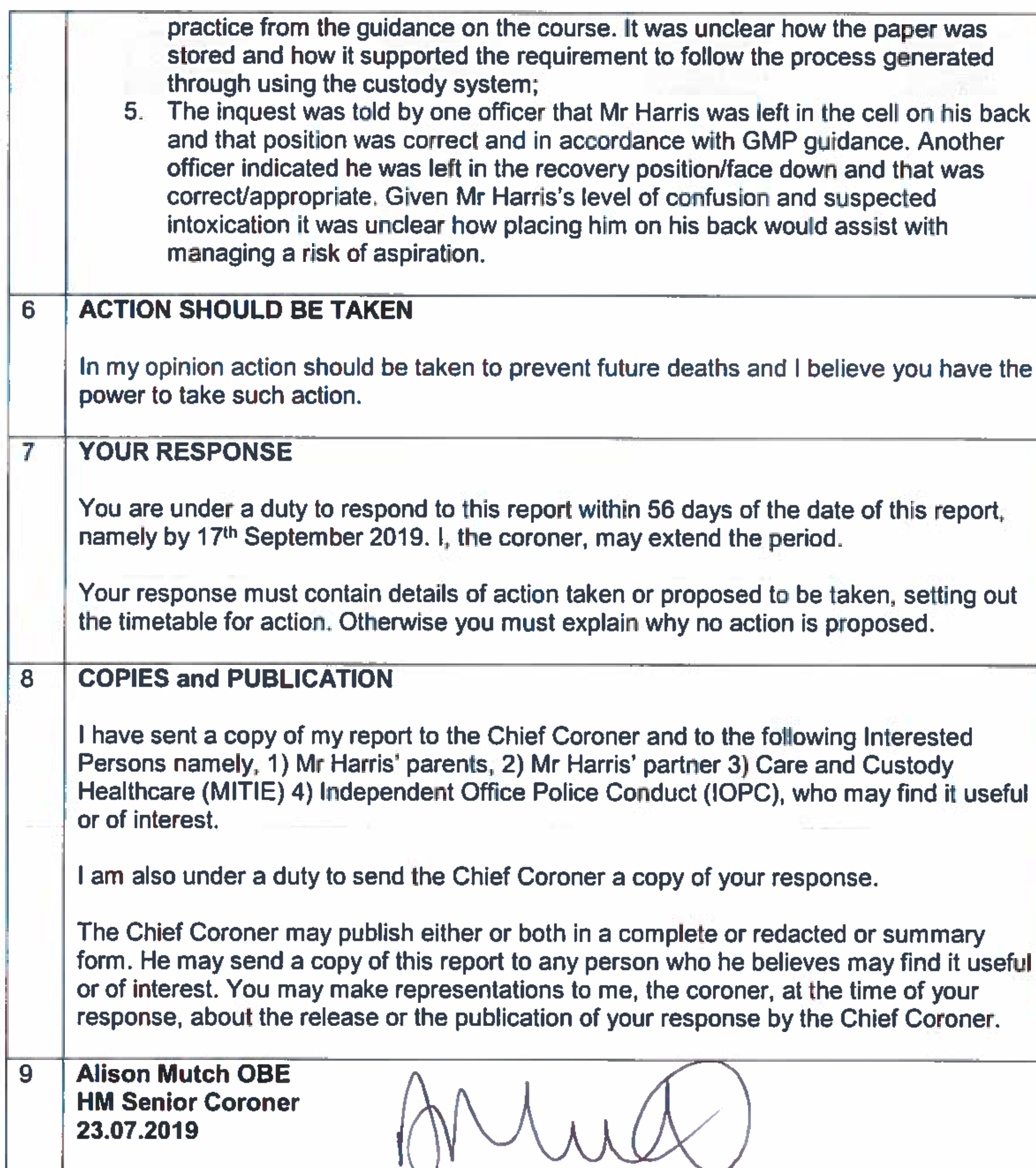
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Greater Manchester Police**
1	**CORONER** I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 20th April 2018, I commenced an investigation into the death of Adam Harris. The investigation was concluded by a Jury on the 13th June 2019 and the conclusion of the jury was one of **Drug Related Death.** The medical cause of death was **1a) Cocaine and alcohol toxicity.**
4	**CIRCUMSTANCES OF THE DEATH** On the 20th April 2018 Adam Harris died at Tameside General Hospital from alcohol and cocaine toxicity. He had collapsed at Ashton Police Station having been arrested and detained by Greater Manchester Police on 20th April 2018.
5	**<u>CORONER'S CONCERNS</u>** 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. The inquest heard that there was no formal documented triage/risk assessment in place when a prisoner was held in the van dock area pending space becoming available in the custody suite. The inquest heard that whilst the average wait time in the van dock area across GMP was 15 minutes on occasions the waiting period could be in excess of 60 minutes; 2. Adam Harris was not arrested until he was in the rear of the Police van. None of the officers present searched him before he was placed in the van or before he was transported to Ashton Police Station; 3. Adam Harris was not transported by the Arresting Officer but by Police Officers operating a divisional van. There was no evidence of a clear and detailed handover between the Arresting Officer and the Transporting Officers. One of the Transporting Officers described the role they played as a police taxi service; 4. The Custody Sergeant did not open a custody record immediately on Adam Harris's arrival in the custody office. He used a piece of paper to record the details that were given to him. He did not input details into the custody record until after Adam Harris had been placed in a cell. He indicated that the custody Sergeant course encouraged the use of paper and he had developed his



	practice from the guidance on the course. It was unclear how the paper was stored and how it supported the requirement to follow the process generated through using the custody system; 5. The inquest was told by one officer that Mr Harris was left in the cell on his back and that position was correct and in accordance with GMP guidance. Another officer indicated he was left in the recovery position/face down and that was correct/appropriate. Given Mr Harris's level of confusion and suspected intoxication it was unclear how placing him on his back would assist with managing a risk of aspiration.
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 17th September 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 the following Interested Persons namely, 1) Mr Harris' parents, 2) Mr Harris' partner 3) Care and Custody Healthcare (MITIE) 4) Independent Office Police Conduct (IOPC), who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **23.07.2019**