[redacted]

Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Chief Constable of Bedfordshire, [redacted]** **Chief Executive of EEAST, [redacted]** **[redacted], Chair of National Police Chiefs Council (NPCC)** **[redacted], Chair of Association of Ambulance Chief Executives (AACE)**
1	**CORONER** I am Emma WHITTING, Senior Coroner for the area of Bedfordshire and Luton Coroner Service
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/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5 November 2013 an Investigation was commenced into the death of LEON BRIGGS aged 39. The investigation concluded at the end of the Inquest which was held before me sitting with a Jury from 4 January 2021 to 12 March 2021. The Medical Cause of Death was found to be: *1a. Amphetamine Intoxication in association with prone restraint and prolonged struggling* *2. Ischaemic Heart Disease* The Conclusion of the Inquest was Narrative Conclusion: "*The circumstances of the death of Leon Briggs are described* ..[see Section 4. below). *The findings of the serious omissions and failures recorded there, result in a conclusion that the death of Leon Briggs was contributed to by neglect*."
4	**CIRCUMSTANCES OF THE DEATH** (as found by the Jury) *On the day of his death, Leon Briggs (Leon), was experiencing a psychotic disorder caused by exceptionally high usage of amphetamines. This resulted in his erratic and irrational behaviour in Marsh Road, Luton and his subsequent detention under Section 136 Mental Health Act, by Police Officers in Willow Way. This was followed by a series of omissions and failures which culminated in Leon's cardiac arrest in the custody suite*

	of Luton Police station and the ultimate certification of his death in Luton and Dunstable Hospital. These omissions and failures by the Ambulance Service and the Police did not provide adequate support to Leon. In the circumstances proved as recorded in the attached questionnaire, the most serious are: *1. A lack of communication and miscommunication throughout, in particular by Bedfordshire Police and the East of England Ambulance at Willow Way and between Police Officers and Custody Officers at Luton Police station.* *2. Leon's restraint mostly in the prone position in Willow Way and in the prone position in Luton Police station, as well as, some inappropriate use of force applied to Leon at times.* *3. The inadequate medical assessment of Leon; a failure to recognise Leon was a medical emergency who should have been transferred to Hospital.* *4. Unsatisfactory conveyance to and supervision of Leon in the police van.* *5. The inadequate continuous risk assessments and monitoring of Leon resulting in a failure to recognise when Leon became in need of urgent medical attention in the cell.*
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. Adequacy of the local S136 Multi-Agency Policy** Whilst the local S136 guidance has changed considerably since the death of Leon, in my view, it is still not fit for purpose for the following reasons: (i) It requires streamlining and re-formatting (including the use of a larger font) to make it easier for all agencies to follow – it may assist to focus on multi-agency activities ONLY (leaving individual agencies to provide their own specific policies to support the multi-agency interaction) (ii) Reference to other regulations might best be avoided (see for example 3.3) so that it can stand as freestanding guidance for those attending fast moving incidents to apply without delay; (iii) The guidance should closely follow the chronology of a relevant incident i.e. it should start with the decision to detain, followed by the relevant risk assessment, appropriate conveyance, place of safety etc. Information regarding permitted periods of detention and roles and responsibilities could be dealt with at the end. *N.B. Whilst it is reassuring to learn that a local 'task and finish' group has been set up within the Mental Health Crisis Concordat Strategic Group (MHCCC) to improve the current Policy and that reference is being made to College of Policing training packages, in effecting these improvements, the group might wish to consider engaging with a national expert in this field such as Inspector Michael Brown who provided expert evidence to the Inquest and has experience of effective mental health policy making*. **2. Lack of Sufficient Training for Police Officers, Ambulance Crew and other Front-Line**

Responders

Although, the MHCCC Strategic Group are progressing joint training for all first responders including hospital staff who might need to assess medical fitness and/or treat S136 detainees, it was clear from the evidence heard at the Inquest that there remains insufficient or inadequate instruction of both police and ambulance crew about the critical issues of recognising and responding to a medical emergency and the effects of restraint including positional asphyxia. Consideration, therefore, needs to be given by National and Local Police and Ambulance services as to whether the current individual service training (including refresher training) is adequate (and of similar level to that provided to those working in Mental Health Units pursuant to the Mental Health Units (Use of Force) Act 2018) to ensure the welfare and safety of S136 detainees.

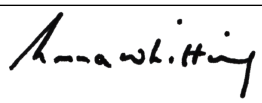
3. Adequacy of Monitoring of Detainees Subject to Restraint

The expert evidence of Dr [redacted] (Consultant Intensivist). Professor [redacted] (Consultant Cardiologist) and Dr [redacted] (Forensic Pathologist) highlighted the effect that restraint has on detainees – not only in terms of the potential stress to the heart if the detainee struggles against such restraint but also in view of the continuing metabolic disturbance it creates which continues long after any restraint ceases or is removed. Indeed, they all agreed that metabolic disturbance from the restraint was one of the factors in causing Leon's cardiac arrest and subsequent death. The evidence of Dr [redacted] confirmed that the effects of the restraint would, however, have been treatable and that, if appropriate action had been taken, his cardiac arrest would likely have been avoided; indeed, he explained that even if action only had been taken at the point that Leon had become unconscious, the relatively simple steps of placing him in the recovery position in the cell and starting CPR, whilst awaiting emergency help, on the balance of probabilities, would have resulted in his survival.

The Jury through their answers to Questions 33-34 of the Jury Questionnaire not only determined that a failure to monitor Leon appropriately in the cell on 4 November 2013 more than minimally caused or contributed to his death but also concluded, in Box 3 of the Record of the Inquest, that "*The inadequate continuous risk assessments and monitoring of Leon resulting in a failure to recognise when Leon became in need of urgent medical attention in the cell"* was one of the most serious failings by emergency services to provide Leon with adequate support.

Since the carrying out of even relatively basic first aid could have made a significant difference to the outcome in this case, it seems critical that the close monitoring of a detainee who has been subject to restraint should be guaranteed in **all** cases. As the Jury found there were specific failures by the Custody team in this case, consideration could perhaps be given to having additional monitoring in respect of such detainees independent of the Custody team.

The NHS England Patient Safety Alert (2015) gives guidance to NHS staff on post-restraint observations: https://www.england.nhs.uk/wp-content/uploads/2015/12/psa-vital-signs-restrictive-interventions-031115.pdf.
Although this has been circulated to some police, it may not be widely known about and even though it may not cover all of the situations which the police will encounter in their work, something similar could be of potential benefit to all police forces across the country.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and 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 29 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 Leon's family. I have also sent it to: **Assistant Chief Constable [redacted] – NPCC Lead on Mental Health** **Deputy Assistant Chief Constable [redacted] – NPCC Lead on Use of Force/Restraint** **[redacted], HM Chief Inspector of Constabulary** 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	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service Dated: 04 October 2021