, they are unable to tell the Court which, if any, joint agency policy applies to them. They are unable to tell the Court whether they are still part of the relevant working group. EMAS have allowed a situation to perpetuate in which they appear, on the face of the policy documents, to be party to an agreement (which includes service level agreements for conveyance) when they simply do not know if this is correct. The upshot of this is that other agencies may be placing reliance on the conveyance terms within the policy when they are dealing with s.136 detention.

My concerns are supported by the guidance available at ss. 16.30 – 16.35 of the [Mental Health Code of Practice](#), which highlights the importance of local policy for s.136 detention. It does not appear that there is compliance with this guidance, published by the Department of Health.

The lack of joined up thinking between agencies locally gives rise to a risk of future death for persons detained under s.136 MHA 1983.

### **3. Police use of an ambulance as the mode of conveyance for s.136 detainees**

I heard evidence that the correct mode of conveyance for persons detained under s.136 MHA 1983 is an ambulance, save in exceptional circumstances (*e.g.* where the detained person's behaviour means it would be inappropriate, or where the wait for an ambulance would exceed 30 minutes).

I also heard evidence, that in the last 12 months an ambulance was called by the police in only 50% of s.136 detentions. Of that 50% in which an ambulance was called, an ambulance only attended on 50% of occasions (so 25% of the total detentions).

Of the nine police officers that gave evidence to me in this inquest on s.136 matters, none of them knew about the police policy on calling an ambulance to convey a s.136 detainee.

Two of the officers knew, anecdotally, that an ambulance was the preferred method of conveyance, but their evidence was that it was common for an ambulance to take well over 30 minutes or not turn up at all.

I am concerned that:

- There is a training issue within the police in relation to s.136 detentions and the correct mode of conveyance. Either officers do not know that they should call an ambulance, or they are ignoring their training/the instructions that they are given. This is born out in the statistics above.
- There is a response issue on the part of EMAS. This may, in part, be explained by the policy/service level agreement confusion within EMAS.

#### **4. Police training on s.136 MHA 1983 detention and mental health**

I heard evidence that there is no national training for police officers on the correct wording to communicate a decision and the reasons for a s.136 detention to the detainee. Further, that there is no specific training in relation to persons who are struggling with their mental health and who may be under the influence of illicit substances. I am concerned that training in the area of mental health generally is lacking, which is impacting upon the approach of the police officers dealing with mental health related incidents.

#### **5. The availability of the Street Triage Team**

I heard evidence that Nottinghamshire is pioneering in its provision of a Street Triage Team, a service that has been available since 2014. This team is comprised of one police officer and one community psychiatric nurse who can travel to mental health incidents to provide assessment and advice to the response officers, particularly in relation to exercising s.136 powers.

I heard that this service is available between 8am and 1am, and that the resourcing of the service (both in terms of the shift patterns and the available cars) was determined by analysis of a data set in 2017.

At the time that the incident arose with Kaine on 3 July 2022, no STT was available as it was out of hours.

I am concerned that there is a need to review the data to ensure that the demand for the service in 2025 is still reflected by the shift patterns. I am concerned, based on the evidence that I heard from EMAS in relation to an increase of ~60% in mental health related calls, that the demand for service may have changed since 2017.

I note that the [Mental Health Code of Practice](#) includes the following guidance at [16.23] in relation to triage and s.136: *“When deciding that detention may be necessary, the police may also benefit from seeking advice before using section 136 powers in cases where they are unsure that the circumstances are sufficiently serious for using these powers. Local protocols should set out how this advice can be provided and who the police should*

	<p><i>contact, including outside of normal business hours</i>". I am concerned that I have not seen any local protocol as to who the police should contact out of hours, and I note that EMAS do have available mental health nurses between the hours of 1am and 8am. This again appears to be a local policy and communication issue.</p> <p><b>6. <u>Mental Health Services – ‘the gap’</u></b></p> <p>I am concerned that there is a ‘gap’ in mental health services for those people who have a dual diagnosis of a recognised mental health condition, combined with a substance misuse diagnosis. Clinically, I understand that substance misuse can provide a barrier to effective treatment of any mental health condition. However, I have heard evidence that there is no service available to patients for management, monitoring and treatment in circumstances where they are unable to abstain from substances but require care for the residual mental health condition. In circumstances where it is clinically recognised that substance misuse can exacerbate the symptoms of many mental health conditions, this gives risk to a clear risk of future death. The evidence that I have heard is that once treatment or referral options for these patients have been exhausted, they are discharged from the Local Mental Health Team with signposting to other services <i>e.g.</i> substance misuse services/charities or CRISIS. These services often required self-referral, which is not realistic for many people in these circumstances. Kaine fell into this gap, and I am concerned that there is a risk of future death for other patients if this gap is not filled. Again, it seems to me that this is an issue of national concern.</p>
<b>6</b>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
<b>7</b>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 September 2025. I, the coroner, may extend the period.</p> <p>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.</p>

8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to:</p> <p><b>Kaine’s family</b></p> <p><b>All other IPs</b></p> <p>who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest.</p> <p>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.</p>
9	<p><b>Dated: 25 July 2025</b></p> <p><b>Ms Alexandra Pountney</b></p> <p><b>Assistant Coroner</b></p> <p><b>South Yorkshire (West)</b></p>