REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The College of Policing.**
1	**CORONER** I am Richard Alexander Hulett Senior Coroner for the coroner area of Buckinghamshire
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 13th July 2011 I commenced an investigation into the death of Shaun Elliott aged 43 years.The investigation concluded at the end of the inquest started on 6th January 2014 and concluded on 24th January 2014. The conclusion of the inquest was a short form conclusion of alcohol/drugs related death together with a narrative . [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Shaun Elliott was a resident in a care home providing supported living for people with mental health issues. He was a vulnerable adult. On 6th July 2011 Shaun did not return from an education outing and was reported to the Police as a missing person on 8th July .Late in evening of 10th July an ambulance was called to an address where Shaun had been staying. He was in cardiac arrest .He was taken to hospital but had sustained irreversible hypoxic brain damage and died on the 11th. The medical cause of death was 1a Acute Bronchopneumonia due to 1b Multi drug use.
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) Extensive areas of the evidence concerned a detailed examination of the Police missing person enquiry and the policies, protocols and resources relating to such enquiries. The policies adopted by Thames Valley Police largely follow national guidelines and the matters raised therefore go to that policy making. I am informed that the College is currently rewriting the NPIA Missing Person Guidance to be replaced by an Approved Professional Practice. (2) The evidence revealed that a missing person coordinator was in post but not on duty at weekends. It was apparent from the evidence that an appropriately experienced coordinator will have the time and know-how to examine cases in fine detail. The officers directly responsible for the enquiry may have many other calls on their time. The IPCC report recommended there be cover 7 days a week. A senior police officer reported that this was under review and that other police forces were being contacted to see how they were addressing the issue..

	(3)Family Liaison. Shaun's family expressed a number of concerns and frustrations in this regard. However relevant to this report specific benefits could be derived from effective family liaison. Namely the family as a source of information together with the potential information sharing and cross referencing. (4).Application of definition of " High Risk" in the context of missing persons. Shaun was assessed as medium risk until 21:00 hours on 10th July. At that time a Chief Inspector had reviewed the information on the database and applied an "enlarged" interpretation of the high risk definition.The evidence revealed that up to that time officers (Sergeants and Inspectors) considered that "High" risk could not apply in the absence of evidence of "Immediate" risk. The Jury concluded that the case should have been categorised as high risk on Saturday 9th July. These definitions are used nationally and are potentially part of your review. The concerns arising are around whether the definition could (for example) be annotated or commented on to clarify when a less literal interpretation can be applied.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 28th 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 or their legal representatives. [redacted]IPCC. Advance Housing and Support Ltd. Shaun's family. Bucks County Council. Thames Valley Police. Oxford Heath NHS Foundation Trust. Police Federation. 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	**DATE 31st January 2014** **SIGNED**