REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] MPS – DLS Holborn Police Station 10th Floor 10 Lamb's Conduit Street London WC1N 3NR
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 2nd September 2010 an investigation was commenced into the death of Mr Valdas Jasiunas. The investigation concluded at the end of the Inquest on the 2nd March 2017. The conclusion of the jury at the Inquest was a narrative conclusion: *Mr Jasiunas was an alcohol dependent vagrant with serious underlying health problems. Following seizure in his cell he was taken to hospital where he later died.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Jasiunas was a 36 year old gentleman who was arrested for begging and taken into police custody at around 13:00 on the 1st September 2010. Mr Jasiunas had a very complex past medical history, to include chronic alcoholic liver disease, severe head injury, seizures associated with both conditions and cerebral salt wasting syndrome. This medical history was not available to custody staff. Mr Jasiunas was assessed as being at risk and was placed on a management plan to be seen by a healthcare practitioner; to be checked and roused every 30 minutes and to be placed in a cell with CCTV. Mr Jasiunas underwent a brief medical review at around 17:00 hours and was deemed to be fit to be detained. At around 21:30 hours an FME inserted information into Mr Jasiunas's custody record indicating that medication had been administered to him. This was an erroneous entry and should have been recorded in the records of another detainee. Custody staff reviewing the custody record were however given the impression of 2 FME assessments and the administration of medication. At around 07:50 hours on the 2nd September 2010 Mr Jasiunas collapsed in his cell. He was found by staff at around 08:00 hours. Attempts were made to resuscitate him and the London Ambulance Service were called. The paramedics arrived and took over resuscitation. Mr Jasiunas was then taken to Newham University Hospital. Despite ongoing resuscitation and care in the Intensive Treatment Unit, Mr Jasiunas passed away at

	Newham General Hospital on the 2nd September 2010. The post-mortem examination gave a cause of death of 1a: Chronic Alcoholic Liver Disease. On the basis of medical evidence heard, the jury also added under II – History of traumatic brain injury and acute hypoxia following seizure activity.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concern. The **MATTERS OF CONCERN** are as follows. – 1. It was noted that staff in custody suites have to deal with a large number of detained persons who suffer from alcohol dependency. The risks of withdrawal to those who are alcohol dependent are wide ranging from shakes and tremors to death. In light of the frequency of dealing with detained persons who suffer from alcohol dependency and in light of the severity of the potential risk, it was considered that a specific question in the risk assessment document as to dependency on alcohol should be included. The current risk assessment simply states "are you dependent on drugs or any other substance". A directly pointed question relating to alcohol is likely to be of greater assistance in ensuring that the risk is clearly identified, assessed and managed. 2. An erroneous entry was inserted into Mr Jasiunas' record by an FME. The entry had the effect of providing false assurance to custody staff. The evidence revealed that errors on the custody records are commonplace and that the current design of the system renders errors easily made. Suggestions for improvements of the system included photographs of the detainee on the computer system; more prominent indication of the detainees surname at the top of the medical form; pop-up prompts to remind the healthcare practitioner to ensure that they have identified the correct detainee before prescribing medication; changes to prevent medication from being entered onto a person's custody record in the absence of an accompanying medical form being completed at the same time. 3. There were some question marks around the full understanding of Mr Jasiunas as English was not his first language. The Medical Director of the Forensic Healthcare services has confirmed that a very helpful leaflet is now provided to detained persons in custody setting out the signs and symptoms of alcohol withdrawal. The leaflet is not yet available in different languages. The FME stated that in East London, a number of detained persons are of Eastern European origin. The leaflet may well assist in ensuring that relevant signs and symptoms are bought to the attention of custody staff. Availability of the leaflet in the most common presenting languages is likely to ensure that more detained persons are able to understand and communicate significant concerns.
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 **4 May 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 Chief Coroner and to the Director of Public Health [redacted] 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]** 8.3.2017 **[SIGNED BY CORONER]**