REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **National Police Chiefs' Council:** [redacted] CBE QPM, National Police Chiefs' Council, 1st Floor, 10 Victoria Street, London SW1H 0NN . Email: info@npcc.pnn.police.uk **College of Policing** Alex Marshall QPM, Chief Executive, College of Policing, 10th floor Riverside House, 2A Southwark Bridge Road, London, SE1 9HA
1.	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire
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** I conducted an Inquest into the death of Mr Philmore Leonard Mills that was heard at Reading Town Hall between the 8th February 2016 and 8th March 2016. The conclusion of the Inquest was in the terms of a Narrative Conclusion attached to this report.
4.	**CIRCUMSTANCES OF THE DEATH** Mr Mills was a 55 year old gentleman who was a patient on the Respiratory Ward at Wexham Park Hospital, Slough with significant comorbidities including terminal Lung Cancer, Chronic Obstructive Pulmonary Disease, Pneumonia, Pulmonary Emboli and Ischaemic Heart Disease. As a result of Hypoxia he became confused and aggressive and, after nursing and security staff were unable to control him, Police Officers attended and in the course of restraining him, Mr

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Mills collapsed and died. This occurred on 27th December 2011. Evidence from three Pathologists described Mr Mills as being at risk of Death at any time but they were unable to exclude the temporal association of restraint and 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 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. –

(1) In the course of the evidence, the Jury heard from two independent experts on restraint techniques and Police training. They both had the opportunity to review the existing Thames Valley Police and ACPO Training in place at the time of Mr Mills' death. This included training for Police Officers when dealing with a subject who may be suffering from excited delirium. Both Officers highlighted the fact that there is no reference to the option of containment as a tactic taught to Police Officers as part of their training in dealing with subjects with suspected excited delirium. In the evidence, containment was identified as one of the tactical options that Officers should carefully consider in any situation.

(2) The Jury heard from one of the two expert witnesses, [redacted] that, while Police Officers are trained as to the medical consequences of the take down procedure in restraining a subject, those consequences do not include reference to the risk of death. While they described the risk of bruising, broken bones etc, they do not suggest that such a manoeuvre could, in certain circumstances, prove fatal to the subject involved.

(3) The evidence surrounding the circumstances of the death of Philmore Mills suggests that this is a potential outcome of which Officers should be made aware.

6. **ACTION SHOULD BE TAKEN**

In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 Friday 13th May 2016. I, the coroner, may extend the period.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	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 representatives of the interested parties to the Inquest which included the family of Mr Mills. You are 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.	**17th March 2016** **Peter J. Bedford** **Senior Coroner for Berkshire**