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 Chief Constable** [redacted]
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 07 June 2021 I commenced an investigation into the death of Andrew Thomas MCCLEARY aged 38. The investigation concluded at the end of the inquest on 24 September 2024. Whilst I expressed my intentions to make this report immediately following the conclusion of the inquest, at your request, this was delayed pending the outcome of your judicial review application. Permission to bring judicial review proceedings was refused on 25 November 2025. The conclusion of the jury inquest was: Unlawful Killing.
4	***CIRCUMSTANCES OF THE DEATH*** *Andrew died due to the use of cocaine and the physiological and psychological effect of restraint. The events that led to his death occurred during the morning of 29th May 2021 and his death was confirmed at 10:37 on 30th May 2021 at Bedford Hospital South Wing after diagnosis of severe global hypoxic injury. Andrew came by his death in the circumstances proved as recorded in the attached questionnaire. Andrew was suffering from the effects of cocaine use and this more than minimally contributed to the cause of his death. The police officers and ambulance staff members in attendance failed to take reasonable steps to establish that Andrew was lacking in capacity as defined in the MCA 2005.* *The police officers and ambulance staff were concerned with Andrew's high heart rate and wanted him to go to hospital for treatment. There was no clear collaborative plan identified or clear communication on how to do this safely. When Andrew was restrained by both police officers and ambulance staff, there was a complete failure to monitor his physical and psychological wellbeing. When Andrew stated he could not breathe, this was dismissed and there was a failure to reassess the actions being taken. As stated by the East of England Ambulance Service, there was no clear collaborative plan with Andrew's capacity to consent to the proposed transfer to hospital, if he had capacity to refuse and what the plan would be or whether he was suffering from fluctuating capacity. There was no multi-agency risk assessment prior to the use of restraint.*
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) 1) There was an evident lack of knowledge and/or concern on the part of the attending officers of the requirements of the Mental Capacity Act (MCA) 2005, particularly when it came to the decision to use force against and restrain Andrew. 2) There was an evident lack of awareness on the part of the attending officers of the risks/effects of using force against and restraining Andrew and of the need for collaborative planning with attending ambulance staff before doing so. 3) There was an evident lack of attention to and/or concern for Andrew on the part of the attending officers both during and after the restraint. The above matters were of particular concern in view of the previous Regulation 28 Report made on 21 October 2021, following the Inquest into the death of Leon Briggs in 2013, which highlighted a lack of training regarding the effects of restraint as well as inadequate monitoring of a detainee subject to restraint on the part of Bedfordshire Police Officers.
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 20, 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] **East of England Ambulance Service** **Independent Office Police Conduct IOPC** I have also sent it to **CEO COLLEGE OF POLICING** 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: 25/11/2025** [redacted] **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**