REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dame Cressida Dick CBE QPM** Commissioner of the Metropolitan Police, New Scotland Yard, Victoria Embankment, London. SW1A 2NJ.
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 the 3rd and 4th of September 2019, evidence was heard touching the death of **Anna Elina Hedman.** Ms Hedman was found drowned in the bath at Flemings Hotel on 28th April 2018.She was 28 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Drowning 2 Cocaine Toxicity **How, when, where the deceased came by her death:** On 28/4/2019, Anna was found drowned in a hotel bathroom at 13:08. There was no evidence of third-party involvement. She had a long history of post traumatic stress disorder, depressive episodes, panic attacks and drug misuse and had recently attempted to take her own life. **Conclusion of the Coroner as to the death:** Anna drowned herself whilst intoxicated with cocaine on a background of enduring psychological illness and drug misuse.
4	**Circumstances of the death.** Extensive evidence was taken and accepted by the court. In summary, the evidence relevant to this report was that a Police Officer was working within the Police call centre on 28th April 2018 as a call taker. His usual role was as a Police Officer answering 999,

	of more than 10 years' experience. He had undergone training to work overtime as a part-time call handler. At around 13:11 he took an emergency call from a hotel concierge who informed him that there was a guest deceased in one of the rooms in a bath underwater. The PC took the caller at his word and did not ask him to lift her out of the water nor check for breathing. He instead asked him to secure the scene and passed the call to the dispatch team. He did not ask for an ambulance, even when prompted to do so by the dispatch team. He stated that he had just treated the death as suspicious and did not consider preservation of life, despite all his experience as a police officer and understanding that preservation of life is the first duty of the police. He stated that had he been called to the scene, the first thing he would have considered was to preserve life, but his training as a call handler had constantly re-iterated to him that he should not act as a police officer when working as a call handler. He blamed his lack of prioritisation of preservation of life on his training. He stated that it was short and rushed, little training was given on the codes to use or protocols to follow, that preservation of life was not stressed as a priority and that he had received little mentoring, and this was just his third day working unsupervised. He could not explain why he had not called an ambulance even when prompted to do so by dispatch. It was accepted that he had coded the call incorrectly. Expert evidence confirmed that Anna was probably dead before she was found and that extrication from the bath water and earlier resuscitation would have been unlikely to have averted her death. The court found that the PC's lack of prioritisation of preservation of life and failure to call an ambulance even when prompted by dispatch were gross failures, but these were not causative in the death. Evidence was also taken in relation to the training provided to police officers planning to work overtime as part-time call handlers. The court heard that the training for part-time call handlers who are experienced PCs is 4 days, much shorter than that of full-time call handlers, whose training lasts weeks, to reflect their pre-existing experience as officers. Training is now delivered by staff who work as call-handlers and is followed by 4 days of coaching/mentoring, compared to 10 days offered to full-time call handlers. It now also now mandatory for a call handler to open a standard operating procedure when entering a call code to help guide the call handler to the correct actions to apply in response of an individual call. Training is also offered on the coding system. For part-time handlers who are deemed to require it, there is an opportunity to extend the coaching/mentoring period. Despite some evident improvement in the training package provided to PCs training as part-time call handlers, especially in relation to the mandatory use of standard operating procedure, the court was still left with some concerns about whether the relatively short training compared to that offered to full-time staff is adequate.
5	**Matters of Concern:** 1. That the training offered to police officers becoming part-time call handlers is too short and rushed, especially in relation to call coding. 2. That the training does not emphasize preservation of life. 3. That the post training coaching/mentoring is insufficient.

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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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. [redacted] 2. [redacted] Chief Operating Officer, Central and North West London NHS Trust, Stephenson House, 75, Hampstead Road, London. NW1 2PL. 3. [redacted] c/o Directorate of legal Services, metropolitan Police Service, 10, Lamb's Conduit Street, London. WC1N 3NR. [redacted] 4. [redacted] Lead Investigator, IOPC, Southern House, 13th Floor, Wellesley Grove, Croydon. CR0 1XG. 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	**25th September 2019.** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**