REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The National Police Chiefs Council and the College of Policing
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 7th July 2018 I commenced an investigation into the death of Andre Felipe Mendes Moura. The investigation concluded on the 15th December 2022 and the conclusion of the jury was one of **Narrative: Andre Moura had taken cocaine in the hours leading up to his death. There was a significant struggle with Greater Manchester Police Officers as he was restrained, during which an episode of acute behavioural disturbance developed. He was put in the back of a police van for transportation. He suffered a cardiac arrest in the back of the van and died after attempts to resuscitate him were unsuccessful.** The medical cause of death was **1a) Cocaine toxicity resulting in hyperthermia and acute behaviour disturbance in association with obesity and struggling against restraint.**
4	CIRCUMSTANCES OF THE DEATH On the 7th July 2018 Andre Moura was declared dead at Tameside General Hospital. He had a cardiac arrest in a police vehicle whilst under police arrest to prevent a breach of the peace. Attempts to resuscitate him were unsuccessful. He had high levels of cocaine in his system, resulting in cocaine toxicity. Acute behavioural disturbance in association with hyperthermia, obesity and a prolonged, high stressing and physical struggle were all contributory factors.
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. –

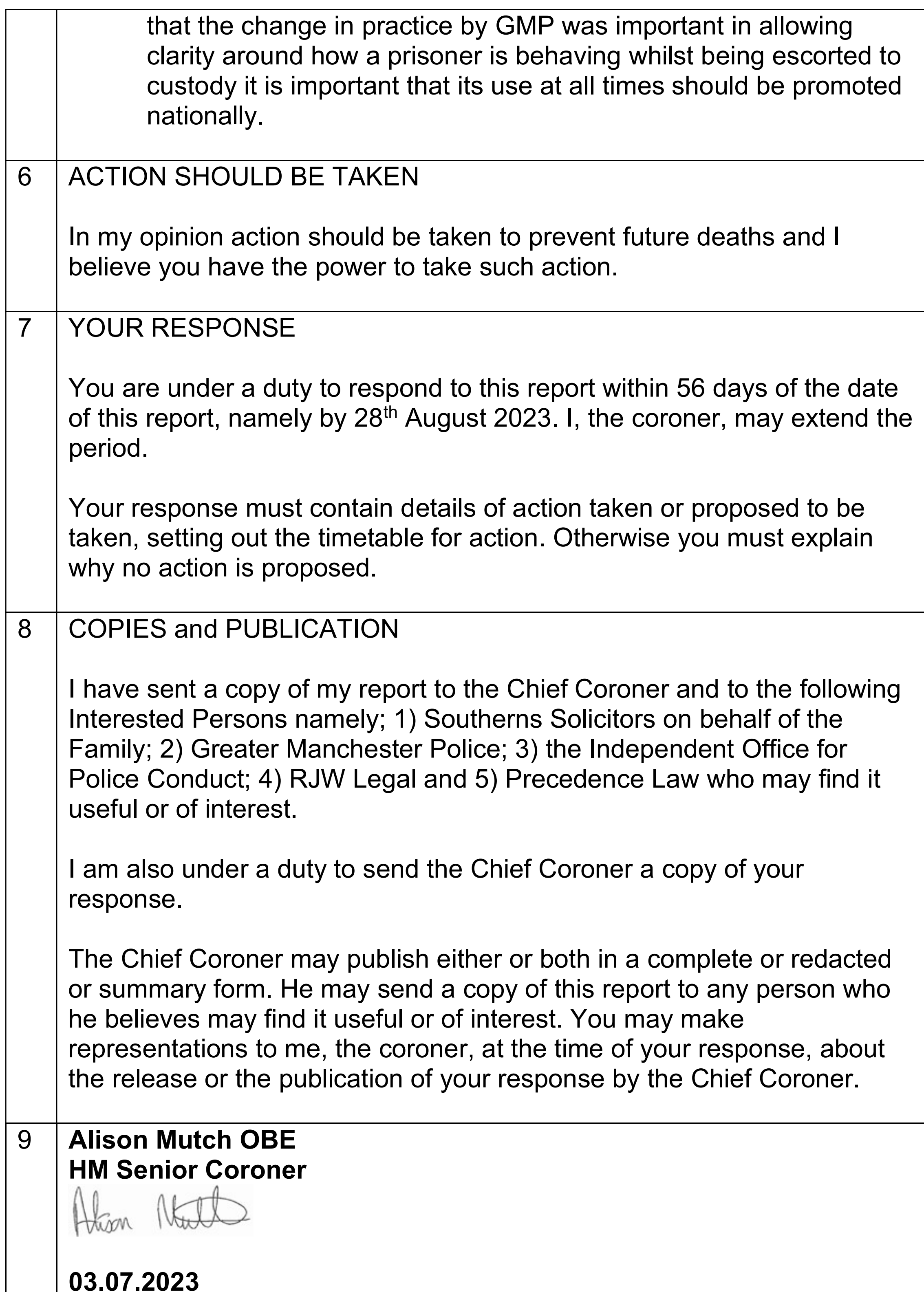
1. During the course of the Inquest, evidence was heard about the understanding and training in relation to Acute Behaviour Disturbance (ABD). All of the officers who had received their College of Policing Personal Safety Training had been trained on the ABD module within that package. However it was clear that the training package had not achieved the objective i.e. to recognise ABD in a real life setting. The Inquest heard that ABD is an umbrella term and not all of the symptoms need to be present for someone to be suffering from ABD. It was clear from the officers' evidence that the videos played in the training particularly of extreme examples of ABD had led them to not consider or recognise ABD in this situation. The Inquest heard that it could be difficult to recognise ABD in a dynamic situation but the training was there to ensure officers considered it in situations where it was a possible explanation for behaviour seen by officers. An emphasis on the nuances and less on extreme examples may assist in improving the recognition of ABD;

2. The Inquest heard that the ABD training did not have any formal way of measuring/testing knowledge but was reliant of the perception of the trainer. A more formalised approach may have increased the ability of officers to recognise ABD;

3. The role for a safety officer which is part of the College of Policing training in a situation such as this was not recognised. The Inquest heard evidence from an expert witness that a safety officer plays a key role in an incident such as the one involving Mr Moura and ensures key information is not lost/shared. This lack of an officer at his head taking on such a role emphasised the fact that although officers had attended the PST training key points had not been retained. Greater emphasis on this role in training would be beneficial in reducing the risk to prisoners being restrained;

4. Many of the officers who gave evidence indicated that they believed that Mr Moura was feigning his lack of responsiveness. This was despite the fact that there was very limited evidence of officers carrying out the recognised AVPU checks. Officers relied on their own perceptions rather than AVPU. An officer who did carry out AVPU did not clearly share his lack of responsiveness with other officers. The Inquest heard that there is no formal training on what officers should do if they believe a prisoner under arrest is feigning unresponsiveness. Clarification and enforcement of the need for objective use of AVPU may well prevent subjective assessments leading to erroneous and potentially fatal conclusions that a prisoner is feigning lack of responsiveness;

5. The officers escorting Mr Moura to the police station did not have their body worn cameras on. Greater Manchester Police (GMP) at the time did not have a policy at that time requiring escorting officers to switch on their Body Worn Video (BWV) cameras. GMP do now require that BWV cameras are on. This is an important change but it was not clear if all forces have implemented such a change. Given that the evidence before the inquest made it clear

	that the change in practice by GMP was important in allowing clarity around how a prisoner is behaving whilst being escorted to custody it is important that its use at all times should be promoted nationally.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 28th August 2023. 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 namely; 1) Southerns Solicitors on behalf of the Family; 2) Greater Manchester Police; 3) the Independent Office for Police Conduct; 4) RJW Legal and 5) Precedence Law who may find it useful or of interest. 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.
9	**Alison Mutch OBE** **HM Senior Coroner**  **03.07.2023**