Dear Judge Devonish,

Inquest into the death of Mr Paul Reynolds – ** May 2021 Regulation 28 Report to Prevent Future Deaths

I am writing in response to the matters of concern raised in your Regulation 28 Report to Prevent Future Deaths report following the Inquest in to the death of Mr Paul Reynolds. Your report and the Constabulary's response have been carefully considered by the Constabulary and I have shared this response via the Suffolk Police and Crime Commissioner to ensure openness and onward accountability.

With respect to the matters of concern, the Constabulary has reviewed the circumstances of its involvement and responds as follows:

1. Officers appeared to be under the impression that pain/pressure testing to determine whether a person was unconscious or simply asleep was an assault rather than being justifiable in certain circumstances.

The Constabulary's involvement with Mr Reynolds stemmed from a reported incident of assault by Pontins Security Officers. Upon finding Mr Reynolds being restrained, the Constabulary training would have directed officers to assess the person being detained and review the evidence being presented. It was clear from the Inquest that the officers involved did not fulfil this assessment robustly and we acknowledge that their evidence identified confusion surrounding their police powers. The Constabulary has enhanced its training delivery and supporting guidance to clarify the importance of the initial assessment and the differences between proportionate and necessary checks of health and the application of force. It will reinforce this learning through practical based assessed scenarios, as part of the nationally revised curriculum design (see paragraph 3), that will specifically test officer's ability to assess a person being detained and determine whether the circumstances warrant a medical intervention or the reinforcement of restraint.

2. The time allowed for training had been reduced from 12 to 4.25 hours. Positional asphyxia training had been ringfenced, but there were questions about the impact of the reduction upon officers.

Suffolk Constabulary's delivery of Emergency First Aid at Work Training and Personal Safety Training are compliant with the requirements of the College of Policing specification. This has been reinforced by external and independent inspections as part of national and local governance arrangements.

However, we recognise that nationally there have been changes to the programme that may have created a perception of a reduction in the time assigned to positional asphyxia. The time allocated to individual areas of the curriculum are subject to change and nationally the focus of positional asphyxia has shifted towards the signals and signs of acute behaviour disorder. This is a precursor behaviour but is part of the same continuum. Material surrounding both acute behaviour disorder and positional asphyxia is delivered in accordance with national guidance and time allocations, but the Constabulary will do more to embed this learning within the wider aspects of its Personal Safety Training through supplementary videos and guidance on its Learning Management System.

3. The College of Policing and NPCC Officer and Staff safety Review made two recommendations to include revising the curriculum to ensure greater consistency, and to implement guidelines to ensure officers are sufficiently skilled in non-physical aspects of conflict management. The time scales for implementation were not stated.

The College of Policing is leading the redesign of the personal safety training programme and we will support the College through this period and implement the new programme upon its adoption. We understand that this new programme will come into fruition during 2022 and will be more scenario orientated. From our understanding of the programme design there will be opportunity for us to re-enact scenarios of concern and, as identified in paragraph 1, we will adopt scenario-based assessments that recreates the events of this incident. This will allow Trainers to assess officer understanding of their medical responsibilities and use of force powers.

4. Officers did not control the scene by clearing the ballroom and switching off the music which would have improved their ability to assess Mr Reynolds' condition.

We accept the concerns raised surrounding the control of the scene. We also recognise that while the first officer attending may have had difficulty in coordinating the various aspects presented, the arrival of other officers gave sufficient opportunity for scene to be controlled. As stated in paragraph 3, we will take this learning into the design of a scenario that will replicate and therefore enable the Constabulary to assess officer's scene management approaches.

Additional Learning

As reflected within our evidence, the Learning and Development department did undertake a comprehensive review of its practices and procedures following this incident. We acknowledge our responsibilities as a professional organisation to learn lessons and our review identified weaknesses within our records management. This resulted in the lapses surrounding the frequency of refresher training for some of the officers involved, as shared during the inquest.

Our review also identified that training material constantly evolves around new information and best practice but that it was equally important to be able to identify officers learning to each iteration of a training package. These two factors, would have enabled the Constabulary to present greater confidence in the completeness of the officer refresher programmes as well as the rationale surrounding any changes to the time allocations, including when these were introduced.

In response to this learning, we have invested in a new skills management system that will make it easier for our learning and development department to track and identify officer training records as well as link these records to the training the officer received.

We trust that this combination shows the seriousness in which we have reflected upon the circumstances of this incident and the changes in our practices that we will implement to prevent its reoccurrence.

Yours Sincerely

