Regulation 28: Prevention of Future Deaths report

Rashan Jermaine CHARLES (died 22.07.17)

	THIS REPORT IS BEING SENT TO: **1. Deputy Assistant Commissioner [redacted]** **Metropolitan Police Service** **6th Floor, New Scotland Yard** **Victoria Embankment** **London SW1A 2JL**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 8 August 2017, I commenced an investigation into the death of Rashan Jermaine Charles, aged 20 years. The investigation concluded at the end of the inquest on 20 June 2018. The jury made a narrative determination, a copy of which I attach, and recorded a medical cause of death as follows. 1a cardiac arrest 1b upper airway obstruction by a foreign body during a period of restraint
4	**CIRCUMSTANCES OF THE DEATH** Following a foot chase by a police officer, Rashan Charles entered a convenience store and put a package in his mouth. There was a struggle, during which the police officer detained him, took him to the ground and, with the assistance of a bystander, handcuffed him.

	During the next few minutes, Rashan lost consciousness and then suffered a cardiac arrest. The police officer quickly asked for assistance, but did not immediately call for an ambulance and did not appreciate that Rashan was choking.
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. There was a point at which Rashan's struggle against search of his mouth became a struggle to breathe because he was choking. The bystander, having been of significant assistance to the police officer in securing the handcuffs, continued to give physical input and running commentary. When updating police officer training, it would seem helpful for those developing policies and protocols to bear the following factors in mind, factors that might not be otherwise evident to police officers. 1. An apparent struggle to resist search or arrest, might in fact be a struggle to breathe, *or might become that*. 2. Choking is not always accompanied by classic signs such as clutching the throat, coughing, red face or bulging eyes, but can be silent and very quick. 3. It can be extremely difficult to assess whether breathing is present *and normal*, particularly in a stressful and/or noisy situation. (I heard evidence that, for training purposes, abnormal breathing could possibly in future be simulated by a virtual reality programme.) 4. Members of the public can sometimes give vital assistance, but this assistance might need to be managed. Analysis of a situation by a member of the public might give helpful insight, but on the other hand might not be accurate. Even a single member of the public might unwittingly distract an officer, especially in a fast paced environment.

	I heard evidence that, at present, MPS training does not include specific advice about how best to utilise members of the public who are willing and able to assist police officers.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 27 August 2018. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • [redacted], medical director, MPS • [redacted], grandmother of Rashan Charles and [redacted] mother of Rashan Charles 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 29.06.18