HEIDI J CONNOR
SENIOR CORONER FOR BERKSHIRE

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. John Campbell QPM, LLB, MA – Chief Constable Thames Valley Police, Thames Valley Headquarters South, Oxford Road, Kidlington, OX5 2NX.** **2. [redacted] NPCC Chair – National Police Chiefs' Council, 10 Victoria Street, London SW1H ONN.** **3. Mike Cunningham, CEO – College of Policing, Leamington Road, Ryton-on-Dunsmore, Coventry, CV8 3EN.**
1	**CORONER** I am Heidi J. Connor, senior coroner for the coroner area of Berkshire.
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 April 2017 I commenced an investigation into the death of Leroy Dacosta Junior Medford, aged 43. The investigation concluded at the end of the inquest on 26th June 2019. The jury recorded a shortform and a narrative conclusion. Their conclusions were: Cause of death: Heroin (diamorphine) toxicity. Short-Form Conclusion: Drug related death. Narrative Conclusion: See attached.
4	**CIRCUMSTANCES OF THE DEATH** We were asked by the family to refer to the deceased as Junior. I have reflected that request in this report.

	I have attached a copy of my summing up to the jury which sets out the factual circumstances in more detail. The key facts are as follows: Junior was arrested by Thames Valley Police Officers on the 1st April 2017. The officers were told by a member of the public that he was "packing". Junior was placed under the Detention and Care of Detainees Suspected of Swallowing or Concealing Drugs SOP ("the drugs SOP") from the start, with two officers required to observe him constantly. The officers observing Junior interpreted "constant observations" to mean observations from the cell door. Crucially, we heard that none of the officers involved in these events was aware that the drugs SOP required an officer to observe from within the cell. This included PCs, Custody Sergeants and a PACE Inspector. We heard evidence that training is disseminated to officers very frequently. This is sent out in a variation of ways – including classroom training, e-learning and on the job training. We heard that the relevant drugs SOP came into force within Thames Valley Police on the 1st July 2016. This was circulated to all police officers. Custody Sergeants (amongst others) were also required to carry out online training. The Custody Sergeants in question had both opened the online training. The Custody Sergeant who made the key initial decisions regarding levels of observation did not consult the SOP and did not appreciate at the time that observations from within the cell were required. Sadly Junior's condition deteriorated whilst in his cell. His deterioration was not appreciated until 03:57, when resuscitation efforts proved futile. He was declared deceased at the Royal Berkshire Hospital at 05:13 hours.
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. – BRIEF SUMMARY OF MATTERS OF CONCERN The Drugs SOP One of the reasons that the drugs SOP was introduced by Thames Valley Police on 1st July 2016 was to prevent exactly what happened in this case. That is (one of) the reasons that the SOP requires an officer to observe from within the cell. We heard that the SOP was circulated to all police officers in July 2016. Custody Sergeants were asked to carry out online training on this in the same month. Clearly no officer would be expected to know any SOP word for word, but these are available to be looked at on computers within the custody suite. A key requirement of the drugs SOP is the requirement for an officer to be within the cell with the detained person. What has concerned me in this case is that not 1 or 2 officers were unaware of this requirement. All officers – of all ranks – who were involved with Junior on the night of 1st April 2017 were unaware of this requirement.

	I was however satisfied that additional training and awareness has now taken place around this particular SOP. It is a SOP that is used more frequently now. Concern Regarding Future Training My concern is a broader one – around how training is disseminated and monitored within the police service. I am satisfied that this is an issue that does not only relate to Thames Valley Police. We heard that the police, like many services and professions, are given regular updates and training, in various formats. It is reasonable to suggest that different people learn in different ways. What this case has illustrated however, is that the current system is not effective or safe. That may be partly because of the pressures on the service. It may be that officers are not given sufficient protected training time to do this. Training is given in many, varied ways. Much of this is on-line. I consider that there should be a national review and debate about the way in which training is delivered to police officers across the country. There should be consideration given to how police forces reassure themselves that training has not just been offered, but has been taken up, and that officers are encouraged to consult SOPs and other guidance that they do not use regularly. This would of course require easy access, digitally, to these procedures and efficient updating and storage of these policies for officers to review. It is a matter for the respondents to this letter to consider the volume of training issued to police officers, and whether this can be safely prioritised. There is perhaps a risk of lack of urgency if training updates are given too frequently. For the avoidance of doubt therefore, the points on which I require a response are: 1. The most effective way to deliver training to serving officers. 2. The volume of this training. 3. Whether training can be prioritised. 4. How police forces can reassure themselves that training is not just being offered, but also taken up. 5. Whether officers are given adequate opportunity to carry out training. 6. How officers can be encouraged to review relevant guidance in situations they are not regularly faced with. 7. Access to and updating of on-line guidance and procedures.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 3 months from the date of this report, namely by **9th October 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: 1. Family's legal representative. 2. Legal representative for a number of separately represented officers at the inquest. 3. IOPC. 4. Legal representative of Mountain Healthcare (who employed the healthcare professional involved in Junior's case). 5. Legal representative of Noonans (the company responsible for providing detention officers at that time). 6. Legal representative for Royal Berkshire Hospital (where Junior died). 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.
	DATE: 9th July 2019 **SIGNED BY CORONER:** pp Spence