DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Constable Kier Pritchard** **Wiltshire Police** **Wiltshire Police HQ** **London Road** **DEVIZES** **Wiltshire** **SN10 2DN** **Ken Wenman Esq** **The Chief Executive** **South Western Ambulance Service** **NHS Foundation Trust** **Abbey Court** **Eagle Way** **EXETER** **EX2 7HY** **Chief Constable Mike Cunningham** **Chief Executive of the College of Policing** **College of Policing,** **1-7 Old Queen Street,** **Westminster,** **London, SW1H 9HP** **Chief Constable Mark Collins** **Dyfed & Powys Police** **(National Police Chiefs' Council Lead in relation to Mental Health)** **Police Headquarters** **PO BOX 99** **LLANGUNNOR** **Carmarthen** **Carmarthenshire** **SA31 2PF**
1	**CORONER** I am DAVID W. G. RIDLEY, Senior Coroner for Wiltshire and Swindon
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 14 February 2017 I commenced an investigation into the death of Eugeniusz Niedziolko and an Inquest was opened by Assistant Coroner, Dr. Claire Balysz on the 11 April 2017. The

	Inquest, which was held with a Jury, was concluded on the 28 June 2017 and the Jury determined that the medical cause of death was **1a) Acute Alcohol Toxicity and Hypothermia.** In box 3 in the Record of Inquest the Jury in relation to the mechanism of the death recorded as regards the how, when and where Eugeniusz came by his death:- ***At 7.45 am on 14 February 2017, Eugeniusz Niedziolko was found unresponsive in a lavatory block at Lush House Car Park, Salisbury, after being left by the police at 3.17 am to sleep off the effects of alcohol consumption in the early hours of that morning.*** ***Eugeniusz was pronounced dead at 8.17 am on 14 February 2017 and died as a result of acute alcohol intoxication and hypothermia.*** The short form conclusion and narrative conclusion recorded by the Jury in box 4 of the Record of Inquest was recorded as follows:- ***"Accident contributed by neglect"*** ***"Narrative Conclusion"*** ***Failure by the Police and Ambulance Services to relay and clarify key information from the control room to front line staff. In addition, failure to follow protocol and document findings by the Police and Ambulance Services was compounded by inappropriate training delivery processes. With insufficient knowledge of the options available this culminated in poor decision making and a lack of professional judgment by the Police who subsequently left Eugeniusz in the toilet block at Lush House car park at 0317 on the 14th February 2017 rather than being taken to an appropriate place of safety to be monitored and receive appropriate care if necessary.***
4	**CIRCUMSTANCES OF THE DEATH** At around 0130 on the morning of the 14 February 2017 the Police were called to attend a believed drunken person that had gained access into a communal hallway area inside a private block of flats at Mill Road Mews in Salisbury. Eugeniusz had been asked to leave a train a few hours earlier in Salisbury partly because it was suspected that he had no ticket but also due to the degree of his intoxication. Police Officers were tasked to attend the flats at 0200 hours and arrived at the flats at 0227, the call having been given "priority" status. Eugeniusz was found by both Officers lying on his left-hand side on the top landing intoxicated and in a pool of his own urine. Right from the outset it was clear that the attending police officers were having communication issues with Eugeniusz whose English was not good at all. Initially they assisted him to his feet and escorted him out of the block of flats whereupon one of the officers called the ambulance service with the intention of them checking Eugeniusz over. The call to the ambulance service was made at 0244. The Paramedics were dispatched at 0248 and arrived at the scene some 4 minutes later at 0252. Contrary to the relevant Paramedic protocol (the Appropriate Care Pathway Policy dated 2014) no observations were carried out on Eugeniusz and as a consequence nothing was recorded. The lead Paramedic opted to carry out a visual examination at the roadside using scene lighting and not inside the ambulance. Neither the lead paramedic nor the trainee paramedic that formed the ambulance crew noted that Eugeniusz had been incontinent of urine. It was clear however that Eugeniusz was drunk and that there was a degree of unsteadiness noted although he was able to walk with a rucksack on his back, slightly staggering but unaided. The lead Paramedic assesses a Glasgow coma scale of 15 and has no reason to believe as do the Police that Eugeniusz did not have mental capacity. Eugeniusz at one point tried to get into the ambulance cab and is stopped by the lead Paramedic. Eugeniusz said that he was a *"good alcoholic"* and that he wanted to go to hospital. When asked why he said *"detox"*. The lead Paramedic went on to indicate that there were no detox facilities at Salisbury at that time of night. In evidence, no one in attendance considered that actually Eugeniusz might have been asking for help as a result of having drunk too much. The lead Paramedic forms the view that the matter is a social issue in nature as opposed to a medical one and decides that hospital was not the appropriate place for Eugeniusz to be taken. The Paramedic at the time had 10 months experience in front line operations. At the time the Paramedics were leaving the scene, one of the options that was being considered was for Eugeniusz to be taken to a nearby hotel. After the Paramedics had left it was ascertained that

Eugeniusz does not have sufficient money for a hotel. Around the same time at 0312 the 2 police officers received an update following a PNC check however only 1 of 3 markers appears to have been effectively communicated to the 2 officers on the ground, both officers in their evidence were clear that they were only aware of the ailment being an alcoholic marker. Their view was supported by the transcript of the recording of the communications that the control room operator had with the officer at the scene. The Control room operative in evidence believed that she would have passed on all 3 markers and would not have picked out 1 or 2 in priority to the complete set. Within 5 minutes of receiving this communication, Eugeniusz had been taken round and deposited in the male lavatory at the Lush House Car Park public lavatory located in Crane Bridge Road, Salisbury, Wiltshire. The police officers had considered taking him to an area frequented by other homeless people near Sainsbury's but decided against that due to concerns that he may be picked upon. Eugeniusz had in his possession a rucksack and a TV box, although both officers were unclear as to whether it contained a television or not and at no stage did they confirm the position. Eugeniusz was able to walk into the lavatory block unaided carrying his rucksack and television. A remaining bottle of Gin was confiscated by one of the Officers and the contents disposed of later. Eugeniusz is left with a 70cl bottle of rum containing about 50ml of rum, which when his body was found was empty. That having been said the Consultant A & E Expert, [redacted] said in evidence that it probably would not have made a difference in respect of the outcome. No arrangements were made to check further on Eugeniusz and he was left alone in the lavatory block which unbeknown to the Officers had no heating in circumstances where the outside temperature dropped as low as 1° Celsius that night. His unresponsive body was found 4½ hours later by a cleaner and his death was confirmed at 0817 by an attending Paramedic. On post mortem examination, including toxicology, blood alcohol levels were recorded at 434mgs per 100ml of litres of blood and 493mgs per 100ml of urine. None of the usual signs in relation to hypothermia were found at post mortem hence in her report [redacted], the Forensic Pathologist, records a single cause of death as **1a) Acute alcohol toxicity**. This as you will see from above was varied by the Jury to include hypothermia which [redacted] in her evidence thought was highly likely at the time of death, despite the absence of the usual indicators, that there was a degree of hypothermia. [redacted] was also of the opinion that more likely than not the level of blood alcohol in Eugeniusz's system was still rising to a point of equilibrium with urine alcohol levels. Both [redacted] and [redacted] were both of the view that it was likely that Eugeniusz had a further period of incontinence prior to death as he was found in a pool of urine and at post mortem his bladder was still relatively full.

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.

[PLEASE NOTE - the whole purpose of this Regulation 28 Report is to avoid a repeat of an incident whereby a heavily intoxicated individual, who quite clearly was not capable of looking after himself, was left alone in a public lavatory on a cold night and died as a result of acute alcohol toxicity and hypothermia on the basis that the police officers concerned felt that they had no other option available to them].

WILTSHIRE POLICE

a) **RADIO PROTOCOL**

When listening to the radio communications there appeared to be a non-existent radio protocol of any form. My concern relative to this particular point is the absence of a protocol which for example requires the recipient of important information such as PNC markers to reflect or even repeat the information that has been given so that it can be established at both ends that the information has been correctly and effectively communicated. The situation that appears to have arisen in this case is that the controller says that all 3 markers were communicated but the transcript supports the 2 officers on the ground recollections that they only received notification of 1. I am concerned that the absence of any check could lead to critical information not being communicated which could lead in certain circumstances to errors occurring that could result in a worst case scenario to a death occurring. This issue of relaying critical

information was highlighted by the jury in their Narrative Conclusion.

b) **TRAINING AND GENERAL LIFE SKILLS** - It was quite clear during the evidence that both police officers had a very limited knowledge in relation to the effects alcohol has on the body. Neither officer asked, nor even attempted to ask, what I would term were obvious questions at the time, namely how much had the individual had to drink and when the last drink was consumed and over what period the alcohol was consumed. Considering the Courts regard Police Officers as experts in relation to drunkenness (officers tend to provide evidence in relation to drink related offences) neither officer appeared to have any idea as regards the link between alcoholism and mental health issues; that sex, age and build being all variables can affect how the body processes alcohol; the fact that alcoholics can be quite difficult to judge having regard to tolerance levels (how much they have consumed becoming essential information so as to factor that relevant information to enable a decision to be reached, not just as to what the risk to that individual was at that stage but also in the foreseeable immediate future (in terms of the next few hours or so). The evidence from the Consultant A & E Specialist, [redacted] was that there was a poor correlation between visual presentation and the amount of alcohol that might actually be in that individual's system. I am concerned here that a blinkered approach adopted by officers attending somebody who is intoxicated can easily lead to the wrong decision being taken and one which is based on assumptions. I have been made aware of changes to training programmes but I am concerned that the training does not provide sufficient awareness and that there may be still a significant number of officers who simply do not have the life experience and general knowledge to factor that experience into professional judgement making. It would not surprise me if your officers in Swindon, more likely than not, have a better awareness of these issues and perhaps they could be looked upon to improve the training and share their experiences to officers elsewhere in the County.

c) **AWARENESS OF MENTAL HEALTH ISSUES**
I have already highlighted a concern with the 2 officers in question who were unaware of the link between mental health and alcoholism that runs in both directions. What was more concerning was that both officers were unaware that acute alcohol intoxication amounts to a mental disorder for the purposes of the Mental Health Act 1983 and a mental impairment for the Mental Capacity Act 2005. This point is being addressed below to the Chief Executive of the College of Policing and also the Council of Chief Police Officers Mental Health Lead as I suspect that the 2 officers involved in this case, as indeed every other Police Officer who gave evidence, was unaware of this until recently. This needs to change as a matter of urgency as in this case the use of Section 136 Mental Health Act 1983 was never considered as an option because neither officer thought that Eugeniusz was suffering from a mental disorder. [redacted] a consultant psychiatrist also expressed a view to the court that he doubted that Eugeniusz actually had mental capacity when appearing to agree to being left in the lavatory block.

d) **COMMUNICATION OF POLICY AND PROCEDURE**
I am aware that following this incident the 2009 Agreement between the Hospitals, Ambulance Trust and Wiltshire Police as regards the assessment of people who appear to be drunk and need of medical assessment was circulated. A newer agreement was also subsequently entered into in June 2017. I am surprised and concerned that even now front-line officers, who gave evidence, were unaware of either of these 2 agreements. It would appear that important communications are being sent out but that there is no effective system in place to check that the important information is received and more importantly is understood. This also applies to e-learning which is capable of abuse if the same questions are asked at the end of modules. Interestingly, I heard from Consultant Paramedic, [redacted] that in relation to their e-learning systems random questions are asked at the end of e-learning modules in an attempt to overcome the risk of abuse. I fully appreciate that front line officers are under huge amounts of pressure with increasing workloads and less resources but my fear is that there will be a repeat of this incident and other issues arising that may lead to a death occurring through the lack of effective communication of policies and procedures which, at the end of the day, are designed to guide front line personnel and ultimately protect them. With busy workloads, an expectation that these documents will be read is unrealistic and arguably idealistic.

e) **2009 & 2017 MULTI PART AGREEMENT** (copies enclosed) - As regards the Agreement in 2009, I noted with interest insofar as the Ambulance protocol was concerned that a risk of deterioration should be assessed and that the patient should be left in the care of a 3rd party, with advice on seeking medical assistance later if required. I am concerned and have aired as to why this is absent from the 2017 Agreement and also I am concerned as to why consideration is not given for a similar provision being incorporated into the police protocol in the 2017 Agreement. Such a measure appears to be eminently sensible as a matter of common sense.

f) **ARREST CULTURE** - I am concerned having heard evidence in particular from [redacted] the former who had been told that you simply do not arrest somebody for being drunk and incapable, the latter having given evidence that there was a culture that you do not arrest for drunk and incapable. If you look at the 2017 multi-party agreement one of the fall-back positions if hospital assistance is not regarded as being necessary is the consideration of arresting that individual for being drunk and incapable. Eugeniusz had no home and was vulnerable as well; the latter confirmed by both [redacted] so the necessity requirement for arrest would have been satisfied. Eugeniusz was clearly drunk (approaching 5½ times the drink drive limit for blood alcohol) and having become incontinent of urine would also have been regarded as being incapable as I see it. In evidence, the officers regarded Eugeniusz as capable at the time they left him – that alone concerns me in terms of a blinkered view as the bladder would have needed time to refill as the body processed the alcohol and the evidence from the experts pointed to a further period of incontinence prior to death. Eugeniusz was so incapable of looking after himself he was unable to relieve himself appropriately even in a public lavatory. If such a culture exists then that is a concern as it removed here an option that was disregarded by the officers concerned and which if exercised may have resulted in Eugeniusz attending hospital or spending the night safe in custody as opposed to having been left alone in a public lavatory block. I would like you to review the guidance given to frontline officers and to consider emphasising that drunk and incapable is still an arrestable offence if the circumstances and necessity warrant such action being taken to protect life. Arresting an individual does not mean that the person will necessarily be charged.

SOUTH WESTERN AMBULANCE

g) **2017 AGREEMENT** – I raised with Consultant Paramedic [redacted], and he is aware of my concern, that given the evidence o[redacted] Consultant in Accident & Emergency who gave evidence that even if the observations had been carried out which to the greatest sense and purpose includes the checks in algorithm on page 10 of 12 of the 2017 Agreement, I am not convinced that if another Eugeniusz was to crop up that this risk of significant deterioration and death would have been picked up and avoided using this algorithm. Sometimes you have to spell it out and there was no questioning in this case as to when the person last consumed alcohol and over what period and what quantity they had consumed relative to the decision-making process. I queried whether especially with somebody who is not being cooperative as to whether the use of a breathalyser (if they were to consent) would aid in the intelligence gathering. There is also no mention of physical presentation. In Eugeniusz's case, he had become incontinent of urine in respect of which I asked all relevant witnesses as to how many people they knew who were deliberately incontinent of urine. The answer, not unsurprisingly, was no-one. That factor from the common-sense point of view either is suggestive of physical issue whereby Eugeniusz was incontinent or that it was related to the degree of his intoxication in that he could no longer control and had no awareness of bodily function in that respect. The algorithm needs to be reviewed and considered in the light of this case specifically so that it would pick up another "Eugeniusz".

h) **2009 & 2017 MULTI PART AGREEMENT** - I have made the point to the police at paragraph e) above that I am concerned that the eminently sensible suggestion that was contained in the ambulance protocol as regards leaving individuals with a 3rd party no longer appears in the 2017 Agreement. I am aware of other Ambulance Services incorporating such an inclusion, notably the London Ambulance Service. Such an

	inclusion appears to me to be a very sensible option and one which would have resulted in Eugeniusz not being left on his own. **COLLEGE OF POLICING & MENTAL HEALTH LEAD, COUNCIL OF CHIEF POLICE OFFICERS** i) I hope in reaching this stage of the report that you will have read the points made above and you will be aware of my concern that until recently it would appear that the College of Policing and police officers within Wiltshire were unaware that acute alcohol intoxication is regarded as being a mental disorder for the purposes of the Mental Health Act 1983 and an Mental impairment for the purposes of the Mental Capacity Act 2005 (although senior Wiltshire Officers have or should have been aware of this concern since June 2017). The code of practice in relation to the Mental Health Act 1983 highlights this and as I understand ever since 1993 acute alcohol intoxication has been recognised by the World Health Organisation in ICD-10 relating to mental and behavioural disorders with acute alcohol intoxication being classified at F10 as being such a mental disorder. Front line officers need to be aware of such matters so that when dealing with situations that confront them that they have a full awareness and understanding of the range of options and powers that they may have available to them. I fully accept and understand [redacted] point that he made in Court that Section 136 of the Mental Health Act 1983 should be sparingly used but that does not mean that it should **not** be used because the Officers concerned do not recognise that the person in front of them has a mental disorder so that they can then go on to consider whether or not the person is in need of immediate care and control and ultimately a mental health assessment. In this case they did not consider Section 136 simply because they did not think that Eugeniusz was suffering from a mental disorder at the time. I would ask you to review the training that is provided nationally to all Police Forces in this respect.
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 4 September 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 Sister of deceased, Bevan Brittan, Solicitors, Force Solicitor, Wiltshire Police Headquarters and Slater & Gordon Lawyers I have also sent it to Policing Minister, Nick Hurd, Jackie Doyle-Price, Dept. of Health & Social Care and Chief Executive, HM Inspectorate of Constabulary 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	Dated 10 July 2018 Signature_____ for Wiltshire and Swindon