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 Executive, East Midlands Ambulance Service** **2 Chief Constable for Lincolnshire Police** **3 Chief Executive for NHS England**
1	**CORONER** I am Paul D SMITH, HM Senior Coroner for the coroner area of Greater Lincolnshire
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 20 October 2021 I commenced an investigation into the death of Robert Shaun GRACEY aged 39. The investigation concluded at the end of the inquest on 18 December 2025. The conclusion of the jury at inquest was that: On 29 September 2021 Robert Gracey came to the attention of Lincolnshire Police, outside Gainsborough Police Station. After a brief interaction due to risk concerns police pursued to 1 North Marsh Road. Subsequent events of the evening led to... The decision of officers not to treat as a medical emergency after the point of restraint. Although minimal attempts, inadequate de-escalation possibly contributed to agitation and paranoia of Mr Gracey. The restraint/other force used against Mr Gracey probably contributed towards his death. The inadequate training by Lincolnshire Police Forces for ABD prior to 29 September 21. The serious inadequate monitoring of Mr Gracey during restraint and during transportation.
4	Mr Gracey came to the attention of the police shortly after 6pm on 27 September 2021 when he was found outside his home in Gainsborough in a paranoid and anxious state. He was detained by police under S136 of the Mental Health Act and transported without incident to Lincoln County Hospital where he told staff he had been taking cocaine. He remained there overnight before being released following a Mental Health Act Assessment. He attributed his behaviour to the amount of cocaine he had consumed and accepted he had a long standing drug habit. He was found not to be suffering any mental health condition which may justify his admission to hospital for treatment. Shortly after midnight on 29 September 2021 Mr Gracey made a 999 call to the police. Officers attended his home address. Mr Gracey was described to be acting

strangely. He appeared not to accept that they were, in fact, police officers and refused to speak to them. As he was at home and in company of a friend the officers left.

A few minutes later Mr Gracey attended at Gainsborough police station which was very close to his home address. He began to bang on the windows and to shout. Officers attended and engaged with Mr Gracey, but he then ran off, followed by officers. Mr Gracey was apprehended by those officers in the garden of his neighbour's house at about 00.35, where he seemed to be calling for help from the occupants and was banging on the window. After an initial engagement at the window, Mr Gracey ran into the garden and officers followed him. Officers restrained him and he resisted being restrained. Various types of force were used. He was held on the ground and handcuffs to the front. Leg straps were then applied, and he was brought to the front of the house and placed on the ground on his back. Six officers were involved in his restraint. At various points in his interaction with officers, Mr Gracey appeared not to believe that the uniformed police officers were "real" police officers and to have feared he was being kidnapped. Reference was made at the scene by a witness to him having taken cocaine and the officers present described him as appearing "heavily intoxicated". He resisted being placed in the back of the police van but was eventually placed, using force, on the floor of the 'cage' area of the van between two bench seats, so that his back was against one bench and his legs were up in front of him (still in straps) on the opposite bench.

Once in the van, Mr Gracey continued to struggle. The van left the scene at about 00.49. to drive to Lincoln Police custody. At around 01.01 officers observed a deterioration in his presentation, although reported that he was conscious and breathing, and made the decision to take him to hospital rather than to custody. At around 01:05 the van was stopped, and the officers checked on Mr Gracey due to concerns regarding his presentation. The officers removed the handcuffs and leg restraints. At approximately 01:08 the van moved off. At around 01:12 Mr Gracey was noted to be non-responsive, and the van was again pulled over. At 01:13, a 999 call was made reporting that he was no longer breathing and had only a weak pulse. CPR was attempted and paramedics attended.

He was taken to Lincoln County Hospital, arriving at 01.52. Resuscitation was again attempted but he was pronounced dead at 02.14.

The cause of death found by the jury was 1a. Effects of Cocaine and restraint and struggle against restraint upon a scarred heart.

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. Despite a very clear recommendation made in a letter dated 24 July 2019 by DAC Twist on behalf of the NPCC that "police forces have established ABD protocols with their local ambulance service so that suspected ABD incidents are treated as medical emergencies (i.e. Cat 1, with a response time of 8 minutes)", there is still no such

	protocol in Lincolnshire. 2. Under the current NHS Pathways system, ABD does not have its own allocation pathway. 3. Under the current NHS Pathways system a referral for ABD will only be allocated a category 2 response in the absence of police restraint.
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 3 March 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 Family of Mr Gracey I have also sent it to HEMS 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: 06/01/2026** **Paul D SMITH**

	HM Senior Coroner for Greater Lincolnshire