REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] – Chief Constable Thames Valley Police, Thames Valley Headquarters South, Oxford Road, Kidlington OX5 2NX 2. [redacted]College of Policing, Leamington Road, Ryton-on-Dunsmoor, Coventry, CV8 3EN 3. [redacted] Chief Executive South Central Ambulance Service NHS Foundation Trust, Unit 7 & 8 Talisman Business Centre, Talisman Road, Bicester, Oxfordshire OX26 6HR 4. [redacted] Managing Director Association of Ambulance Chief Executives (AACE), 25 Farringdon Street London EC4A 4AB
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner for the coroner area of Berkshire. We were asked by the family to refer to the deceased as Neal. I have reflected that request in this report.
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 21st December 2021, I commenced an investigation into the death of Neal Terence Saunders, aged 39. The investigation concluded at the end of an inquest on 2nd December 2022. The jury recorded a narrative conclusion. Their conclusions were: <u>Cause of death:</u> I a Multiple Organ Failure I b Cardio-Respiratory Arrest I c Acute and chronic effects of cocaine use (myocardial infarction, agitation and resistance against restraint)

	Narrative conclusion: Neal was restrained by police for 58 minutes and held prone for 14 minutes prior to his first cardiac arrest. Medical evidence indicated that this cardiac arrest was due to a heart attack caused by cocaine - induced vasoconstriction of a coronary artery. Police are trained to avoid prolonged restraint in cases of ABD but are not trained in how to assess when restraint becomes prolonged. Neal was intermittently aggressive and struggling against restraint throughout, and police risk assessment was that the restraint continue as it would not be safe to remove it. Neal stated at point that he "couldn't even breathe" but medical evidence was that he could breathe throughout although it was "laboured". It was appropriate that Neal was restrained for the duration of the incident, as there was no safe, practicable alternative, although resistance against restraint contributed to his death. JRCALC guidelines for paramedics indicate that transportation of ABD patients prone is dangerous. The paramedic was not aware of the JRCALC guidelines which state that "use of the prone position should be avoided wherever possible or used for a very short period of time only" – but was aware that the prone position should be avoided generally. Police officers suggested positional options for transport from the flat to the ambulance, but the paramedic decided to transport Neal prone. We conclude that the degree of attention paid to Neal's positioning in the ambulance was unsatisfactory. Neal's prone position was not causative of death but may have more than minimally contributed to it. A Thames Valley Police radio operator was mistaken when she stated that Neal was suffering with ADD as opposed to ABD. This resulted in the initial call being graded as category 3 response by South Central Ambulance Service. This was not causative of death.
4	**CIRCUMSTANCES OF THE DEATH** The key facts in this case are as follows:- The police attended Neal's address shortly before midnight on 3rd September 2020. His father had reported that Neal had assaulted him and damaged his flat. When the two officers who attended attempted to handcuff Neal after arresting him, other officers were sent and a total of six officers attended the scene. Neal's father reported that Neal had used cocaine recently, and had been behaving in a paranoid way. Soon after, Neal was restrained on the floor, an officer considered whether Neal was suffering from Acute Behavioural Disturbance (ABD), and an ambulance was requested. The ambulance arrived almost an hour later. Whilst waiting for the ambulance, Neal was kept in a restrained position on his side. When removed from the property, and whilst being transported in the ambulance, Neal was held in a prone position with his hands handcuffed behind his back. It was clear from the evidence that advice was taken from the paramedics about Neal's positioning, but also that the paramedics did not know how long Neal had been restrained for, prior to their arrival. En route to hospital, Neal suffered a cardiac arrest. CPR was given and there was a return of spontaneous circulation. Neal was taken to hospital, but sadly died there at 14:20 on 4th September 2020.
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.

Brief summary of matters of concern

Police training

There was extensive BWV footage in this case, which both I and the jury were able to see multiple times. It appeared to me, (and presumably to the jury, given their conclusion), that the officers at the scene were trying to take Neal's welfare into account. The real issue was around their training. Whilst there may not have been any realistic or practicable alternative to restraining Neal, at least initially, it was clear from the evidence that none of the officers recalled their training which had told them that "prolonged" restraint should be avoided.

The training gives no guidance as to what constitutes "prolonged" restraint, and this an issue which the jury highlighted. There are also a number of concerns regarding College of Policing training in this respect.

The key concerns around training can be summarised as follows:-

1. How long is "prolonged" restraint?

2. One of the witnesses questioned whether the guidelines applied at all if somebody is under arrest, particularly regarding "contain rather than restrain". Given that these are police guidelines, it seems to me likely that they would apply, whether a person is arrested for public order offences or other matters (but that should be clarified).

3. The College of Policing slides regarding ABD state that a "Cat 1 call" should be made to the ambulance service. The slides go on to say that the ambulance service should respond to ABD as a "category 1" [response]. It is clear that categorisation would be a matter for the ambulance service rather than the police, and this training may result it inappropriate expectations on behalf of officers at scene, who are expecting an ambulance to arrive more quickly that it in fact does. This in turn could affect their decision making.

4. The guidelines also refer to providing "chemical sedation". This appears to me to indicate an incorrect understanding of what is likely to be done medically by a first responding paramedic or emergency care assistant.

5. It was interesting to note that the parts of the training the officers did seem to remember were around when the training was provided in a very physical way (around positions for restraint etc.) and the final slide "ABD = A&E". It appears that the more "classroom based" training is less well received. I understand that the College of Policing is changing its methods, and it may be that an educational consultant with policing background could assist with this in trying to achieve training which will stick with those being trained more effectively.

6. Is there a better way for the College of Policing to ensure that the training has worked and is embedded?

Training generally

I raise 2 points here:

1. Checking of guidance which is infrequently used

2. Joint training with ambulance services

	Thames Valley Police and the College of Policing will be aware of my Regulation 28 report dated 9th July 2019, following the death of Leroy Medford in 2017. I raised a number of concerns about police training, and received responses from Thames Valley Police and the College of Policing. These are publicly accessible documents on the Chief Coroner's website. I am concerned that the issues raised around training in that report have been insufficiently addressed. The only substantive change appears to relate to better remote access to guidance. In both inquests, the guidance was in relation to a matter which is not commonly faced by police officers. Whilst I consider ABD training could and should be improved, I accept that there has to be proportionality, given that officers will require training in a number of areas, some of which are far more frequently relevant than this. In addition to achieving better training, I consider that Thames Valley Police (and police nationally), should consider a change of approach. I consider that police officers should be mandated to review guidance (whether APP guidance or otherwise) in any scenario that they have not (or not recently) dealt with. I fully appreciate that this will need to have a "where practicable" caveat, since that will not always be operationally possible. In this case, however, there was ample time for an officer to check. One of the officers is heard saying words to the effect of "there is nothing more we can do here", whilst waiting for the ambulance to arrive. I consider that Thames Valley Police (and police forces nationally) should consider not only requiring officers to do this wherever possible, but also for control to remind teams to do this or assist them with that. It would be best practice for this to be recorded on the log as having been completed. This could be achieved by a phone call to a senior officer, or by checking guidance directly. It was suggested by the Medical Director of South Central Ambulance Service that police and ambulance services should work together in reviewing their policies and perhaps train together as well. This is something I would endorse completely. <u>Ambulance issues</u> One of the reasons that I consider that joint training would be more effective is that it would appear (based on the evidence I heard at least), that police are potentially given more training on ABD than paramedics. We heard, for instance, that police training includes reference to prolonged restraint being dangerous. The paramedic evidence we heard indicated that this was not known by them, and not referred to in JRCALC guidance. I consider that the JRCALC guidelines should be reviewed to account for this, and potentially to recommend that paramedic staff be encouraged to ask how long somebody has been restrained for when they arrive, as this may affect their management. There should also be care taken regarding terminology, to ensure that all services refer to this umbrella term using the same terminology.
6	**YOUR RESPONSE** In my opinion, action should be taken to prevent future deaths and believe you and your organisations have the power to take such actions.

	Your response is required in 56 days, i.e. by Friday 10th February. In view of the Christmas break, more time will be considered by the coroner if needed.
7	**COPIES and PUBLICATION** I have sent a copy to the chief coroner and the following interested persons:- 1. Family's legal representatives 2. Legal representative for Polaris Medical, the private ambulance service who attended at the scene I have not addressed this report directly to Polaris Medical, even though it was their employees who attended. This is because the issues are wider and for the AACE and local NHS Trusts predominately. Any changes in JRCALC or other guidance would apply to them equally. I am also under a duty to send the chief coroner a copy of your response.
8	**15th December 2022**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**