

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS***Re: Marc Antony Cole, deceased*

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"> <li><b>1. The College of Policing</b></li> <li><b>2. The Home Secretary</b></li> </ol>
1	<p><b>CORONER</b></p> <p>I am an assistant coroner for the coroner area of Cornwall &amp; the Isles of Scilly.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>The investigation was commenced on the 26<sup>th</sup> May 2017 and concluded by an inquest before a jury on the 28<sup>th</sup> January 2020.</p> <p>The cause of death recorded by the jury was:-</p> <p>1(a) Use of cocaine, episode of altered behaviour including self-harm, exertion, excitement, the use of x26 Taser Device and restraint.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On the 23<sup>rd</sup> of May 2017 Mr Cole, who been acting in a paranoid and psychotic manner, ingested as substantial amount of cocaine before jumping from a first floor window of a friend's home.</p> <p>He was in possession of a large knife with which he stabbed a woman in her garden before walking in the roadway and was seen to be slashing with the knife at his own throat and neck.</p> <p>The police arrived and, following a confrontation with Mr Cole, Tasered him on three occasions.</p> <p>He suffered a cardiac arrest at the scene and was rushed by ambulance to a local hospital where he was pronounced dead by medical staff.</p> <p>The jury, in dealing with the cause of death found specifically "excessive of cocaine taken resulting in paranoid and erratic behaviour with the use of the Taser having more than a trivial impact on Mr Cole's cardiac arrest"</p>

5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>It was said by a number of witnesses that the Taser is not a device without risk but that there is limited data as to its effects upon individuals (both generally but more particularly in those classified as vulnerable).</p> <p>In evidence it was clear that there is no understanding about the potential for incremental risk with multiple Taser activations and no training provided as to the maximum number of activations nor of their duration which is appropriate or safe.</p> <p>The evidence was that the training given to police officers in this aspect is as set down by the College of Policing and that it is silent as to the potential incremental risk of multiple and or sustained activations (the so called 'detention under power').</p> <p>It was clear from the evidence of ██████ (an intensivist consultant) that a Taser does carry a risk – despite, he said, the claims of the manufacturers - but the extent of that risk is far from clear.</p> <p>Two forensic pathologists gave evidence and confirmed their joint opinion that the Taser caused (together with other things) Mr Cole's death in that it played a more than minimal, trivial or negligible part.</p> <p>Although I found as a fact that the training given to the police officers was appropriate I did so ONLY upon the basis that it was given based upon the limited knowledge presently available.</p> <p>I am concerned, based upon the evidence that was led before the jury, that there is insufficient independent data as to the lethality of Taser use and that, therefore the advice and training provided to police officers may be deficient or incomplete.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p> <p>Perhaps by a wholesale review of the effects of multiple Taser activations and the effects of sustained activations (whether in isolation or in combination) so that fuller and more comprehensive advice, guidance and training can be given to those officers who are authorised to carry Tasers.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2<sup>nd</sup> April 2020 I, the coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken,</p>

	setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- The Family of the Deceased, The Chief Constable of the Devon &amp; Cornwall Police, The South Western Ambulance Service. I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>6<sup>th</sup> February 2020</b></p> <p><b>Geraint Urias Williams</b></p> 