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]
1	**CORONER** I am Crispin OLIVER, Senior Assistant Coroner for the coroner area of County Durham and Darlington
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 19/12/2022 15:14an investigation was commenced into the death of Steven Lee RUDDICK 31/07/1984. The investigation concluded at the end of the inquest on 13/11/2025 15:15. The conclusion of the inquest was that See attached Chronology of Events and see attached sheet..
4	**CIRCUMSTANCES OF THE DEATH** Mr Steven Lee Ruddick was transported by GEOAmey to University Hospital North Durham en route to HMP Durham to have his ankle checked. Whilst in the police waiting room at the hospital, Mr Ruddick [redacted] having been to the toilet, and died very shortly [redacted]
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) It emerged during the evidence that there is a material difference between police procedures for managing a detained person on close observations and those of GeoAmey and, it is understood, HM Prison Service in relation to using the toilet in the scenario in this case. In police custody, the detained person would be in standard cuffs and the officer would be present and observing directly during the toilet visit. In GeoAmy and Prison Service custody, in contrast, the detained person would be in a 1 metre closet chain and would be attached to the officer by means of a 1.5-2 metre chain and he/she would used the toilet without the officer observing directly. While this preserves the privacy and dignity of the detained person it can also, as in this scenario, potentially offer him/her the opportunity of removing prohibited items from the rectum without being observed and relocating them on his/her person. [redacted] Further the jury did conclude that the manner in which the Level B search immediately following the toilet visit was conducted on that occasion possibly contributed to the death. Finally, by way of explanation, the evidence on the contrast in the approach of

	police and GeoAmey/HM Prison Service on this issue only emerged during the evidence of witnesses to the Inquest itself and it's significance not predicted by either myself or any of the Interested Persons or their representatives before the Inquest. By that stage, MOJ had been stood down as an Interested Person (which was agreed across the board) since the Pre-Inquest Review in February 2025. Further, it was only established at the very end of the Inquest during submissions on Regulation 28 matters that the policy and procedures governing custody in the scenario here relevant is provided by PECS rather than by GeoAmey itself. Clearly, had either of these factors been different, then MOJ would have had a chance to contribute
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 January 13, 2026. 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] I have also sent it to who may find it useful or of interest. 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: 18/11/2025** [redacted] **Crispin OLIVER** **Senior Assistant Coroner for** **County Durham and Darlington**