Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Constable of Gwent Police.
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 25/02/2021, an investigation was opened touching upon the death of Mouayed Mamoun Bashir. The investigation concluded at the end of the inquest on 02/02/2024. <u>The conclusion of the inquest was recorded as a narrative conclusion in the following terms:</u> On the 17th February 2021, Mouayed Mamoun Bashir took an unknown quantity of cocaine. This resulted in him developing symptoms in keeping with Acute Behavioural Disturbance (ABD). Mouayed barricaded himself in his bedroom and was heard banging, shouting and breaking objects. At 08:50, Mouayed's family were concerned for his welfare and proceeded to contact emergency services. At 09:01 the first police officer arrived and informed the control room that the ambulance was required. Gaining entry Mouayed was agitated, police officers restrained him for his own safety and for the safety of others. We believe from the evidence we heard that there was insufficient knowledge and understanding around identifying some of the signs of Acute Behavioural Disturbance. Throughout, Mouayed's condition was deteriorating, police officers and family continued to update the ambulance service. An ambulance arrived at 10:04. The priority was to transfer Mouayed to hospital, but it was difficult to manoeuvre him out of the house. Shortly after he was transferred into the ambulance at 10:37, Mouayed went into cardiac arrest.

	Police and paramedics commenced cardiopulmonary resuscitation (CPR) and conveyed Mouayed to the Grange University Hospital, Llanfrechfa, where the clinicians continued to attempt to revive Mouayed. Sadly, they were unsuccessful and Mouayed died at 11:41 on 17/02/2021. In conclusion, Mouayed's death was caused by cocaine intoxication, this was contributed to by the effects of ABD following a period of restraint. <u>The medical cause of death was:</u> 1a) Intoxication with cocaine and the effects of cocaine, following a period of restraint.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mouayed's death are best described in the narrative conclusion. As you can see the jury have referenced the police's knowledge of ABD in their conclusion.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - At the inquest all the police officers who attended MB gave evidence and they all stated under oath that they did not consider that MB was suffering from ABD at the time. However, when completing the Use of Force forms afterwards, all bar one of the officers involved in restraint indicated that ABD had been an impact factor. There is an ambiguity which could not be properly explored at the inquest, largely due to the passage of time. However, this suggests that officers may have thought about ABD but did not mention it to others, which would be contrary to the "Speak Up and Speak Out" principle. This is a principle, the inquest heard, that is critical to ensuing that the voices of junior officers are heard in these difficult and potentially life-threatening situations.
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. <u>I should be grateful if the following information be provided to me:</u> Confirmation as to whether the training on ABD has been reviewed and the principle of "Speak Up and Speak Out" enshrined therein, reflecting the acknowledged difficulties in identifying ABD even by experienced officers.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 08 April 2024. I, the Coroner, may extend this 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 necessary.
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person(s) • The family of Mouayed Mamoun Bashir • Welsh Ambulance Trust • [redacted] • IOPC 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 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	**DATE 12/02/2024** Signed:  Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**