Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Home Office : The Right Honourable Kit Malthouse M.P., Minister for Crime and Policing** **2 National Police Chief Council:** [redacted] **3 College for Policing (Training)** **4 Chief Constable Avon and Somerset Police:** [redacted]
1	**CORONER:** I am, Fiona M. King, Assistant Coroner for the area of West Sussex
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 06 June 2018 I commenced an investigation into the death of Hamish John Cameron HOWITT aged 20. Hamish had died in Frome in Somerset on 1st July 2016 the Investigation and subsequent Inquest being transferred in 2018 at the request of his parents who lived in West Sussex. The investigation concluded at the end of the inquest on 22 July 2021. The conclusion of the inquest was that: Hamish, a previously fit young university student died unexpectedly overnight following an evening spent with friends in Frome going to a concert and drinking. The medical cause of death established that he died from the combined effects of Alcohol, a Traumatic Brain injury and self - administered Ketamine. None of these 3 causes would have individually resulted in his death. The alcohol and ketamine consumed were considered to be at relatively low levels.
4	**CIRCUMSTANCES OF THE DEATH :** While walking home at approximately 23:35 there was an altercation on the street in Frome with another group of males. Hamish immediately complained that he was injured and bystanders called the police. Police Officers attended and spoke to Hamish for approximately 7 minutes. They concluded that Hamish had been drinking, was coherent and understood them. He told them that one of his friends had been involved in an incident and that he had intervened to prevent a fight and had been hit in the face. Hamish showed the officers his face and pointed to his forehead. The Officers recorded that they could see no injury. Concluding that Hamish was suffering the effects of alcohol they advised him to go home with his friends, which he did. Once he returned to [redacted] he was in pain and before going to bed took an amount of Ketamine that resulted in a post mortem finding of [redacted] of blood. Low therapeutic doses of ketamine in a hospital setting were given to be at a waking level average of [redacted] of blood. Ketamine at such a level would not alone have caused death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) (1) it is highly unlikely that Hamish would have died had he gone to hospital when the police saw him after the incident. Police at the scene did not recommend or encourage this course of action. (2) The apparent effects of alcohol when assessed by police (who are not medically qualified) can frequently mask serious underlying conditions such as traumatic brain injury (in this case) but also symptoms of post epileptic attack; diabetic high/low; and drug taking (either prescribed or illegally used). (3) Police Officers who come into contact with the public are not medically qualified but must be trained at both a national and local level to take steps to ensure those who appear inebriated and are complaining of injury are taken to hospital/seen by ambulance services. (4) Police training material and national policy setting should include directives to this effect.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th November, 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: [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 23/09/2021** **Fiona KING** **for** **West Sussex Coroners Service**