College of Policing

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Elisabeth Bussey-Jones

Assistant Coroner for West Sussex

3 June 2019

Dear Ms Bussey-Jones,

I am writing to explain the actions that we have taken, together with others, to address the concerns raised in the Reg 28 Prevention of Future Deaths notice that you issued in respect of the death of Mr Duncan Tomlin (deceased) to the College of Policing (College) dated the 12th April 2019 I was not aware of this incident previously and I am sorry to learn of the tragic circumstances surrounding the death of Mr Tomlin My thoughts are with his family and friends

I understand that the jury in the case of Mr Tomlin returned a narrative conclusion which found his death was contributed to by neglect. The medical cause was found to be "cardiorespiratory failure due to both restraint in a prone position and the effects of cocaine and mephedrone"

These findings led to you raising the following matters of concern

1 ***Importance of heightened risk to a person in a prone position when multiple factors affecting breathing are present.*** *The current and earlier training plans, manuals and policies examined as part of the inquest evidence make clear references to risks associated with (a) positional asphyxia, (b) handcuffs and limb restraints, (c) irritant spray, (d) acute behavioural disturbance or symptoms thereof (e) lack of oxygen due to physical exertion, (f) drug / alcohol intoxication, and (g) seizures*

Although there is some cross referencing between the various risk factors, the heightened risk to a person in prone restraint when a number of these factors are present is not emphasised or sufficiently emphasised The multifactorial matters that can impact on a person's ability to breathe in a position of prone restraint when experiencing such multiple factors are critical to the assessment of risk

2. ***Timing of decisions and opportunity to assess.***
A further concern relates to how officers are trained to prioritise options available to them and the timing of decisions in circumstance similar to those in this incident It is appreciated that officers are not medically trained, they do make clinical decisions and a more detailed history will be taken formally in custody suites However, officers do need to be in a positon to have sufficient information to enable them to assess the safety of a restraint situation in which they are involved, and this includes sharing of information and requesting information when participants in the restraint may not have been present from the onset These points are particularly so when medical evidence suggests fatal consequences can arise in a matter of minutes and that by the time a detainee is unresponsive, action may be too late In this inquest a priority of the officers, said to be in line with their training, was to remove the restrained person from the scene as soon as practicable The officers also gave evidence on the risks involved in turning the detainee on his side and the possible acts that a violent individual can take towards officers and themselves which raise other risk of harm

However, my concern is that in future similar situations officers may prioritise the need to act speedily to remove a person from the scene, rather than, when a measure of control is obtained (such as the use of handcuffs and limb restraints), taking the opportunity to take stock in order to assess the detainee they are dealing with and why they are struggling or resisting Are they dealing with a person who is struggling because they are violent, or because they are confused, or psychotic, or in post seizure state, or because they are in pain, uncomfortable or struggling to breathe?

Once a measure of control is obtained, speed of incidents is dictated by the actions of the officers decide to make and balancing the risks of harm which, in the case of positional asphyxia, are fatal and therefore must be a priority

3 ***Monitoring***

The training plans, manuals and policies considered in evidence in this inquest refer to monitoring in different ways, depending on the circumstances Phrases such as close, constant, careful and regular monitoring are used Guidance as to what constitutes monitoring does not appear to be included within literature available to officers A different type of monitoring may be required for, for example, a detainee who poses a suicide risk or who has a known medical condition, as compared to the type of monitoring required for a person restrained in the prone position, particularly when affected by other factors impacting on breathing Listening to noises associated with breathing may be entirely insufficient, particularly when they can be hard to hear, misheard or misinterpreted

4 ***Commencing CPR***

The evidence relating to current training and training at the time of the death concerned in this inquest indicates that CPR should commence when a person is not breathing normally (described as 2-3 breathes in 10 seconds for and adult and 3-5 breathes for second for small children) or if breathing is distressed (snoring, rasping) known as agonal breathing

The evidence in this inquest was that individual officers of some experience understood CPR should commence when breathing had stopped Whilst this may be a misunderstanding on the part of individual officers, owing to the importance of commencing CPR at the earliest opportunity when time is critically of the essence, the timing of when CPR should start should be a central point of when training CPR and when reacting to situations akin to that seen in this inquest

5. *Understanding aspects of Epilepsy and Seizures*

The training material that has been provided to me by Sussex Police covers many aspects of epilepsy and seizure that were explored during this inquest. The training material indicates that if it is available to the trainer, participants will be shown a video which informs the viewer of the way that a person might present post seizure, namely confused, vulnerable, perceiving aggression from others and at risk of lashing out due to misunderstanding I have also been provided with a copy of a training manual provided by Epilepsy Action which was sent to ACPO in 2011 Aspects of the evidence from the family in this inquest were entirely inconsistent with the less common presentation of a person in an atypical or post seizure state

Although epilepsy was not found to be causative in this inquest, in another situation with a similar set of circumstances, the reaction of a person suffering an atypical seizure or in post seizure state, could be misconstrued as violence an resistance were officers not to appreciate that fact that their presentation may be part of a medical condition and restraint in such circumstances could have inherent and fatal risks It is therefore of importance that training extends beyond the two more well types of seizure and that post seizure behaviour is also understood in general terms

In responding I will explain the role of the College of Policing (the College) and what has either been done or where work and review is currently being undertaken in order to address each cause for concern in turn

An Overview
The College is the professional body for policing and provides everyone working in policing with the skills and knowledge necessary to prevent crime, protect the public and secure public trust

The College has three complementary functions:
- Knowledge developing the research and infrastructure for improving evidence of 'what works'. Over time, this ensures policing practice and standards are based on knowledge, not custom and convention

- Education supporting the development of individual members of the profession The College sets educational requirements to assure the public of the quality and consistency of policing skills, and facilitate academic accreditation and recognition of our members' expertise.

- Standards drawing on the best available evidence of 'what works' to set standards in policing for forces and individuals, for example, through authorised professional practice and peer review

The College licences Home Office Forces, including Sussex Police, to use the Personal Safety Programme to train their staff The programme is endorsed by the National Police Chiefs Council (NPCC) Self Defence Arrest and Restraint (SDAR) group of which the College is a member The Personal Safety Programme uses the National Personal Safety Manual (NPSM - a secure online manual of guidance and tactical options) and other national training products, including centrally prepared PowerPoint presentations, as its source of training material

The College owns and publishes the NPSM in conjunction with the NPCC SDAR and the SDAR national practitioners' working group The SDAR are responsible for updating, developing and maintaining the NPSM and other national training products SDAR membership includes physicians, self-defence and restraint trainers, academics, senior managers and experts (including from the Independent Office for Police Conduct, the Home Office, the Defence science and technology laboratory and the Police Federation amongst others) The College publishes the NPSM to the police service and then individual forces choose the tactical options contained within it that best meet the needs of their officers and staff in responding to local threats and deliver this through a local Personal Safety Training programme

The current recommendation to chief officers (ACPO Personal Safety Training guidelines 2009) is that forces must ensure that personal safety training is delivered with such frequency as to maintain competence and develop skills and knowledge As a minimum, forces must ensure that staff receive assessed refresher and development training on an annual basis, unless an auditable risk assessment clearly identifies why this frequency is not necessary for a particular role

The College also licences Home Office Forces, including Sussex Police to use the First Aid Learning Programme The programme is endorsed by the National Police Chiefs Council (NPCC) and the Health and Safety Executive (HSE) The College of Policing is responsible for ensuring appropriate quality assurance processes are in place to guide forces in the implementation of the HSE guidelines relating to the provision of first aid

The First Aid Learning Programme has five modules and the national recommendation is that police officers receive a minimum of Module 2 training (the equivalent to the qualification of an HSE Emergency First Aider)

Action to address the causes for concern raised in your report:

1. **Importance of heightened risk to a person in a prone position when multiple factors affecting breathing are present.**

All officers and staff are expected to be trained in and understand the medical implications that arise from the use of force and which are contained within NPSM (Module 4) 'medical implications These medical implications clearly address the risks associated with Positional Asphyxia They specifically include,

amongst others, the risks associated with body position, especially being in a prone position and being unable to escape a body position and drugs/alcohol

The SDAR have historically assisted in the effective oversight and response to national issues which include the consideration of Regulation 28 PFD reports and their matters for concern The SDAR are in the process of considering the matters that have been raised by the tragic death of Mr Tomlin and have received medical advice that the combination of multiple risk factors may increase the risk of positional asphyxia occurring The SDAR will amend the existing advice with a specific safety warning to officers about this potential increased risk

The SDAR have previously looked at the issues of Acute Behavioural Disturbance (ABD) and Positional Asphyxiation and in 2016 produced national training tools for officers to assist them to understand and respond to the risks involved as well as ensuring that they were properly addressed within the NPSM This has continued to be updated as new information has become available

The SDAR are currently completing a review of the national ABD training package which is provided through a College PowerPoint for training in the risks of prone restraint in light of recent findings from the Terrence Smith inquest in Surrey and that of Mr Tomlin This will include important updates and the reinforcement of existing good practice to help improve the safety of all Once this work has been completed, the NPCC lead for SDAR, Deputy Assistance Commissioner (DAC) Matt Twist will write to chief officers advising them to include this information in the Personal Safety Training programmes within their forces

2. Timing of decisions and opportunity to assess.
Dealing with individuals who are presenting a high level of aggression and agitation is extremely difficult and officers may not be able to initially establish if the subject is resisting because they are being violent or because they are in an agitated state due to mental ill health, a pre-existing medical condition or are struggling to breathe The overarching principle in the use of force is to gain control Officers will utilise the national decision model to make an informed decision on the appropriate tactical option which will enable them to gain control of the situation

The SDAR have considered this matter for concern and is amending the guidance, using 'safety boxes', to emphasise that, once control has been gained, officers should take an opportunity to 'take stock' and reassess the risks to establish if there are any medical implications which would require any immediate medical intervention and to follow their first aid training if this is the case The guidance will also include a link to Module 5 of the NPSM, 'Personal Management', as that includes content on how the human brain works and of the influences of the rational and irrational mind on decision making

Advice is given in the national ABD training package on sharing information with other emergency services Officers are advised to utilise the ATMIST (age of subject, time of incident, mechanism of injury / medical condition, injuries sustained or suspected, signs and symptoms and treatment given) handover to ensure that the relevant information is passed on the medical professionals The SDAR will also be reviewing this advice in light of the matters of concern that you have raised

3. Monitoring.
The national ABD training package contains information regarding the use of a safety officer whose sole responsibility is to monitor the restrained subject Officers are instructed to 'Speak up, Speak out' and voice their concerns, regardless of rank, if they observe any sign or symptom that could indicate that the subject is in distress

Personal Safety Training has for many years included the role of the 'safety officer' who's role is (i) to secure the person's head within the multi-officer restraint techniques, and (ii) to communicate with the person to help establish 'calm, rapport, and control' The overarching responsibilities of the safety officer are to monitor the person's breathing and visible life-signs during the restraint period, and to direct colleagues (owing to

their vantage point and ability to monitor of the person's demeanour and welfare) during the restraint and especially during the exit phase

Although the guidance instructs officers to monitor the subject's airway the SDAR will further amend the guidance to emphasise the role of the safety officer The guidance will emphasise the need for staff to follow their first aid training (which also contains advice on monitoring) and to act immediately if they identify that the subject is in need of medical assistance

Additionally the SDAR will be looking at how best to amend the national ABD training package to provide some detail of what monitoring actually means based on medical advice

4. Commencing CPR. & 5. Understanding aspects of Epilepsy and Seizures
As already mentioned the First Aid Learning Programme has five modules and the national recommendation is that police officers receive a minimum of Module 2 training (the equivalent to the qualification of a HSE Emergency First Aider) While Module 2 does not seek to provide coverage of all medical conditions it does cover conducting CPR and managing a casualty who is convulsing, as a high level learning outcome (and is included as part of the rolling three year refresher training process)

It is recognised within the training that, in instances where officers are required to use restraint following suspicions of drug consumption, incidents should be dealt with as a medical emergency

The Police First Aid Programme is monitored via both the College's own governance and the national NPCC portfolio The NPCC portfolio includes the Health and Safety Executive, and is supported by a dedicated subject matter expert group of force first aid leads, and a national clinical governance structure which includes a broad range of independent clinical expertise

Consideration of the learning from Inquests is already a standing item on the first aid forum's agenda and the matters for concern raised in your report will be examined at the next scheduled meeting in July The issues raised will also be brought to the attention of the national clinical governance panel who are also meeting in July for their consideration

The College and NPCC will also ensure that there is liaison between the First Aid and SDAR groups that are considering these causes for concern to ensure that advice provided to practitioners is consistent across the two portfolios

Summary
The College is committed to continuing its work with forces and the National Police Chiefs' Council to raise standards of practice in the care of suspects in detention and custody This includes their safe restraint and care while in police custody I would like to thank you for bringing the circumstances of Mr Tomlin's death to our attention so that we can ensure that our future work is informed by the events that culminated in his death

Please let me know if you require any further information

Yours sincerely

[redacted]

Faculty Lead Uniformed Policing