HM Coroners Office
The Court House, Woburn Street
Ampthill, MK45 2HX

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Constable of Bedfordshire,** Bedfordshire Police Headquarters, Woburn Road, Kempston, Bedford MK43 9AX
1	**CORONER** I am **Emma Whitting**, Senior Coroner for Bedfordshire & Luton
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 23 August 2018 the Acting Senior Coroner for Bedfordshire & Luton commenced an investigation was into the death of Mr David Bird, aged 51. The investigation concluded at the end of the Inquest held by me, on 9 May 2019, when my determinations and conclusion were delivered. The medical cause of death was found to be: 1a Hanging The Conclusion of the Inquest was a Narrative Conclusion: *The Deceased intentionally took his own life but the failure to arrange a medical assessment prior to his release from police custody the previous day possibly contributed to his death*
4	**CIRCUMSTANCES OF THE DEATH** *On Saturday 18 August 2018, on becoming aware that the Deceased had seemingly been preparing to take his own life in the bedroom of his home, Bedfordshire Police submitted a Vulnerable Adult Referral in respect of the Deceased. Following allegations of harassment against him and a further concern for his welfare, the Deceased was then arrested on 19 August 2018 and taken into police custody. He was interviewed under caution by Northamptonshire Police who requested he undergo a medical assessment prior to his release. Despite making this request, three times, the Deceased was released by Bedfordshire Police, at approximately 01.30 hours on 20 August 2018, without such an assessment. On 21 August 2018, having last been seen at around 09.00 hours, he was found hanging by a ligature made of rope from the ceiling beam in his bedroom at 15.45 hours. Notes signed by him at the scene confirmed an intention to take his own life.*
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 could 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) **Adequacy of Training of Custody Officers in interpreting the behaviour/demeanour of detainees:** Although both Bedfordshire Police Custody Sergeants had received in their training (as evidenced by the Power-Point presentation exhibited as "EMO2") guidance on interpreting 'Behaviour' in the ABCDE of Vulnerability Assessments, both Sergeants had interpreted David's response that he was '*on Top of the World*' to the Question '*How are you feeling*?' on being booked in, *literally*, - when, in fact, this might be interpreted as having an element of irony requiring further exploration; (2) **Adequacy of Training of Custody Officers in formulating a suitable care-plan for a detainee; in particular, identifying the need in the Pre-Release Risk Assessment (PRRA) for Mr Bird to see a Health Care Practitioner (HCP) before release:** Although both Custody Sergeants had received in their training (as evidenced by the Power-Point presentation exhibited as "EMO2") guidance on formulating a Care-Plan and page 28 of that presentation gave the following example: "*DP has been returned from interview from OIC, became tearful during interview and made comments that indicated possible self-harm risk on release, Obs level changed to LI30mins obs. PRRA considerations – DP to see HCP before release, DP has been told to see his GP about how he feels, he lives with his partner so there is someone at home to give support*", Mr Bird was released without a being seen by the HCP even though: i. David had already been identified as a Vulnerable Adult (in term of a possible suicide risk) by Bedford Police on 18 August 2018 and a further concern for welfare had been raised in respect of him by Northamptonshire Police on 19 August 2018; ii. He had been very tearful and distressed during his interview describing himself as 'one with no home, no life, no job'. iii. The IO and his colleague had requested a medical assessment for him prior to release 3 times
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 **29 July 2019**. 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 Mr Bird's family.

	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	**3 June 2019 SIGNED BY HM SENIOR CORONER:**