Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive, East Midlands Ambulance Service** **2 Chief Constable for Nottingham and Nottinghamshire Police**
1	**CORONER** I am Ms Alexandra Pountney, Assistant Coroner for the coroner's area of South Yorkshire (West) (sitting in Nottingham and Nottinghamshire coroner's area).
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** An investigation into the death of Kaine Regan FLETCHER was opened on 28 September 2022, and the final inquest hearing is currently being heard by me, sitting with a jury. The final inquest hearing started on 30 June 2025 and is due to conclude on 25 July 2025. The evidence is currently ongoing.

4	**CIRCUMSTANCES OF THE DEATH** Kaine was a 26-year-old male with a diagnosis of Paranoid Personality Disorder and a history of substance misuse. On 2 July 2022, Kaine called the police via 999 making threats to kill, if the police did not attend to him at his mum's address. A double-crewed, marked police vehicle attended Kaine and arrived at 16:00. On arrival, the response officers formed the view that Kaine was suffering an acute episode of mental illness, and that they may need to exercise their s.136 MHA 1983 powers to detain him. Kaine told the officers that he had recently used cocaine. The officers requested assistance from the Street Triage Team, a team formed through collaboration between Nottinghamshire Police and Nottinghamshire Healthcare NHS Foundation Trust, who duly attended to assess Kaine arriving at 17:04. The Street Triage Team comprised of one police officer and one community psychiatric nurse, travelling together in a marked police car. Kaine was assessed by the community psychiatric nurse not to require a Mental Health Act Assessment, and so the police did not exercise their s.136 powers. Rather, having had his physical health checked by paramedics between approximately 17:27 and 17:42, he was conveyed by marked police car back to his residential dwelling at the YMCA in Hucknall. The police incident log confirmed that Kaine was at the property by 19:46. On 3 July 2022, at 00:04 and 00:16, respectively, two 999 calls were made by a member of Kaine's family to EMAS due to a concern that he may have attempted to take his own life and, by the later call, that he was uncontactable by phone. EMAS advised the family member that the incident had been logged as a Category 3 response, and that there was an 8 hour wait for an ambulance. At 00:33 a member of Kaine's family called the police to report their concerns. A police resource was allocated to the incident, and two response officers in a marked police vehicle arrived at the YMCA at 01:55 to conduct a 'safe and well check'. Those officers quickly formed the view that Kaine was suffering an acute episode of mental illness and

	that he had taken illicit substances, namely cocaine and nitrous oxide. To begin with, Kaine is amenable to attending hospital voluntarily for a Mental Health Act Assessment. He followed the police officers out of the building and got into their marked police car. The situation changed rapidly and within seconds of being inside the vehicle, Kaine vocalised his belief that the officers are not really police. The officers showed Kaine their ID, but the situation persisted and one of the officers detained Kaine using her s.136 powers; handcuffs are applied. This happened at around 02:34. More units were requested and arrived at the scene. Kaine began to resist the detention, and there was then a period of approximately half an hour where Kaine was being restrained by officers. The restraint continued as officers attempted to gain effective control of Kaine so that they could convey him to a place of safety by police vehicle. During the period of restraint, Kaine's physical condition deteriorated, and at 03:03 EMAS are called when the police recognise that he was displaying symptoms of Acute Behavioural Disorder. The incident was then deemed a medical emergency. EMAS arrived on scene at 03:18. Kaine was pre-alerted to the Queens Medical Centre Resuscitation Department and conveyed there by ambulance. He arrived at 03:47. Despite the best efforts of the medical teams at QMC, Kaine had developed rhabdomyolysis and went into multi-system organ failure, which culminated in an unsurvivable cardiac arrest. Kaine died at 09:46 on 3 July 2022. The cause of death provided by the Home Office Pathologist is: 1(a) the physiological effects of exertion following a period of restraint, combined with cocaine and other substances.

5	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: **<u>Confusion over applicable local policy and working standards for dealing with s.136 detention</u>** I am concerned that there is a lack of understanding by the police and EMAS on local policy and working standards for dealing with s.136 detention. At the outset of this investigation, a direction was given for disclosure of "*Local memoranda or policies concerning how EMAS and Notts police jointly manage health incidents*". In response to that direction, a number of policies were disclosed, including a document entitled "*Nottingham and Nottinghamshire Multi-Agency Policy & Procedure Review Group Memorandum of Understanding: Joint Agency, sections 135 and 136 Mental Health Act 1983 Procedures"*. Various versions of this policy were disclosed to the coroner, including a 2018, 2021 and 2024 version. During the course of the inquest so far, I heard evidence from both the police and the ambulance service in relation to the local policy for managing s.136 incidents. The police and the ambulance service do not share an understanding of which policy they are expected to adhere to and whether there is a joint local policy. The police consider that the document above (as amended) is the applicable framework, whilst EMAS are currently unable to tell me if this policy has agreed to by them, notwithstanding that they appear as one of the agencies that formed part of the working group for each version of the MOU. The witness who gave policy evidence on behalf of EMAS told me that they only work to their own internal local standard, which is different to that in the MOU.

	Persons detained under s.136 of the Mental Health Act 1983 are some of the most vulnerable in society. Their liberty has been removed, and they are reliant upon state agencies to protect their right to life. I am extremely concerned that there is no joined up thinking, or understanding, between the police and the ambulance service as to which policy and which working standards apply when furthering the protection of that right. I am concerned that this lack of basic understanding of policy and working standards by emergency services, if it persists, poses a risk of preventable future deaths.
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 11 September 2025. 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: **Kaine's family** **All other IPs** **Chief Executive, East Midlands Ambulance Service** **Chief Constable for Nottingham and Nottinghamshire Police** 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. She may send a copy of this report to any person who she 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: 17 July 2025** **Ms Alexandra Pountney** **Assistant Coroner** **South Yorkshire (West)**