	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) [redacted], Director, Brittania Jinky Jersey Limited, Ainsdale House, Shore Road, Southport PR8 2PZ** **(2) [redacted], Operational Director, Brittania Hotels Group Limited, Halecroft, 253 Hale Road, Hale, Cheshire WA15 8RE**
1	**CORONER** I am Jacqueline Devonish, area coroner, for the coroner area of Suffolk
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 19 April 2021 I commenced an investigation into the death of Paul Steven Reynolds, aged 38. The investigation concluded at the end of the inquest on 10 May 2021 . The conclusion of the inquest was that Mr Reynolds died following an unlawful restraint by the neck and further in prone position at Pontins Pakefield in Lowestoft, Suffolk on 14 February 2017. The inquest concluded that Pontins security had unlawfully restrained Mr Reynolds by the neck and then placed him in an unlawful prone restraint without conducting effective monitoring of his breathing. The medical cause of death was concluded to be 'Complications Arising from Restraint of an Intoxicated Obese Individual in a Prone Position, with Compression of the Neck and Potential Obstruction of the Upper Airways'.
4	**CIRCUMSTANCES OF THE DEATH** On 11 February 2017 Paul Reynolds attended the Pontins holiday leisure park in Lowestoft. During the evening of the 14th there was an incident between guests in the communal area of the leisure park. As a result of this incident Mr Reynolds was restrained by security and other staff until police arrived. He was grabbed from behind in a bear hug, taken to his knees in a neck hold and placed on the ground in a prone restraint. During the 11 minute prone restraint, captured on CCTV, Mr Reynolds did not appear to make any movement, although the Pontins staff involved in the restraint gave evidence that he had be wriggling, resisting the restraint, talking and later murmuring. He had also apologised and asked to be let up. This information had not been shared with the police. The police arrived just after Mr Reynolds was heard snoring, and presumed to be asleep. The effectiveness of the monitoring by Pontins staff was deemed to be unsatisfactory as Mr Reynolds was in fact unconscious and no member of staff had recognised this. A guest had identified to Pontins restraint staff that Mr Reynolds was at risk of breathing difficulties, but this was ignored. The police arrived and arrested Mr Reynolds by applying handcuffs and eventually placing him in the police van. On route to the Police Investigation Centre the police stopped the vehicle when they noticed Mr Reynolds

	appearing unwell. They took Mr Reynolds out of the van and performed CPR until the paramedics arrived. Mr Reynolds was conveyed to James Paget University Hospital where he died with hypoxic brain injury due to a lack of oxygen to the brain, on 16 February 2017. Experts attending the inquest gave evidence that Mr Reynolds may have fallen unconscious within seconds of the neck hold. This was exacerbated by moving him into a prone restraint with his legs tucked up to his buttocks and failing to relax the constraint and get him back to his feet or into recovery position.
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 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) The Physical Intervention Policy August 2016 places the onus on staff to seek additional training. (2) Pontins does not undertake any internal training or employ external trainers for security staff. (3) Unbadged staff are allowed to participate in restraint (4) Ground restraint remains in the PI policy as an appropriate method to contain an incident even though this is not taught in SIA accredited courses. (5) At no point during the prone restraint was Mr Reynolds placed in the recovery position. Neither did any member of staff appear to seriously consider the potential for positional asphyxia by closely or effectively monitoring Mr Reynolds breathing. (6) There appeared to be no clarity in the Policy about who should take charge of an incident or what the responsibilities are for security staff and Managers. (7) There appeared to be a lack accurate information and clarity around what information should be shared with the police about the incident. (8) There was no documented evidence of the induction or any other training for staff.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 July 2021. 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], and [redacted]. I have also sent it to [redacted], SIA 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 other 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.
9	**11 May 2021** *Jacqueline Devonish*