REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Constable South Wales Police** **Peter Vaughan QPM, Chief Constable** **South Wales Police Headquarters** **Cowbridge Road** **Bridgend** **CF31 3SU** [redacted] 2. **Mitie Group PLC** **Care & Custody (Health)** **Central Hub, Queens Road Police Station, Queens Road, Bridgend, CF31 3UT** **The lead Doctor is** [redacted] **The Medical director'** [redacted] 3. **Dr Andrew Goodall Director General of Health and Social Services/Chief Executive, NHS Wales** **& Chief Medical Officer Wales** **Second floor, Cathays Park (1), Cardiff** **CF10 3NQ**
1	**CORONER** I am Colin Phillips, acting senior coroner, for the coroner area of Swansea Neath & Port Talbot
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 4th January 2015 I commenced an investigation into the death of David Nigel Phillips aged 71. The investigation concluded at the end of the inquest on 8th September 2016. The conclusion of the inquest was an Open Conclusion and the medical cause of death was 1a Drowning.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was David Nigel Phillips and he died on the 4th January 2015 at the beach alongside Mumbles Pier Mumbles Swansea where he was found drowned lying on his back in a rock pool. David had a history of mental illness and had previously attempted to take his own life on a number of occasions. The day before he died he was found intoxicated at the wheel of his parked car in Rhossilli Gower. He was arrested and taken to Swansea Central Police Station. He was examined by a Senior Forensic Nurse (Mitie) who carried out a fitness for detention, interview and release assessment. David was assessed at low risk of self-harm.

	David stated in interview that he had been attempting to take his own life. He had driven to Rhossili and had consumed alcohol to desensitise himself before proceeding to end his life. David expressed concerns that his prescription of diazepam had been reduced to a lower dose which he did not feel to be sufficient. He was charged and bailed to appear at Swansea Magistrates Court at later date and then released to his partner (who he had disclosed in interview to be also suffering from depression and causing him concerns). David was a type 2 diabetic and had alcohol related issues. The following morning David was found dead on the beach near Mumbles Pier. Cause of death was initially given as unascertained by the pathologist in her autopsy report but having heard and seen further evidence including photographic evidence this was changed to drowning. However, It was not possible to establish exactly where when or how he came to enter the water. Although the circumstances pointed to deliberate self harm this could not be proven beyond all reasonable doubt. It was not possible to exclude a possible insulin related cause, accident or a deliberate act. No note of intention was found. The evidence does not fully or further disclose the means whereby the cause of death arose to the required standards and an open conclusion was recorded. Although, suicide could not be established to the criminal standard of proof, the circumstances pointed to this as a strong possibility as to how David came to his death.
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. – Many people who come into custody or police contact do so with physical or mental vulnerabilities or both. The safer detention and handling of persons in police custody guidance, strongly promotes and advises engaging the right healthcare professional at the right time and in the right place. David Phillips was aged 71. Generally people over 65 years who self-harm should be assessed by mental health professionals experienced in the assessment of older people who self-harm. A mini- mental state examination tool was used. My concerns are that:- (1) An experienced mental health doctor or nurse should have been called to carry out the assessment rather than a nurse. The quality of the assessment is critical rather than a box ticking exercise. (2) The Health Care Professional did not have access to detainee's medical records to accurately identify reasons as to why and how medications are changed or as to when this may or may not have occurred. An ability to review medication and if necessary prescribe medication would be helpful and access to medical notes is critical. Access to electronic Individual Heath Records to include mental health records

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe organisations 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 11th November 2016. 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] the daughter of the deceased. 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	**16.09.2016** **Signed** ..... **Colin Phillips** **Acting Senior Coroner** **Swansea and Neath Port Talbot**