REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Constable Shaun Sawyer** **Devon and Cornwall Police Headquarters** **Middlemoor** **Exeter** **Devon** **EX2 7HQ**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner for the Exeter and Great Devon District
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 2nd March 2015 I commenced an investigation into the death of Mark Craig BANKS, aged 44. The investigation concluded at the end of the inquest on 13th October 2015. The conclusion of the inquest was Alcohol Related Death.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased, a long term alcoholic with mental problems, was homeless when he suffered from exposure in an unmade tent by the Braunton side of Bradiford Water outlet on the Tarka trail. He succumbed in the early hours of 23rd February 2015 in bad weather. Alcohol was a factor.
5	**CORONER'S CONCERNS confirmed by the unexpected, late submission (post Inquest) of an Independent Police Complaints Commission report on 8th June 2017.** 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. (1) Failure to contact ambulance service after caller request in addition a failure to record the request on the incident log. (2) Failure to grade the call correctly when there was a clear danger to Mr Bank's life. (3) RE: [redacted] at Page 176 of the Independent Police Complaints Commission report – insufficient efforts to search and check upon Mr Banks' wellbeing when asked to attend the scene.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and the Devon and Cornwall Police Force have the power to take such action.

	1. The Devon and Cornwall Police review its grading and deployment policy and operational practices regarding the call grading and incident creation to ensure that they are compliant with the National Standard for Incident Recording and the National Call Handling Standards, making any necessary amendments. 2. That Devon and Cornwall Police develop Standard Operating Procedure for identifying the location of incidences which do not take place at a fixed address, including those involving vulnerable people found in public places. This could include prompts for call handlers to ask callers what they see around them in different directions, whether they can provide any additional detail at all to identify the location and whether they can attend/remain at the scene if the location remains unclear.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th October 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 following Interested Persons. 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** 14th April 2017 **Signed**..... **Dr Elizabeth A Earland MB.Ch.B., D.A.,Dip.Law,L.P.C,Hon.LLD** **HM Senior Coroner** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**