Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**, Chair of National Police Chiefs Council** [redacted]**, CEO College of Policing**
1	**CORONER** I am Jacqueline DEVONISH, Senior Coroner for the coroner area of Cheshire
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 04 January 2016 I commenced an investigation into the death of Carl FULLALOVE aged 29. The investigation concluded at the end of the inquest on 11 October 2023. The conclusion of the inquest was that: Narrative Conclusion - On the night of 13 December 2015 at 00:12, Carl Fullalove was witnessed jumping on cars by residents of Melverley Drive. Officers arrived to find Carl leaning against a wall with a calm demeanour although his conversations led officers to believe he was under the influence of a substance. Signs of ABD were not present to officers for them to have considered Carl a medical emergency as he could walk and talk and did not otherwise appear unwell. All available information to the officers was passed to control and subsequently custody suite so an FME was not requested on standby. Carl was adequately assessed by all within the custody suite and within cell 9. Prone restraint in cell was necessary and justified however it is felt that it did contribute to the death of Carl negligibly on the balance of probabilities.
4	**CIRCUMSTANCES OF THE DEATH** On the night of 13 December 2015 at 00:12 Carl Fullalove came to his death: i. He was observed jumping on cars in Melverley Drive at 00:12. This caused local residents to call the police. ii. Carl was shouting about dogs and behaving bizarrely. iii. Carl was under the influence of a substance. iv. Carl was handcuffed, arrested and taken into police custody where he was placed in cell 9 in Blacon Custody Suite. v. Carl was placed in prone restraint onto a mattress to enable disrobing and a search to be carried out. During this, he was found to be non-responsive and suffering from cardiac arrest by the FME. vi. The ambulance arrived and took Carl to the Countess of Chester Hospital having secured

	a return of spontaneous circulation. vii. He subsequently died on 14 December 2015 at 14:13 hours.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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)Whilst the jury did not make any finding of acute behavioural disturbance (ABD) in this case, much evidence was heard about the training in identification of the signs and symptoms. National training of police officers on the identification of ABD is focused on a triad of warning flags being, hot to touch, exhibiting constant or near constant activity and extreme agitation or aggression. Some evidence identified that Carl Fullalove did not exhibit these triad symptoms but did exhibit other nuanced symptoms in the long list delivered in training. It was evident that his symptoms were not recognised as ABD due to drug intoxication, and that the consequential risks associated with prone restraint were not therefore considered. Prone restraint ultimately led to his death. There were six experts providing evidence to the inquest two of whom identified that Carl would not have died had he been recognised as unwell at the point of arrest and assessed by a health care practitioner. Such attention would have provided a calming intervention for his heart rate and breathing prior to being placed in prone restraint, which exerted additional pressure on his ability to breath freely. (2)A research paper before the inquest, namely 'Consensus on Acute Behavioural Disturbance in the UK, September 2023 recommends that the focus remain on the triad of warning signs. ABD is clearly difficult to distinguish from drug intoxication by a non-medical practitioner. The rigidity of the training with focus on specific symptoms can cause police officers to miss other signs. The Superintendent, and head of 'Protecting Vulnerable People' for Cheshire accepted that with hindsight the use of prone restraint was inadvisable in this case. (3)Significant training on ABD had been delivered by Cheshire Constabulary through the College of Policing Personal Safety Training package module, the key to which was to identify an underlying medical condition to refer to a health care practitioner. That may be a lot to expect of police officers in a dynamic fast paced setting. The use of the term ABD may be a distraction. (4)The effect of stimulant drugs and the need for calming de-escalation in an upright position, rather than prone restraint, had not been noted in either the training material or the research paper presented to the Court. This is on the background of recognising from College of Policing guidance that a high percentage of deaths in prone restraint are in drug related cases. (5)The First Aid Learning Programme (FALP) will be in place within Forces by April 2024 and includes amongst other things positional asphyxia, unconscious and not breathing, and ABD but does not mention training in calming intervention that on balance of probabilities may have led to a different outcome in this case.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 December 12, 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 **Carl Fullalove's parents** **Cheshire Constabulary** I have also sent it to **The Rt Hon Chris Philp MP, Minister for Policing, UK Parliament** 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 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 by the Chief Coroner.
9	**Dated: 25/10/2023**  **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**