	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Commissioner [redacted], City of London Police, 182 Bishopsgate, London EC2M 4NP 2. Commissioner [redacted], Metropolitan Police Service, Broadway, London, SW1H 0BG 3. [redacted], Interim Chief Executive Officer College of Policing Units 1-6 Citadel Place, Tinworth Street, London, SE11 5EF 4. Mr Sadiq Khan, Mayor of London, City Hall, The Queen's Walk, London SE1 2AA
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** This report arises from the death of **Mr Joseph Agnew**, who died on 15th December 2016 aged 63 at Kings College Hospital ([redacted]). I opened an inquest into the death on 13th January 2017, which was concluded on 17th November 2020. The delay in hearing the inquest was due to a police homicide investigation, which the CPS decided should not be prosecuted. The delay in writing this report is occasioned by the Covid-19 pandemic which created unprecedented pressures on the coroner's service. The jury recorded the medical cause of death as 1a Bronchopneumonia 1b Hypoxic Cardiac Arrest 1c Alcohol and Diazepam intoxication It was drug and alcohol related death

4	**CIRCUMSTANCES OF THE DEATH** This death was an out of hospital cardiac arrest, resuscitated and admitted, but found to have a devastating brain injury, dying five days later. On the evening of 8 December 2016, he refused to get off a bus at its terminus at Peckham bus garage. The bus company called the Metropolitan Police (MPS) to assist with his removal from the bus. Whilst awaiting members of the MPS, a bus driver flagged down a passing police car from City of London Police (CoLP). Two members of the CoLP force attended the incident and removed Mr Agnew from the top deck of the bus, by this time it was 00.40 hours on 9 December 2016. After removal from the bus, they propped Mr Agnew in a nearby bus shelter, and left the scene. Within 30 minutes members of the MPS attended the scene in response to the initial call and found Mr Agnew lying face down in the bus shelter. Their attempts to rouse him were unsuccessful and an ambulance was called. The jury recorded these matters in the circumstances, but they were not found to be causative of his death: • Training provided to officers around managing intoxicated individuals with reduced responsiveness was inadequate • Inadequate checks were carried out in assessing his breathing, airway and primary survey. • There was a serious failure not to carry out an assessment of his respiratory rate and pulse • Training was insufficient with regard to action to take when he was intermittently snoring.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN:** The attention of different organizations is drawn to each according the evidence and the opportunity to mitigate the risks. **1. For the attention of CoLP and College of Policing:** CoLP officers were not taught how to assess people to meet the agreed criteria for finding someone "drunk and incapable". A senior officer was not content that the officers involved had given a satisfactory level of questioning nor welfare checks. The risk to life continues since there appears to be no clarity for officers from their training as to when to refer an intoxicated person for medical attention.

2. For the attention of CoLP, MPS and College of Policing:

No police officers who gave evidence understood the significance of snoring in a person with a reduced level of consciousness, nor how to monitor breathing. My independent expert in A&E gave evidence that snoring indicates partial airway obstruction. He dismissed perceptions of officers that there was such a thing as good or bad snoring. He opined that in a person with reduced consciousness officers should assume that snoring needs medical attention. The person needs assessment to exclude when it is not a concern. Whilst he acknowledged the difficulty of assessing breathing, he stressed its importance as an indication of medical emergency, gave little weight to the value of chest movements which officers used, and highlighted the danger signs of very slow or very fast breathing. He also stressed that concern for medical attention should be triggered by unrousability. The evidence suggested that officers were unaware of all these matters and had not learnt how to effectively monitor breathing.

3. For the attention of the MPS:

Two MPS officers who attended the scene gave evidence that they would do nothing different even in hindsight. No evidence was presented as to the post incident performance reviews and individual learning, and there is uncertainty about the adequacy of the corporate process of learning from incidents. There is a lack of assurance to the public that the risks related to the decisions of these officers or other incidents have been mitigated for the future.

4. For the attention of the Mayor of London:

Evidence was heard that whilst the police can refer chronic rough sleepers to charities, there is no facility to which police can refer acutely intoxicated homeless people found on buses. It was reported that such facilities do exist elsewhere and that they create a place of safe refuge where monitoring can be effectively conducted. The potential of such a facility to save lives is drawn to the attention of the Mayor.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. I believe that the listed organizations would wish to learn of the evidence given in the inquest about the circumstances of this death and are in a position to mitigate or prevent future deaths.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 23rd April 2021. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I am also copying this report to the interested persons: [redacted], Solicitor for the Family from GT Stewart Solicitors, [redacted], Solicitor for City of London Police, [redacted], Solicitor for MPS, Directorate of Legal Services and [redacted], Solicitor for Police Officers from Reynolds Dawson Solicitors I also copy this to the Independent Office for Police Conduct, Royal College of Emergency Medicine, Transport for London, London Ambulance Service, Crisis UK and to my expert witness, Dr [redacted], consultant in Accident & Emergency Care, who have professional interests. I am 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	**26th February 2021**  Andrew Harris, Senior Coroner