



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 [REDACTED] 2 National College of Policing 3 National Police Chiefs' Council (NPCC)
1	CORONER I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 the 22nd October 2024 I commenced an investigation into the death of Ann Sabrina LASKOWSKY aged 65. The investigation concluded at the end of the Inquest on the 26th September 2025. The conclusion of the inquest was that Ann died as a consequence of naturally occurring disease contributed to by self-neglect and exacerbated by her long standing dependence on alcohol.
4	CIRCUMSTANCES OF THE DEATH Ann Sabrina Laskowski had a long history of significant mental health conditions associated with historic trauma and consequently, she struggled to form relationships of trust with professional and medical services. Ann also had a long history of alcohol dependency and was known to be an adult at risk. At 1200 hours on the 5 th October 2024, the inactivity alarm in Ann's home was triggered, because no movement had been detected inside the flat for over six hours. When Attempts were made to contact Ann, no response was received and so the emergency services were contacted due to the concern for her welfare. At that time, the Ambulance service were unable to attend due to an increased demand for services and so the police were asked to attend, to check that Ann was safe and well. At 1330 hours, two police officers attended at Ann's home and when they entered, they found her slumped on the sofa. It was noted that Ann was breathing, with body worn camera footage confirming that neither of the Officers commented upon the normalcy of Ann's breathing, which is noted on the video as being both rapid and audible. Attempts were made to elicit a response from Ann, with Officers loudly calling to her and requesting that she open her eyes and wake up. The Officers also sought a response by tapping Ann's legs at different times and squeezing her hand, however Ann did not open her eyes nor did she wake up. At no stage was Ann considered to be alert, however, both officers considered that she had responded to prompts via some movement of her head and arms and by making noises,

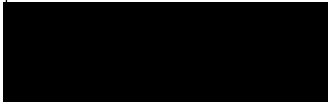


	with the officers considering that such movements and sounds were signs that she was responsive. Having decided that Ann was fast asleep and could not be woken, the Officers concluded that she did not require medical attention and therefore an ambulance was not required. Shortly after 1830 hours, an Ambulance attended Ann's address where Paramedics found her slumped upright on the sofa, appearing very unwell, she was noted to be unresponsive with rapid breathing. Ann was subsequently taken to Bradford Royal Infirmary where imaging undertaken the following day, confirmed a diagnosis of ischaemic colitis with bilateral consolidation of Ann's lungs and cirrhosis of the liver. Despite treatment, Ann's condition continued to deteriorate and she passed away at 1403 hours on the 6th October 2024. Expert evidence provided during the course of the investigation, confirmed that at the time the police officers attended at Ann's address, she was profoundly unwell and even if, medical attention had been sought for Ann at the time, it would not have prevented her death.
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) <u>1. The adequacy of First Aid Training provided by West Yorkshire Police</u> The body worn camera footage which was played during the course of the inquest, clearly shows that when the Officers arrived, they found Ann lying slumped on the sofa, appearing pale with an increased respiratory rate. Ann was profoundly unwell and required urgent medical attention. The attending Officers did not recognise the severity of Ann's condition and instead considered that Ann was asleep but could not be woken. This of itself, raises significant concerns in respect of the nature and adequacy of the training that had been provided to the officers at the time. Expert evidence received during the course of the Inquest concluded that even if the Officers had sought medical attention when they attended, given the severity of her condition, such treatment would not have prevented her death. During the course of the Inquest, evidence was received from a variety of sources, in respect of nature and quality of the First Aid Training provided to Officers, in both their initial training and their annual refresher training. This evidence demonstrated an overwhelming lack of clarity in terms of the way in which officers are trained to assess whether an individual is alive, breathing and conscious, something which it is expected that Officers can assess, in line with their authorised professional practice. The very nature of this evidence was such as to raise significant concerns as to the impact of this training upon the preservation of life. There were two main areas in which the lack of clarity and consequent inadequacy of training were of particular concern:- a. The assessment of whether a person is breathing normally and how this is to be assessed; and



	b. Whether an individual is responsive or unresponsive, particularly in cases where there may be some involuntary movements from the individuals concerned. <u>2. The knowledge, use and training in respect of available resources</u> In the course of the Inquest, I heard evidence in respect of a resource or service, known as the 'Partner Triage Line'. This is a service which has been provided for a number of years by the Yorkshire Ambulance Service which provides a direct line for police officers to speak to a medical practitioner at the emergency operations centre, to seek advice, with the facility for the Officer to send photographs to the practitioner to help inform their advice and an ability for the practitioner to conduct a live video assessment. Differing evidence was heard at inquest in terms of the knowledge of individual officers in respect of that service, with one officer being unaware that there was such a service or resource. In the course of my investigation, I received further evidence confirming that the telephone number for the 'Partner Triage Line' is visible and accessible in the contact environment and is then sent to officers on request, but that it is not known or promoted to those officers carrying out operational duties, who are those who are likely to need it the most. I have significant concerns in relation to the knowledge of this valuable resource and its overall lack of use and promotion amongst those Officer who might need it the most. In particular my concerns relate to the following:- a. The lack of knowledge and use of the service throughout West Yorkshire Police given the lack of dissemination and promotion amongst all of the officers to whom it would be of benefit, providing them with the tools to enable them to properly and effectively carry out their duties; and b. The lack of specific policy, guidance or training for Officers in respect of how the service can be used to support them in carrying out their duties, enabling them to keep members of the public safe. This is of particular concern, given that the service has now been available for a number of years.
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 December 02, 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 ██████████ Yorkshire Ambulance Service (YAS) 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. 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	Dated: 07/10/2025  Charlotte KEIGHLEY Assistant Coroner for West Yorkshire Western Coroner Area