

# **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

#### THIS REPORT IS BEING SENT TO:

Chief Constable of Warwickshire Police Chief Constable of West Midlands Police National Police Chiefs' Council

### 1 CORONER

I am Louise Hunt Senior Coroner for Birmingham and Solihull

## 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 06/11/2017 I commenced an investigation into the death of Keiron Christopher Bould. The investigation concluded at the end of an inquest on 12th June 2018. The conclusion of the inquest was Suicide.

# 4 CIRCUMSTANCES OF THE DEATH

The deceased left his home address at 17.30 on 17/09/17 to smoke cannabis. He had an argument with his girlfriend earlier in the day and had taken her morphine tablets. He drove to a car park at the bottom of Ryecroft Close in Chelmsley Wood where he was seen in his parked vehicle at 21.45. His vehicle remained in the same position with him sat in the driving seat, being seen by two dog walkers in the area several times until he was found still in the driving seat at 16.16 on 18/09/17. He last used his mobile phone when he read a text at 22.52 on 17/09/17. He likely took the morphine overdose around 12 midnight. His phone was not working at the time. Paramedics attended and he was taken to Birmingham Heartlands Hospital where he was pronounced deceased at 17.30. He was reported as a missing person to police just after midnight on 18/09/17. The incident was initially dealt with by Warwickshire police who the transferred the case by email to West Midlands Police at 01.53. The following morning police made further inquiries but were unable to locate Keiron before he was found by others.

Following a post mortem the medical cause of death was determined to be: MORPHINE OVERDOSE

### 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. -

1. When each force received a missing person report soon after 12 midnight on 18/09/17, there was no communication about who would take primacy of the inquiry. There should be a system in place to ensure verbal communication confirms who is dealing with any incident.

|   | 2. When Warwickshire police decided to transfer the case to West Midlands police an email was sent at 01.53 to a generic email address. There was a 4 hour delay in this email being picked up and actioned. There should be a system in place to ensure verbal commination about a transfer so the receiving force is aware of the referral.         |
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| 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 by 8 August 2018. 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:-  |
|   | Mr Bould's family and   |
|   | 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 | 13/06/2018 Signature  |
|   | Louise Hunt Senior Coroner  |
|   | Birmingham and Solihull   |