Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. The Chief Constable
   Mr G York QPM
   Sussex Police
   13 London Rd,
   Pulborough
   RH20 1AP

2. Chief Executive Officer
   Sir H Orde QPM
   Association of Chief of Police Officers (ACPO)
   10 Victoria Street,
   London
   SW1H 0NN

3. Chief Executive Officer
   Mr M Cunningham QPM
   College of Policing Ltd
   Leamington Road
   Ryton-on-Dunsmore
   Coventry
   CV8 3EN

1 CORONER

I am Elisabeth Bussey-Jones, Assistant Coroner, for the Coroner area of West Sussex.

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

The Inquest was initially opened on the 8th August 2014. I had conduct of the matter as Coroner from the 1st December 2015.
The inquest was suspended due to other legal processes taking place.
The Inquest resumed on the 11th March 2019, lasted 4 weeks and 2 days and concluded on the 9th April 2019.
It was an Article 2 Inquest with a Jury. The Jury returned a narrative conclusion which found the death was contributed to by neglect.
The medical cause of death was found to be: "Cardiorespiratory failure due to both restraint in a prone position and the effects of cocaine and mephedrone".

4 CIRCUMSTANCES OF THE DEATH

The narrative conclusion of the Jury sets out the circumstances of the death as the Jury found them to be:

"Duncan Tomlin died 29 July 2014 at Princess Royal Hospital, Haywards Heath due to cardiac arrest, following the use of a combination of drugs together with police prone restraint.

On the evening of 26 July 2014, following the use of a combination of drugs mixed with alcohol, Duncan's behaviour became irrational and erratic although at that point he remained coherent. The loud and aggressive nature of the disturbance at Ryecroft, Haywards Heath, led to a call from a neighbour to the police believing there was a domestic assault in progress.

Upon the arrival of the police, Duncan ran away and was pursued into Wood Ride, where he was detained in the prone position, and captor spray was used. He continued to resist and struggle, and so the restraint escalated to the use of handcuffs and leg restraints. Additional officers arrived along with a police van. There was no clear continuity of the sharing of information relating to the risk assessment of Duncan's care as different police officers exchanged positions within the restraint, and it was unclear who was in charge in this fast-moving situation. During this period of restraint, prior to and after the arrival of other officers Duncan was resisting and making loud, albeit incoherent noises and so the police drew the conclusion he could still breathe.

Duncan was removed to the van, still in the prone position, including folding his legs back to allow the doors of the van to close.

There was an insufficient sense of urgency to move Duncan onto his side to address the risks of positional asphyxia from prone restraint coupled with the use of handcuffs, limb restraints, the effects of Captor spray and the suspicion that Duncan had taken stimulant drugs. Duncan should have been moved onto his side earlier.

Following a kick, Duncan continued to be restrained in the prone position in the van. A short period of time later, concerns were raised about Duncan's condition. The handcuffs and leg restraints were not removed at this point. He became unresponsive and a call was made for an ambulance, but due to a shortage of available SECAMB resources, the nearest available help was too far away so the decision was made to take him straight to the hospital. Duncan had a pulse but his breathing was laboured.

At the point when the officers could no longer find a pulse the decision was made to take Duncan out of the van to commence CPR. Officers were immediately despatched to collect a defibrillator from the police station and to fetch a doctor from PRH.

A return of circulation was gained following approximately 30 mins of CPR, first by police officers until paramedics and a doctor arrived. Duncan was stabilised and was taken to hospital where he received intensive treatment but following multiple organ failure, he died at 03.59 on 29th July 2014.

Although the police receive training in Positional Asphyxia and the available policies extensively cover it, the efficacy of this training is inadequate.

The death was contributed to by neglect".

Although Duncan Tomlin's history of seizures and epilepsy does not feature in the Jury's conclusion, knowledge and understanding of epilepsy was examined in detail in the Inquest due to the fact that before police arrived at the scene a phone call had been made to Ambulance Services reporting that Duncan Tomlin had suffered a suspected seizure of a different kind to a grand mal seizure, and the fact that it was suspected a seizure had occurred was also told to the police officers who first arrived at the scene.

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 :

Importance of heightened risk of prone restraint when multiple factors affecting breathing are present

1. The current and earlier training plans, manuals and policies examined as part of the evidence in this inquest make clear references to risks associated with: (a) positional asphyxia; (b) handcuffs and limb restraints; (c) incapacitant spray; (d) acute behavioural disorder 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 and the heightened risks to a person in a position of prone restraint when experiencing such multiple factors are critical to the assessment of risk.

Timing of decisions and opportunity to assess

2. A further concern relates to how officers are trained to prioritise options available to them and the timing of decisions in circumstances similar to those in this inquest. It is appreciated that officers are not medically trained, they do not make clinical decisions and more detailed history will be taken formally in custody suites. However, officers do need to be in a position to have sufficient information to enable them to assess the safety of the restraint situation in which they are involved, and this includes sharing information and requesting information when participants in the restraint may not have been present from the outset. 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 all 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 risks 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 by the use of handcuffs and limb restraints), **taking an 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 a post seizure state, or because they are in pain, uncomfortable or struggling to breathe?
   Once a measure of control is obtained, the speed of the incident is dictated by the actions 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.

Monitoring

3. The training plans, manuals and policies considered in evidence in this inquest refer to monitoring in different ways, depending on the circumstance. Phrases such as close, constant, careful and regular monitoring are used. Guidance as to what constitutes monitoring does not appear to be included within the 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.

Commencing CPR

4. 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 in 2-3 breaths in 10 seconds for an adult and 3-5 in 10 seconds for small children) or if breathing is distressed (snoring, rasping) known as agonal breathing.
   The evidence in the inquest was that individual officers of some experience understood CPR should commence when breathing had stopped. Whilst that 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.

Understanding aspects of Epilepsy and Seizures

5. The training material which has been provided to me on behalf of Sussex Police covers many aspects of epilepsy and seizure that were explored during the 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 in which a person may 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 consistent with the less common presentations of a person in an atypical or post seizure state.

Although epilepsy was not found to be causative in the death in this Inquest, in another situation with a similar set of circumstances, the reactions of a person suffering an atypical seizure or in a post seizure state, could be misconstrued as violence and 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 known types of seizure and that post seizure behaviour is also understood in general terms.

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 June 08, 2019. 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 the following Interested Persons:

The Family of Duncan Tomlin;
[redacted];
Police Officers Watson, Bennett, Jewell, Jackson and Sergeant Glasspool; and
The Sussex Police

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.

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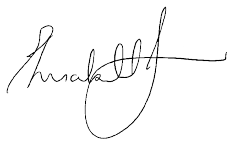

Elisabeth BUSSEY-JONES
Assistant Coroner for
West Sussex Coroner's Service
Dated: 12/04/2019