Regulation 28: Prevention of Future Deaths report

Susan Sian JONES (died 15.02.15)

	THIS REPORT IS BEING SENT TO: 1. **Commander Lucy D'Orsi** **New Scotland Yard** **10 Broadway** **London SW1A 0BG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 19 February 2015, I commenced an investigation into the death of Sian Jones, aged 47 years. The investigation concluded at the end of the inquest earlier today. The jury made a narrative determination, which I attach. They concluded that Ms Jones's death resulted from methadone and alcohol intoxication, coupled with inadequate police policies, procedures and training. The medical cause of death was recorded as: 1a diffuse cerebral ischaemia 1b cardiorespiratory arrest 1c combined toxic effects of alcohol and methadone in an individual with myocardial fibrosis and significant atherosclerotic stenosis of two major epicardial coronary arteries

4	**CIRCUMSTANCES OF THE DEATH** Ms Jones suffered a cardiorespiratory arrest in Hornsey Police station whilst waiting to see specialist officers to make a statement concerning an allegation of a historical sexual assault.
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** related to policy in respect of the monitoring of non detained members of the public by police officers. I heard evidence at inquest that there is no specific protocol or training regarding the monitoring of members of the public in police stations who are not in police custody. This was acknowledged by the Metropolitan Police Service to be a gap. In seeking to plug this gap by way of policy development, it may be helpful for you to consider the following. • Snoring is not always a reassuring sign and may indicate a partial airway obstruction. A partial airway obstruction can be life threatening. • In considering whether snoring is sign for concern, the fact of intoxication by alcohol or drugs or both – even if the individual is capable – is highly relevant. In addition, officers should bear in mind that members of the public sometimes lie about alcohol or drug taking, even when there seems no obvious reason to lie. • Any relevant information gleaned by officers, for example that an individual is a methadone user, should be passed on to colleagues with responsibility (and preferably recorded in some way or other). • The only way of determining whether snoring is benign is by rousing, most particularly by waking the individual and determining whether they are able to sit up and hold a conversation. • The rousing itself may have a therapeutic purpose even over and above its value as a tool of assessment. And an unresponsive individual must be treated as a medical emergency. • All police officers and staff should know the location of the nearest defibrillator. If they are attending a police station for the first time, they should make themselves aware of its location.

	In terms of feedback regarding officer training generally and for the officer who led this resuscitation attempt, I should also point out that after Ms Jones's cardiorespiratory arrest, the cardiopulmonary resuscitation given was later noted by a paramedic to be extremely effective.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 30 December 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • [redacted] sister of Sian Jones • [redacted] daughter of Sian Jones • Chief Inspector [redacted] policy lead 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.10.16