REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive – Coventry City Council**
1	**CORONER** I am S McGovern, Senior Coroner, for the coroner area of Coventry
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** I opened an investigation on 14 August 2014 into the death of Amar MAJID, late of 198c Dillotford Avenue, Coventry. I concluded the inquest on 11 November 2014 and returned a conclusion that his death was a drugs related death
4	**CIRCUMSTANCES OF THE DEATH** Mr Majid was found dead in the disabled toilets of the Public Library, Smithford Way Coventry at approximately 3.00pm. He was found with a syringe in his hand and material believed to be heroin. He died from heroin toxicity. I heard evidence that he was in the toilet from approximately 10.00am
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. – I heard evidence from [redacted] (Business Improvement Manager) of Coventry City Council (CCC) that the disabled toilets in the library are used by individuals abusing drugs. Mr Majid was present in the toilet from 10.00am and heard to be making noises. I was concerned that no-one checked on his well-being for over 5 hours, despite what I understand to be hourly cleaning of the toilet. Earlier intervention may have prevented his death. I invite you to consider the installation of ultra-violet lights in the disabled toilet to make the location less attractive to intravenous drug users. Also I invite you to review your procedures concerning checking the toilets as it seems there was confusion as to the correct procedure to follow when a toilet was occupied for

	a considerable period of time. Mr Majid was in the toilet from about 10.00am to the door being opened at about 3.00pm. That delay may have contributed to his death although I was unable to make firm findings on that point.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 6 January 2015. 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 (a)[redacted](brother) 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	**11 November 2014** **Senior Coroner** **S McGovern**