REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. [redacted]Mother of the Deceased** **3. Practice Plus Group** **4. Mitie Care and Custody** **5. IPRS Aeromed** **6. Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Area Coroner, for the coroner Area of Avon
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 4th July 2023 I commenced an investigation into the death of Ms. Amy Jo Cross age 31 years. The investigation concluded at the end of the inquest on 3rd October 2025. The conclusion of the jury was was that the medical cause of death was I(a) Consequences of chronic alcohol misuse with sudden cessation of alcohol consumption. The conclusion of the jury as to the death was natural causes.

4	**CIRCUMSTANCES OF THE DEATH** On 9th June 2023 Ms. Cross was arrested by police officers in Torquay and taken to Torquay Police Station where she was detained. She reported withdrawal symptoms due to drugs and/or alcohol and was seen at the police station by a registered nurse from Mitie Care & Custody. No medication was administered at that time. That same day Ms. Cross was transferred to Exeter Custody Suite where she was seen the following morning, the 10th June 2023, by a paramedic from Mitie Care & Custody. There were concerns that she was still experiencing withdrawal symptoms and Ms. Cross was administered dihydrocodeine and diazepam for opiate and alcohol withdrawal respectively. A short while later she was then taken to Exeter Magistrates Court for a court appearance. Whilst in the court cells she reported feeling unwell with nausea and gastrointestinal symptoms and was seen by a registered nurse from IPRS Aeromed. Ms Cross was administered cyclizine tablets for her nausea and omeprazole tablets for her gastrointestinal symptoms. Following the court appearance Ms. Cross was remanded in to custody and transported to HMP Eastwood Park where she arrived at around 15:45 hours on 10th June 2023. Ms. Cross reported that she was feeling nauseous and had vomited on the journey to the prison. As part of the reception process at the prison she was seen by a paramedic from Practice Plus Group who was concerned that Ms. Cross had withdrawal symptoms. A video consultation then took place a short while later at around 16:52 hours with a GP also from Practice Plus Group who prescribed methadone and diazepam for opiate and alcohol withdrawal symptoms respectively. At 18:43 hours, before any medication was administered to Ms. Cross, she was found unresponsive in her cell. A Code Blue was sounded and paramedics attended. Despite all efforts she could not be resuscitated and she was pronounced dead at 19:47 hours. During the course of my investigation I became aware that the only information relating to Ms. Cross which was passed from the police, to the prisoner escort service operated by Serco, to the court, and to the prison was the digital Person Escort Record (PER). This document completed initially by a police officer in Torquay did not have up to date details of any medical interventions and no further details were added later. When Ms. Cross arrived at the prison it was not known to healthcare professionals at the prison as to what medication had been administered either at a police station or at the court. There was no system in place to transfer healthcare related information or any clinical records between the various organisations involved in Ms. Cross' care on the 9th and 10th June 2023.
5	**<u>CORONER'S CONCERNS</u>** 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) There is no system to ensure that important healthcare information including recent administration of medicines and the results of physical observations is passed between separate providers of healthcare in the criminal justice system at the time a person is conveyed between the police, the court and the prison. (2) There is no standard medical records system which can be accessed by each healthcare organisation to ensure the efficient and effective transfer of medical information.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 16th December 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 [redacted] mother of the deceased, Practice Plus Group. Mitie Care and Custody, IPRS Aeromed, and the Chief Coroner. I shall send a copy of your response to [redacted] and the above organisations. I have sent a copy of my report to the Chief Coroner. 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. She may send a copy of this report to any person who she 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	**20th October 2025** [redacted] **Area Coroner**