REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Police Crime Commissioner for Hampshire** **St George's Chambers** **St George's Street** **Winchester SO23 8AJ** 2. **The Chief Constable** **Hampshire Constabulary Police Headquarters** **West Hill** **Romsey Road** **Winchester SO22 5DB**
1	**CORONER** I am David Clark Horsley, senior Coroner, for the Coroner area of Portsmouth and South East Hampshire.
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 18th August 2015 I commenced an investigation into the death of James David Barrett, age 66. The investigation concluded at the end of the inquest on 5th February 2016. The conclusion of the inquest was: - Medical cause of death: 1a) Severe Ketoacidosis and Hypothermia 2) Alzheimer's Dementia and Diabetes Mellitus - Coroner's conclusion as to the death: Death due to an Accident.
4	**CIRCUMSTANCES OF THE DEATH** On 7th August 2015 James David Barrett, who suffered from Alzheimer's Dementia, went missing from his home. Despite a missing person search having been instituted by the emergency services on 8th August 2015, he was not found until 13th August 2015. He was pronounced deceased at the scene of his discovery by an attending police officer at 15.10 hours that day.
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. – The matters that concern me relate to issues raised in a report given to me at the Inquest by Sergeant 2637 Turner of Hampshire Constabulary. I attach a copy of his report upon which I have highlighted these issues. If the mapping of the search for Mr Barrett had been completed on one mapping system, I believe the search for him could have been conducted more quickly and effectively.

	This could be done in future if the police search advisers had available to them a stand-alone mapping system rather than relying on a volunteer organisation to map out searches. I was told that a bid for such a mapping system by the police search team has been turned down by Hampshire Constabulary and I would ask that this decision be reviewed in the light of the circumstances of Mr Barrett's death. I was also told that the search for Mr Barrett could have been more effective if searchers had been equipped with tracking devices which would allow search organisers to see precisely where searchers had looked for him. I should be grateful if Hampshire Police could consider obtaining there devices for use in missing persons searches.
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 11th April 2016. 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 Mr Barrett's family. 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	**Monday, 15th February 2016** **SIGNED BY CORONER** **David Clark Horsley**