Regulation 28: Prevention of Future Deaths Report

Mark Adam YAFAI (died 01.07.15)

THIS REPORT IS BEING SENT TO:

Chief Constable of West Midlands Police, Office of The Police and Crime Commissioner West Midlands Lloyd House, Colmore Circus Queensway, Birmingham B4 6NQ

1. **CORONER**

   I am: Delroy Henry, Assistant Coroner, Coventry. The Coroner's Office, The Register Office, Coventry City Council, Cheylesmore Manor House, Manor House Drive, Coventry, CV1 2

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 9th July 2015, I commenced an investigation into the death of Mark Adam Yafai, aged 27 years. The investigation concluded at the end of the inquest on 31st October 2016 at Coventry Coroners Court. The conclusion of the jury was that death was "drug related with a narrative", a copy of which I attach to this letter.

4. **CIRCUMSTANCES OF THE DEATH**

   On 30th June 2015 Mark Yafai was staying at the Allesley Hotel in Coventry. At about 04:00am on 1st July 2015, Mark Yafai was arrested by [redacted] in the hotel car park for affray. Mr Yafai was searched prior to arrest and taken to Coventry Central Police station, arriving at 04:20am. His detention was authorised at 04:47am. As part of this process, Mr Yafai was again searched at the custody desk, declared that he had used cocaine. Mr Yafai had a marker on the Police National Computer about drug use. Mr Yafai was placed in a cell at about 05:10am. Hourly observations were prescribed but in fact Mr Yafai was checked in his cell every 30 minutes. At 05:56am, Mr Yafai's was found him on the floor in his cell convulsing and frothing at the mouth. An ambulance was called at 05:57am. The ambulance arrived at 06:07am leaving the station at 06:36am and arriving at hospital at 06:43am. Mark Yafai was in cardiac arrest and, in spite of efforts by hospital staff to resuscitate him for 30 minutes, was pronounced life extinct at 07:10am. A post-mortem and toxicological analysis were conducted, the cause of death as "acute cocaine toxicity".

5. **CONCERNS**

   During the course of the inquest, the evidence and information 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. The Safer Detention Policy and Handling of Person in Custody Composite Policy as updated August 2014 was replaced by the WMP Detention and Custody Policy Inc.

Standard Operating Procedure with effect from the 22nd December 2015. The earlier policy was in operation at the time Mark Yafai died. The earlier policy lacked clarity or guidance in how the phrase "under the influence" must be interpreted. The phrase is unsuitable since it confers a very broad discretion upon a custody officer to not have the detainee examined by a Health Care Professional, despite a detainee has disclosed recently consuming drugs. The impact upon risk assessment and levels of observation is clear and significant. A broad discretion of an officer when determining risk concerning medical matters including drug use is inadequate. The jury made a determination in similar terms.

ii. The evidence was the policy is accessible. Accordingly, it is paramount that the policy must provide clear unambiguous guidance/ direction to custody officers particularly in relation to drugs which can have serious consequences for an individual who has consumed. The circumstances of this inquest touching upon the death of Mark Yafai accentuated this point. The evidence was that cocaine can have toxic effects even from small quantities (as little as 0.03g). Consumption can be via a number of means and the effects delayed depending upon the method of ingestion. There is no antidote to cocaine toxicity. The evidence was custody officers range of knowledge about drugs and the effects can and do differ and this can have a bearing upon risk assessment given the terminology in the policy and broad discretion officers have.

iii. The 2015 policy retains that same unclear terminology i.e. "believed to be under the influence of drugs or withdrawing from drugs" and "will be seen by a Health Care Professional (HCP) as a matter of course".

iv. It does not deal with the instances in which a detainee irrespective of presentation (which is not itself any easy assessment when a detainee is being observed by an officer most likely for the first time with no information against which a comparison may be made as whether their current presentation is indeed "normal") has disclosed the recent consumption of drugs. What is "a line" or any quantitative opinion on drugs consumed is a very subjective assessment by the detainee and/ or the custody officer.

v. An assessment as to the effect of any drugs is best assessed a by a Heath Care Professional. That was the evidence and information that emerged in the inquest. Standard medical observations can be undertaken ranging from a check as body

temperature to elevated heart rate or blood pressure which may be indicators that drugs are having an adverse effect upon the body.

vi. Earlier identification of these matters may prevent death particularly since treatment for many drugs, particularly cocaine, is symptomatic. Close observation of a detainee is clearly significant since early treatment of symptoms can have an impact upon an individual's survivability.

vii. The policy in other respects does use directional/ non discretion type terminology in some respects when dealing with drug issues. It is thus currently inconsistent in this respect on this topic and in interrelation with Risk assessment and appropriate observation levels which are a focus of custody personnel.

6 **ACTION SHOULD BE TAKEN**

In my opinion, action should be taken to prevent future deaths and I believe that 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 **4th January 2017**. 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**

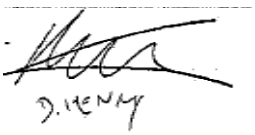
I have sent a copy of my report to the following:

1. HHJ Mark Lucraft QC the Chief Coroner of England & Wales
2. Mark Yafai's parents

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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 DATED - **9th November 2016**



SIGNED BY Assistant CORONER -