	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dave THOMPSON, Chief Constable West Midlands Police**
1	**CORONER** I am David REID, H.M. Senior Coroner for the coroner area of Worcestershire.
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 [the details below are fictional]** On 12 December 2018 I commenced an investigation into the death of Jason Paul DEVOTI, then aged 46. The investigation concluded at the end of the inquest on 10 January 2020. The conclusion of the inquest was misadventure, the medical cause of death being: 1a acute ethyl alcohol poisoning.
4	**CIRCUMSTANCES OF THE DEATH** (1) Jason Devoti had a history of mental health issues and alcohol dependency. In the weeks leading up to his death he had had a number of hospital admissions having been heavily intoxicated and expressing suicidal thoughts. Mental health assessments found him not to be suffering from any enduring mental illness, but rather to be someone who, when under the influence of alcohol, was more likely to engage in risk-taking behaviour. (2) On 5 October 2018 Jason was admitted to the Alexandra Hospital, Redditch having told paramedics that he had taken an intentional overdose of diazepam and drunk half a bottle of vodka. On arrival at hospital he denied any overdose, and having been medically and mentally assessed, was discharged. At the time of his discharge, he was unable to return to his mother's address (where he had been staying) and therefore attended the offices of Redditch Borough Council, who arranged accommodation for him in Aston, Birmingham, through an agency called Select Homes. He was taken to Select Homes' offices by taxi, and from there to the accommodation at [redacted] (3) Later that day, in the afternoon/early evening Jason spoke to his mother by phone and confirmed that he had arrived at the address. That was the last contact he had with any member of his family. (4) On 7 October 2018, there having been no further contact from Jason, his sister-in-law [redacted] phoned West Mercia Police expressing concerns about his safety. At that time, the family were unable to provide the police with Jason's address. West Mercia Police carried out a number of enquiries and, having failed to locate him, classified him as a Medium risk Missing Person, i.e. the risk of harm to Jason was assessed as likely but not serious. (5) On the morning of 8 October 2018 West Mercia Police identified the address at which Jason was believed to be staying. As a result, they emailed West Midlands Police (within whose area the address fell) at 1235hrs asking them to carry out a check on Jason at the address. In that email, West Midlands Police were advised of the recent background history, the risk level (Medium) and the contact details of the landlord of the address.

(6) West Midlands Police accepted the request, and created their own incident log requiring a P2 priority response. This required officers to attend the address within 60 minutes. The incident log was transferred to and accepted by a Dispatcher within the Bournville control room at 1331hrs. That log was not looked at by 3 consecutive Dispatchers, despite having become overdue after 6 hours at 1931hrs. When a Dispatcher did eventually look at the log at 0653hrs the following morning (9 October 2018) he entered "for allocation when resourcing allows" because there were no officers available to attend the address.

(7) During the course of the morning of 9 October 2018, having heard nothing from West Midlands Police, West Mercia Police continued their enquiries, and eventually arranged for one of their officers to meet the landlord at the [redacted] address. They discovered Jason deceased in his room at the address at 1140hrs that morning.

(8) By the time of Jason's discovery West Midlands Police had taken no action in respect of their incident log, despite having accepted the incident and opened a log more than 22 hours earlier, and despite the incident being graded as a P2 priority response by them.

(9) At inquest, the pathologist who carried out the post-mortem examination on Jason confirmed in evidence that:
   (a) Jason died as the result of acute ethyl alcohol poisoning (his blood alcohol level was 483mg/dL; his urine alcohol level was >500mg/dL);
   (b) it was not possible to say when he died;
   (c) whenever he did die, it is probable that he was consuming alcohol within the 12 hours before his death (as opposed to within the 12 hours before he was found at 1140hrs on 9.10.18);
   (d) it is possible that he was alive at 1430hrs on 8 October 2018 (i.e. an hour after West Midlands Police accepted the incident), but no more likely he was alive then than at any other specific time;
   (e) if he had been found unconscious at 1430hrs, it is possible that treatment may have saved his life (but one can't say higher than that).

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.

The **MATTERS OF CONCERN** are as follows. –

(1) Chief Inspector [redacted] who investigated the incident on behalf of West Midlands Police, accepted in his evidence to the inquest that the West Midlands Police had failed not only to deal this particular incident log, but also many other P2 incident logs which were open at the time, as they should have;

(2) The four police Dispatchers working in the Bournville control room gave evidence to the inquest that:
   (a) At the time of these events a very large number (150-200) of P2 incident logs would regularly be outstanding at the beginning of a shift;
   (b) That many of those logs would be "overdue" – which meant not only that they had passed the one hour deadline, but in fact that more than 6 hours had passed since the log was last looked at;
   (c) That those operating the terminals which would have to try to deal with these logs were overwhelmed by the number of logs they had to deal with;
   (d) That if there was an escalation process in force at the time, then:
      (i) Either dispatchers were not sufficiently aware of the process so as

to be able to act in accordance with it; or

(ii) They were being given the impression by supervisors that there was little point in escalating overdue logs to them, as there was little that could be done;

(e) That the reason for the large number of logs being overdue was mainly because there were insufficient officers to deploy to incidents, but also because there were not enough staff in the control room to work through the logs;

(f) That measures taken to reduce the number of overdue logs (known as [redacted]) would provide only temporary respite before the number of overdue logs built up again;

(g) That at various times since these events, there had been little improvement in the situation: in January 2019 the situation was "still overwhelming" ([redacted]); in June 2019 there would always be a lot of overdue logs ([redacted]); in October 2019 there were still too many P2 logs that were not being dealt with in time ([redacted]); the current situation is "a little better" in that "more robust decisions are being taken by call takers", but there are still problems now, and "the crux is that we don't have enough police officers on the streets to deal with incidents" ([redacted]).

(3) I heard evidence from [redacted] a Senior Leader within the West Midlands Police's Force Contact Department about changes which have been put in place to try to deal with the problems identified above. I was told that:

(a) Figures suggested that compared with a backlog of 189 P2 logs in the Bournville Control Room in October 2018, there were 54 P2 logs open on 8.10.19, and 27 open on 7.1.20;

(b) A new Command & Control system is due to be introduced shortly;

(c) The triage terminal at Bournville would no longer hold onto open logs, but would only review new logs and pass them onto other terminals straightaway;

(d) Dispatchers would be able to identify differing levels of risk within P2 incidents, and tag those with higher levels of risk for supervisors to be aware of;

(e) Whilst there were still the same numbers of logs coming through, control rooms were better able to manage how to deal with them, resulting in a decrease in the number of outstanding logs which required resourcing.

(4) In order to try to assist with understanding the figures involved, I was provided with a number of tables designed to give a "snapshot" of current logs and available police resources at particular times, viz. 8-9 October 2018, 8 October 2019 and 7 October 2020. In my view, this provided limited assistance as (a) the column giving the total of logs open appeared to be incorrect as it did not tally with the figures within other columns; and (b) it was not possible to see how many of the open logs were overdue, and in particular how many of the P2 logs had passed the critical one hour mark without a response.

(5) I am concerned at how overwhelmed those working in the Bournville control room had been by the increased demand on resources, and how their views about any improvement in the situation in the months following Jason's death did not appear to match what I was told by [redacted] I was also concerned about the lack of awareness of and implementation of whatever escalation process may have been in place in the control room at the time of these events; this suggests a lack of appropriate training. Whilst I understand that the West Midlands force is undergoing a period of transition so far as their control rooms are concerned, I am not satisfied that measures have yet been put in place to ensure that all those working in control rooms have received sufficient and appropriate training to deal with situations of increased demand.

(6) I therefore remain concerned that in times of increased demand, and particularly

	unanticipated demand, there is a risk that West Midlands Police will be unable to resource and attend a P2 incident within the 60 minute period that is their stated aim, and that that in turn will create a risk of death of the subject of such a P2 incident, if vulnerable and at some risk of harm as Jason Devoti undoubtedly was.
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 13 March 2020. 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) Deighton Pierce Glynn solicitors, who act for Jason Devoti's family; (2) West Mercia Police; (3) Independent Office for Police Conduct. I have also sent it to David Jamieson, West Midlands Police & Crime Commissioner 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	**21 January 2020** **Signed:**