East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF: 6562

27 June 2019

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Cressida Dick, The Commissioner of the Police of the Metropolis, MPS Directorate of Legal Services, 10th Floor, 10 Lambs Conduit Street, London, WC1N 3NR**
1	**CORONER** I am Miss N Persaud Senior Coroner for **East London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 04/07/2017 I commenced an investigation into the death of Edir Frederico Araujo DA COSTA. The investigation concluded at the end of the inquest on 6 June 2019, which was heard with a jury. The conclusion of the jury following the inquest was: *Misadventure – Mr Da Costa died from the consequences of cardiorespiratory arrest suffered when his airway became obstructed by a plastic bag containing drugs, which he had placed in his mouth.*
4	**CIRCUMSTANCES OF THE DEATH** The jury reached the following findings of fact: • The vehicle Mr Da Costa was travelling in was stopped by police officers at approx. 21:59 on the 15th June 2017. Mr Da Costa exited the car and had interaction with the police officers • Either before or after exiting the car Mr Da Costa placed a plastic bag containing around 88 wraps of Class A drugs into his mouth • Mr Da Costa was taken to the ground by officers in an attempt to restrain him. • 4 officers were involved in the restraint • CS spray was used to gain control of Mr Da Costa in order to place his hands in handcuffs • Mr Da Costa's hands were placed in handcuffs while he was in the prone position • 20-30 wraps of Class A drugs were observed on the ground near Mr Da Costa's mouth • The above actions occurred from approx. 21:59 – 22:04 • Mr Da Costa became unresponsive due to the obstruction of his airway by the plastic bag • Mr Da Costa's handcuffs were removed and he was placed in the recovery position

	• The first aid primary survey was commenced by an officer • While the primary survey was taking place ARV officers arrived at approx. 22:05 • A call was placed for an ambulance by an officer at approx. 22:05 • ARV officers took over first aid and CPR was started at approx. 22:09 • The ambulance call was initially categorised as a C3 (lower priority & 30 minute response) as Mr Da Costa was reported as being "conscious and breathing" • The MPS controller provided an incorrect address and incorrect map reference to the LAS. This caused a delay of a few minutes in the LAS being provided with the correct address however this delay did not contribute to the outcome • The first LAS vehicle was dispatched at approx. 22:13 and arrived at approx. 22:18 • The LAS clinical team leader removed a plastic bag containing some wraps at approx. 22:37. More effective ventilation was provided after this time • The ambulance arrived at Newham University Hospital at approx. 22:44 • Spontaneous circulation returned at approx. 22:47 • The initial CT scan in the emergency department showed signs of severe hypoxic brain injury • Mr Da Costa received care in Newham University Hospital until 21st June 2017. During his time in the ITU Mr Da Costa was on life support when following a brain stem examination life support was removed and he passed away • The post-mortem examinations confirmed that cause of death was hypoxic ischaemic encephalopathy, as a result of cardio-respiratory arrest and caused by a foreign body airway obstruction. No other significant traumatic injuries were found
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) The evidence at the Inquest revealed that not all police officers are up to date with mandatory Emergency Life Support training. In addition, the current system in place makes it difficult for supervisors to check whether members of their team have received mandatory training. I request that the working group, driven by Met training, review the attendance of officers at mandatory ELS training and review the systems in place for supervisors to monitor attendance. I request that in doing so they consider the concerns raised by Inspector BC in his evidence at the Inquest. (2) The evidence at the Inquest did not provide assurance that a safety officer had taken control of the restraint or that one officer was taking the lead in communicating with Mr Da Costa and/or monitoring his condition. In addition, the officers who gave evidence considered that the role of the safety officer mainly applied to restraint in a controlled custody setting. The MPS are requested to review the training provided to staff in relation to the role of the safety officer in a street setting and to consider whether a reminder of the importance of the safety officer role, in the street setting, should be issued to staff (by way of bulletin or otherwise). (3) The Inquest heard that it is well documented that members of the public may swallow plastic bags to evade arrest or conceal evidence. Placing plastic bags in the mouth raises a very high risk of choking. Police officers should be aware of these risks. The MPS are requested to review the training provided to police officers to ensure they are fully informed about the specific risks around the use of plastic bags and the associated risk of choking. (4) The evidence given at the Inquest hearing revealed a concern that the use of CS spray, when a person has something in their mouth, could increase the risk of a complete airway obstruction. The MPS is

	requested to review the guidance and procedures in place for officers, in relation to the use of CS spray where a person is believed to be holding items in their mouth. (5) The evidence at the Inquest revealed that agonal breaths were likely to have been missed. The officer provided the description of the breaths as looking like "yawning." The independent expert stated that these were, beyond reasonable doubt, agonal breaths. The MPS is requested to review the training to officers around the recognition of agonal breaths. Within the training, the MPS may wish to incorporate the helpful descriptions provided by the officer in this case. (6) Evidence was heard at the Inquest that errors were made in communicating information to the LAS. This was in part due to the noise levels within the communication's command centre for the London Borough of Newham. The MPS is requested to carry out an immediate review into the noise levels within the communication command centre and to take steps to reduce noise levels as far as possible. The longer term plans that the MPS have put in place to review their communications command centre is very much welcomed but it is considered that interim, proportionate measures should be explored. (7) The controller who was communicating with the LAS received information that Mr. Da Costa had stopped breathing. She did not use the correct procedure to update the LAS in relation to this life threatening deterioration. The MPS are requested to review the operation of the procedure for updating CADs and to take any necessary action to ensure that staff are fully aware of the correct procedure to be adopted.
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 **22 August 2019**. 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 [redacted] (father of the deceased); LAS and Mr Matthew Cole (Director of Public Health). 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	27/06/2019 Signature Miss N Persaud Senior Coroner **East London**