	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Inspector [redacted], Operational Training Manager, Norfolk & Suffolk Constabulary** **[redacted], Chair of National Police Chief's Council**
1	**CORONER** I am Jacqueline Devonish, area coroner, for the coroner area of Suffolk
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** On 19 April 2021 I commenced an investigation into the death of Paul Steven Reynolds, aged 38. The investigation concluded at the end of the inquest on 10 May 2021. The conclusion of the inquest was that the police failed to identify that Mr Reynolds, who was being held in a prone restraint by three security staff at Pontins Pakefield was unconscious upon their arrival. The medical cause of death was found to be 'Complications Arising from Restraint of an Intoxicated Obese Individual in a Prone Position, with Compression of the Neck and Potential Obstruction of the Upper Airways'.
4	**CIRCUMSTANCES OF THE DEATH** On 11 February 2017 Paul Reynolds attended the Pontins holiday leisure park in Lowestoft. During the evening of the 14th there was an incident between guests in the communal area of the leisure park. As a result of this incident Mr Reynolds was restrained by security and other staff until police arrived. He was grabbed from behind in a bear hug, taken to his knees in a neck hold and placed on the ground in a prone restraint. During the 11 minute prone restraint, captured on CCTV, Mr Reynolds did not appear to make any movement, although the Pontins staff involved in the restraint gave evidence that he had be wriggling, resisting the restraint, talking and later murmuring. He had also apologised and asked to be let up. This information had not been shared with the police. The police had been informed that Mr Reynolds had hit security officers and had been very violent and that he was now pretending to sleep. There was no evidence that he had in fact hit anyone. The police arrived just after Mr Reynolds was heard snoring. They presumed he was asleep. He was spoken to, cautioned, handcuffed behind his back, and placed in a supported seated position on the floor with his chin flopping to his chest. His legs were out in front of him. No officer received a direct verbal response from Mr Reynolds. He was then lifted and carried unresponsive to the police van where he was seated on the floor of the cage in a W position diagonally. His head was leaning against the Perspex screen.

	On route to the Police Investigation Centre the police stopped the vehicle when they noticed Mr Reynolds appearing unwell. They took Mr Reynolds out of the van and performed CPR until the paramedics arrived. Mr Reynolds was conveyed to James Paget University Hospital where he died with hypoxic brain injury due to a lack of oxygen to the brain, on 16 February 2017. Experts attending the inquest gave evidence that Mr Reynolds may have fallen unconscious within seconds of the neck hold applied by Pontins security. This was exacerbated by them then moving him into a prone restraint with his legs tucked up to his buttocks, and failing to relax the restraint and get him back to his feet or into recovery position. The police became aware that Mr Reynolds had been in prone position for around 10 minutes before they arrived but did not consider him to be a medical emergency based upon the information they had been given.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are 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. (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. (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. (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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 9 July 2021. 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: [redacted] and [redacted]. I have also sent it to [redacted] at the Police Federation and [redacted], IOPC who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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.
9	**11 May 2021** Jacqueline Devonish