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: 1. The Home Office
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 2/8/2018 an investigation was opened into the death of **Mustafa Dawood Bakhat ABDELKARIM (Mustafa Dawood)** The investigation concluded at the end of the inquest on: **5/11/21** when a jury determined the following: <u>The conclusion of the inquest was recorded as a narrative in the following terms</u> On 30th June 2018 Mustafa Dawood was working at the Shaftesbury Hand Car Wash on Albany Street in Newport. At 10:08 Immigration Officers attended to undertake an enforcement visit. Mustafa ran away from the Officer in Charge and was pursued into a warehouse. Mustafa climbed on shelving and then though a metal door eventually accessing the roof of the building. Mustafa ran across the roof and fell through some plastic roofing material into the room below. Mustafa sustained severe fatal head injuries and was conveyed to hospital. Despite the efforts of the officers at the scene to resuscitate Mustafa and the clinical teams, Mustafa died from his injuries at the University Hospital of Wales in Cardiff at 14:45 on 30th June 2018. 1. During the pursuit Mustafa started to climb and it was determined that the pursuit should be abandoned. Nonetheless officers remained relatively close and did not withdraw to a distance away from him. We consider that maintaining this proximity contributed to Mustafa's death. 2. We consider that the decision to abandon the pursuit was not effectively communicated to all officers and that could have been a contributing factor to Mustafa's death.

	3. The decision for the officer to keep his baton in a racked position could have contributed to Mustafa's death 4. The officers were not appropriately trained in pursuit procedures, and this could have contributed to Mustafa's death. The medical cause of death was: **1a) Traumatic subarachnoid haemorrhage.**
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mustafa's Dawood's death are set out in the narrative provided by the jury and need no further explanation
5	**CORONER'S CONCERNS** During the course of the inquest, 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. Training in Pursuit for Immigration Officers. The jury heard that during the induction process all Immigration Officers are introduced to the Pursuit Policy. However none of the Officers had undergone training in pursuit or in how to make decisions in those stressful situations. The jury determined that the lack of training could have contributed to Mustafa Dawood's death as has been reflected in their conclusion.
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. I should be grateful if the following information be provided to me: 1. Confirm whether any steps have or will be taken to provide practical training to Immigration Officers in pursuit situations.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **14/01/2022,** 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 Mustafa Dawood Bakhat ABDELKARIM** 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 19/11/21** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**