REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **National Police Chiefs' Council of NPCC Central Office, 1st Floor, 10 Victoria Street, London, SW1H 0NN** **College of Policing: nationalpolicingcurriculumenquiries@college.pnn.police.uk**
1	**CORONER** I am Gareth Glyn Lewis, Area Coroner for the coroner area of Carmarthenshire and Pembrokeshire.
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 12th February 2015 I commenced an investigation into the death of Darran Hunt. The investigation concluded at the end of an inquest on 3rd February 2017. The conclusion reached by the jury was a narrative one namely that: After being directed to the Sunken Gardens, Llanelli by CCTV Operatives, the Police questioned three individuals believed to be involved in handling illegal substances. The three became non-compliant and Mr Hunt attempted to evade detention. Sometime during the following struggle with police officers Mr Hunt placed a significantly sized package in his mouth. The deployment of PAVA spray and the ensuing strong physical contact on Mr Hunt may have been contributing factors in the resultant fatality.
4	**CIRCUMSTANCES OF THE DEATH** (1) At approximately 14:00hrs on 8th February 2015 police officers were dispatched to deal with an incident of suspected drug taking involving Darran Hunt ("Mr Hunt") and two acquaintances. (2) Police officers tried to detain Mr Hunt and his acquaintances for the purposes of taking them back to Llanelli Police Station for a search pursuant to section 23 of the Misuse of Drugs Act 1971. (3) Mr Hunt ran away from the police officers. He was chased by the officers who caught up with him a short distance away. The officers struggled with Mr Hunt and it is believed that during this struggle he placed a package into his mouth in an attempt to conceal it from the officers. (4) One of the Police Officers in his evidence (supported by CCTV) said that he put his open hand on Mr Hunt's chin in an attempt to pull down the jaw and open Mr Hunt's mouth. (5) Mr Hunt continued to resist so another police officer deployed her PAVA spray in an attempt to gain control of the situation. At this point Mr Hunt drops to his knees and appears to become compliant. (6) A short while later Mr Hunt gets back to his feet he is then taken to the ground and handcuffed to the rear by officers. (7) Whilst Mr Hunt is on the ground it becomes apparent to the police officers that

	Mr Hunt is choking and struggling to breath. The Police officers make concerted efforts to remove the blockage from Mr Hunt's airway but they are not able to do so. A request is made by the police officers at 14:19hrs for an ambulance to attend. (8) An Ambulance Trust First Responder arrives on the scene at 14:26hrs. Using Magill's forceps the First Responder is able to remove from Mr Hunt's airway a package measuring approximately 8cm x 5.5cm x 2.5cm. (9) Basic and Advanced Life Support methods were used but Mr Hunt could not be saved and life was pronounced extinct at 14:41hrs. (10) The cause of death was given by the Pathologist as 1a upper airways obstruction due to the presence of foreign material.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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** is as follows: There appears to be an apparent lacuna or, at least, confusion in respect of training for Police in relation to situations where a detained person puts a potentially harmful substance or item in their mouth. 1. Use of PAVA Spray It has been suggested by the expert during the course of the Inquest that "luck" will determine whether a person sprayed with PAVA spray will inhale or exhale at the point immediately after being sprayed. There is clearly a risk therefore that a person with an object in their mouth could choke on that item if they inhale immediately upon being sprayed. At present there does not appear to be any guidance for officers on whether they should use PAVA spray in the circumstances of this case. Consideration needs to be given to whether guidance/policy should be issued to officers about if and when PAVA spray should ever be deployed in respect of a detainee who is believed to have placed something in their mouth. 2. Forced Search of mouth Clarification is needed on the extent to which individual police forces are expected/mandated to adopt Module12 of the Personal Safety Manual and in particular the practical technique of undertaking a forced search of the mouth. It appears that Dyfed Powys Police have not been trained on the method of forcible search of the mouth whereas South Wales Police have. The concept of a forced search of a detainee's mouth is in stark contrast to the guidance/direction given by Faculty of Forensic & Legal Medicine (FFLM). Officers are, as part of their training, directed to the FFLM guidance for further reading which provides that a forced search of a detainee's mouth "is not ever appropriate to prevent the swallowing of an object". There is significant inconsistency in this area and consideration needs to be given to the status and endorsement that the Police give to the FFLM recommendations in its guidance entitled "Management of Choking in Police Care & Custody – Recommendations for Police Personnel". Consideration should also be given to whether the FFLM recommendations apply in the context of just custody suites or more widely such as in the street (as in this case). It is of concern that there is a 2006 case with not too dissimilar facts in the South Wales Police Force area. In that case, the lack of training in relation to the forced search of the mouth of a detainee and control and restrain where a detainee has been seen to put something in their mouth were issues highlighted by the Inquest. One of the recommendations of the Preventing Future Death's Report in that case was that officers should be trained in the technique of forced searching of the mouth. There is an apparent shortcoming in the cascading of information across the different police forces.
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 the 26th April 2017. 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 Person: [redacted] (parents) Chief Constable, Dyfed Powys Police, Police Headquarters, PO BOX 99, Llangunnor, Carmarthen, SA31 2PF 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	**1st March 2017** **Signed:**