REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	The Chief Constable of Dorset Police, Police Headquarters, Winfrith, Dorset DT2 8DZ
1	CORONER
	I am Mr Richard T Middleton, Assistant Coroner for the coroner area of Dorset
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/200925/schedule/5/paragraph/7
3	http://www.legistlation.gov.uk/uksi/2013/1629/part/7/made INVESTIGATION AND INQUEST
	On 4 September 2019 I commenced an investigation into the death of Cheralyn CLULOW. The investigation The conclusion of the inquest was: Drug related death
	1a Multi-organ failure
	1b Stroke 1c Infective Endocarditis (Staph. Aureus & Steptococcus) II Intravenous Drug use
4	CIRCUMSTANCES OF DEATH
	Ms Clulow lived alone in local authority accommodation at Bournemouth. She was offered support from the Specialist Drug and Alcohol Service but in the 4 months preceding her death she did not attend 5 out of 5 key working appointments. On 28/8/19 neighbours had concerns for her welfare and notified the Council who in turn contacted Dorset Police. Officers attended late on 28/8/19 and could not gain access to the property beyond the communal door. Officers attended on 29/8/19 and forced entry and discovered Ms Clulow semi conscious. Paramedics were called and she was taken to hospital. Scans revealed she had suffered extensive and multiple strokes. Her health continued to deteriorate and she died in hospital on 30/8/19.

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. -

- (1) The Police Officers who were tasked with the initial attendance could not gain access beyond the communal doors.
- (2) The Police Officers did not believe it was proportionate (based on the information which they had) to force entry through the communal doors which required specialist input. They were aware that a colleague had purchased for himself a fire drop key (to be used in emergency situations which could be used to override the communal lock door. There was a delay in gaining access to the address of the deceased.
- (3) The Police Officers had no formal information as to where they could source a fire drop key. There was no knowledge of formal steps to be taken to access to a fire drop key particularly as access to communal properties is that more difficult to gain.
- (4) There appears to be no general distribution of such keys or key fobs to Dorset Police Officers in order to gain access to shared accommodation by officers in an emergency situation 24 hours a day, 365 days per year.
- (5) There appears to be no training or dissemination of information as to how such keys can be obtained.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Chief Constable of Dorset 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 9 March 2021. 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. The Interested persons as follows:

Civilian Investigator Complaints and Misconduct Unit
Dorset Police

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.

Dated:

12 January 2021

Mr Richard T Middleton H M Assistant Coroner for Dorset