## Regulation 28: REPORT TO PREVENT DEATHS

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1 The Chief Constable HAMPSHIRE & ISLE OF WIGHT CONSTABULARY** |
| **1** | **CORONER**<br><br>I am Jason Pegg HM Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 17th November 2021 I commenced an investigation into the death of Marcel Maksymilian WOCHNA aged 15. The investigation concluded at the end of the inquest heard between 4th and 13th September 2023 sitting with a jury. The conclusion of the inquest was:<br><br>Narrative Conclusion: On 8th November 2021 the deceased drowned in the River Itchen, Southampton, Hampshire. The deceased jumped into the River Itchen feet first, voluntarily to evade arrest. There was insufficient immediate action taken by attending officers to attempt to rescue Marcel once he had entered the water which probably contributed to his death. The police officers had inadequate knowledge of the working by water policy. Marcel's death was contributed to be neglect. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Two police officers attended Cobden Marina located on the River Itchen during the early hours of 8th November 2021.<br>It was a dark, cold night, the river temperature was 12 degrees Celsius.<br>The pontoon was unstable causing it to wobble.<br>The police officers found the deceased and another young male on a moored boat.<br><br>The other male, who was described as "compliant enough", was moved onto the pontoon and handcuffed to the rear.<br>The officers decided before arriving at the scene that they would handcuff any suspect found.<br><br>The deceased then exited the boat and stood on the pontoon and held by an officer.<br>The deceased pulled away from the officer and deliberately jumped into the River Itchen.<br><br>When the deceased jumped into the river the attending police officers did nothing.<br>The officers believed that the deceased had swam away.<br>The officers did not recognise that there was a real and immediate risk to the life of the deceased when he entered the water. Neither officer had heard of Cold Water Shock.<br><br>Expert evidence indicated that Cold Water Shock is likely to incapacitate within 2 minutes, cardio-pulmonary arrest is likely to follow within 4-5 minutes.<br><br>Hampshire Constabulary had at the relevant time, and continues to have, a "*Working near Water Procedure [21344]*". The Procedure sets out the risks of operating near water, including Cold Water Shock, together with mitigating measures and the necessity for a dynamic risk assessment when operating close to water. |

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| | Neither officer had seen nor was aware of the "*Working near Water Procedure*" on 8th November 2021.<br>One officer had served for 11 years, one had recently completed their training.<br>Both officers operated from a police station covering the River Itchen which flows through a busy city and has Southampton Water to the south.<br><br>The attending officers accepted that had they been aware of the Procedure on 8th November 2021 they would have known of the real and immediate risk to life associated with Cold Water Shock.<br><br>In 2011 Hampshire Constabulary introduced their own Constabulary wide on-line training package relating to working near water.<br>That training package makes no mention of Cold Water Shock.<br>The training package makes no mention of the procedure to adopt when seeking to effect a rescue from water namely, "*Shout, Reach, Throw, Row, Go*".<br>The "*Shout, Reach, Throw, Row, Go*" is a recognised procedure and utilised by Hampshire Constabulary Marine Unit.<br><br>Hampshire Marine Unit apply handcuffs as a last resort to detain a person when operating near water, which includes on a pontoon.<br>When handcuffs are used as a last resort the detained person is handcuffed to the front in order to afford the detained person the opportunity to tread water or take hold of an object in the event they come to be in the water. The risks of handcuffing a person to the rear whilst in close proximity to water were not recognised by the attending (Non-Marine Unit) officers. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation and inquest the evidence revealed matters giving rise to concern in relation to Hampshire & Isle of Wight Constabulary police officers. 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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>1. Lack of awareness of Cold Water Shock and the associated immediate risk to life;<br><br>2. Lack of awareness of the recognised "*Shout, Reach, Throw, Row, Go*" procedure ;<br><br>3. Lack of awareness of risks associated with the use of handcuffs, particularly so to the rear, when detaining a person near water;<br><br>4. Absence of effective dissemination, access and awareness of the Hampshire Constabulary "*Working near Water Procedure*" and the risks, mitigations and the need for necessary dynamic risk assessments set out therein. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th November, 2023. I, HM Coroner, may extend the period.<br><br>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. |

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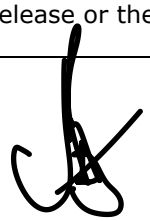
| **8** | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>[redacted] (Mother of the deceased)<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either 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.<br><br>You may make representations to me, HM Coroner, at the time of your response about the release or the publication of your response by the Chief Coroner. |
| **9** |  <br><br>**HM Area Coroner**<br>**Hampshire, Portsmouth and Southampton** |