Ian Learmonth QPM
Chief Constable

Coroner M.E. Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
LONDON
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24th December 2013

Dear Madam,

I refer to your Regulation 28 Prevention of Future Deaths Report dated the 11 November 2013 concerning Timothy Patrick Clayton deceased and this letter serves as my response in accordance with Regulation 29.

The Coroners and Justice Act 2009 replaced Rule 43 Reports with Reports on Action to Prevent Future Deaths (PFD) under paragraph 7 Schedule 5 of that Act and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. It is accepted that Coroners have a duty not only to determine how an individual came by their death but also where appropriate to report about that death with a view to preventing future deaths.

I am aware that normally a PFD report will be made after the conclusion of an Inquest. However, a report can be made before an Inquest is heard so long as there has been compliance with Regulation 28(3) and that will only be when the Coroner has considered all of the documents, evidence and information that in the opinion in the Coroner is relevant to the investigation. It is with this condition in mind that I suggest that that criteria perhaps has not been met in this particular referral.

The report from the Coroner states the concerns that there is a risk that future deaths will occur unless action is taken by Kent Police and that it is the Coroner's statutory duty to report to me. The reference to the use of a PFD report is due to the perceived belief that 6 transplant organs were lost to potential recipients and that 6 organs represents 6 lives. This PFD report concerns the issue therefore of organ donation from Timothy Clayton, a 45 year old homeless male who was a homicide victim. The circumstances concerning his death thereby being a live criminal investigation. Following receipt of the PFD report, however, a formal review has been commissioned and completed into the circumstances that led to the report being issued. The review has thoroughly considered the circumstances and the Coroner's concerns and is therefore appended hereto.

In accordance with the requirements of Regulation 29, I now write to confirm that all Senior Investigating Officers in Kent Police and Essex Police have been reminded of the guidance contained within the Journal of Homicide and Major Incident Investigation published by the National Policing Improvement Agency. All Senior Investigating Officers are to be advised that any challenge to a decision by HM Coroner is through the Courts processes.

An urgent review is to be conducted to consider the number and availability of family liaison officers to ensure suitably trained staff are available for deployment when required in homicide investigations. This will ensure that families are in possession of full and appropriate information at all times.

The circumstances that arose in this particular case will also be included into future Senior Detective training and has been drawn to the attention of senior personnel in the Association of Chief Police Officers Homicide Working Group for national consideration.
What is also of note, however, is that no one has been provided with either the original or a copy of Mr Clayton's organ donation card, despite this appearing to have been the catalyst for the consent being sought from the family. The family had not requested the consideration of organ donation.

Despite the Coroner's assertion that 6 deaths were preventable if the organ donation had been completed, in fact only the kidneys were potentially viable but as Mr Clayton was a known homeless alcoholic, the viability of these organs for successful transplantation is therefore unknown. The use of a report in accordance with Regulation 28 by the Coroner is therefore questionable.

There is still considerable distress being experienced by the family of Mr Clayton as his body has not been transferred to Kent which has caused an additional burden on them.
In accordance with the provisions of Regulation 29(8)(b) of The Coroners (Investigations) Regulations 2013 I would request that the review document appended to this letter is not disclosed for publication as it contains third party information which does not have the consent for publication and is provided to the Coroner and the Chief Coroner in response to the Regulation 28 PFD report.

Yours sincerely

Ian Learmonth
Chief Constable