Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Department of Health** Department of Health Richmond House 79 Whitehall London SW1A 2NS 2. [redacted] **(Regional Manager)** G4S Forensic & Medical Service (UK) Ltd Units 6-9 The Bardfield Centre Great Bardfield Braintree, Essex CM7 4SL 3 [redacted] Deputy Director Head of Court Services Serco Wincanton Bloxham Mill Barford Road Bloxham, Oxfordshire OX15 4FF 3. **ACPO** 1st Floor, 10 Victoria Street London SW1H 0NN
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 6th December 2011 I opened an investigation into the death of Wayne Spencer Malcolm Broad, aged 51 years old. The investigation concluded at the end of the inquest on the 11th November 2013. The conclusion of the inquest was "Narrative verdict", the medical case of death was ;1a hypoxic brain injury, 1b cardiorespiratory arrest, 1c seizure activity associated with alcohol withdrawal and under paragraph 2 chronic

	alcoholism.
4	**CIRCUMSTANCES OF THE DEATH** Mr Broad was arrested on the 15th November 2011 at his home address, for failing to appear at St Albans Magistrates Court the day before. Mr Broad was under the influence of alcohol when arrested and taken to Hatfield Police Station to appear the next day at Hatfield Remand Court. Mr Broad was under the influence of alcohol at the time of his arrest and the custody sergeant, when he was taken to Hatfield Police Station, recognised the need for Mr Broad to have medical attention, and taken into custody. Mr Broad was seen by a nurse and gave a history of heavy consumption of alcohol. The nurse took telephone advice from a doctor and medication was prescribed for Mr Broard to take. The following morning Mr Broad was collected by SERCO officers but before being taken to court became unwell complaining of palpitations and chest pain and was taken by ambulance with SERCO to hospital. Having been seen in hospital Mr Broad was returned to Hatfield Police Station but became unwell again. The magistrates bailed Mr Broad and he was taken by ambulance to Barnet Hospital where he was admitted. Mr Ward was taken to a ward where later on in the evening he began to suffer from delirium tremens and having assaulted a member of staff and taken refuge behind a nursing station where he defended himself against all staff with a fire extinguisher until police arrived. Mr Broad was arrested and remained under police guard. Mr Broad became more unwell and collapsed. Despite resuscitation Mr Broad suffered a hypoxic injury and sadly died on the 30th November 2011.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) That was no dedicated substance misuse team available to look after Mr Broad when he was in the custody suite at Hatfield Police Station, as there would have been had Mr Broad been detained in prison. (2) Police are required to make risk assessments and have requirements when dealing with the handcuffing of seriously ill detainees. There should be alignment with particular regard to those who are seriously ill and in general SERCO policy should come into alignment with ACPO guidance on the use of handcuffs. (3) Specially trained nursing staff should be available at hospitals for dealing with patients with substance misuse.

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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 Friday 14th March 2014. 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 Representative of members of the family of Mr Broad I am also under a duty to send the Chief Coroner a copy of your response. 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	**17th January 2014**