

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. The Chief Constable of the North Wales Constabulary2. The Security Industry Authority3. The Secretary of State for the Home Department
1	<p>CORONER</p> <p>I am Karon Monaghan QC, Assistant Coroner, for the Coroner area of North West Wales</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>An investigation into the death of Mr Hywel LLewelyn Hughes (date of birth 11 January 1971) concluded at the end of the Inquest on 26 June 2014. The conclusion of the inquest was that: (i) the medical cause of death was traumatic asphyxia; (ii) the actions of police officers attached to the North Wales police force on coming upon Mr Hughes were not appropriate and (iii) it is more probable than not that the actions of the police officers more than minimally contributed to the death of Mr Hughes.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 2 May 2003, Mr Hywel LLewelyn Hughes was forcibly removed from Joops nightclub, Bangor, by employed members of the door staff at about 23.10. After a struggle with two members of the door staff between approximately 23.10 and 23.18, he was restrained by them in a face down position on the road. During the period of this restraint, he was unable to breathe and suffered injuries which ultimately caused his death. Two police officers attached to the North Wales police force arrived on the scene at approximately 23.18 and transported Mr Hughes to Caernarfon police station from where he was conveyed to Ysbyty Gwynedd, arriving at approximately 00.30. Mr Hughes was declared</p>

deceased at Ysbyty Gwynedd at 19.30 hours on 3 May 2003.

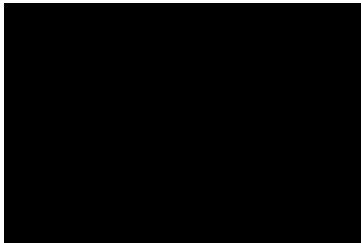
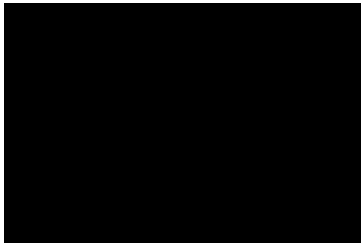
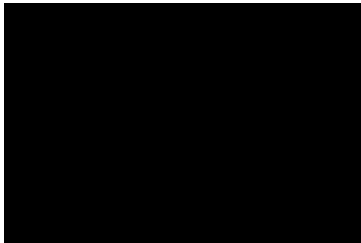
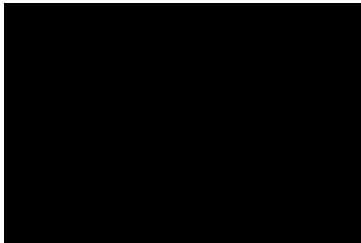
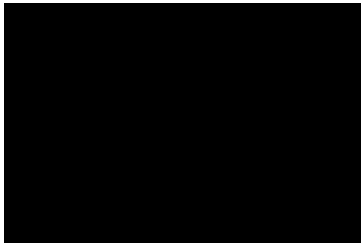
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CORONER'S CONCERNS

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 training on positional asphyxia presently provided to police officers by the North Wales Police Force does not include guidance on the significance of 'snoring' and in particular that it is not inconsistent with deep unconsciousness and obstruction to breathing.
- (2) The design of the 'bubble cars' in existence at the time of Mr Hughes' death and apparently still in use pending their phasing out, is such that the condition of a detainee held in the rear of the vehicle may not be easily monitored (because of the presence of a Perspex screen that may affect the ability to see and hear a detainee).
- (3) The design of the new 'bubble cars' may impede an officer's ability to hear a detainee (and thus identify irregularities or difficulties in breathing) because of the presence of a (albeit smaller) Perspex screen.
- (4) Twenty deaths apparently related to and/or following restraint by door supervisors have occurred since the introduction in 2004 of (rolled out) compulsory licensing of door supervisors, by the Security Industry Authority ("SIA") (established by the Private Security Act 2001, in 2003). There have been four restraint related deaths involving twelve door supervisors (all of whom have been charged with either murder or manslaughter) since April 2013, that is, following the introduction (in February 2013) of mandatory training as a condition for the awarding (or renewal) of a licence to work as a door supervisor anywhere in the UK.
- (5) The SIA does not undertake any review or inquiry into those deaths indicated by Inquest or criminal findings to be related to restraint by door supervisors to determine whether there are any lessons to be learnt in so far as their licensing or other responsibilities are concerned.
- (6) The SIA's standards of conduct, training and levels of supervision issued pursuant to their statutory responsibilities under section 1(2)(e) of the 2001 Act, namely the "Specification for Learning and Qualifications for Door Supervisors" (Feb 2010) and the "Specifications for Learning and Qualifications for Physical Intervention Skills" (Aug 2010), do not include a requirement for training or knowledge on the dangers inherent in restraint, specific modes of restraint, positional asphyxia or traumatic asphyxia.
- (7) The SIA does not audit the training provided to door supervisors by

	<p>accredited training providers, particularly on issues of restraint and asphyxia (traumatic and positional).</p> <p>(8) The mandatory training that door supervisors are required to undertake as a condition of the award of a licence by the SIA does not integrate training on asphyxia into the training on restraint (it is addressed by a limited and discrete element).</p> <p>(9) The licensing requirements for door supervisors do not include a requirement for a first aid qualification.</p> <p>(10) It is not clear that all persons presently working as door supervisors have yet undertaken physical intervention training (it appears that those who already have a licence will only be required to undertake 'top training' when they seek renewal of a licence).</p> <p>(11) There have already been four 'Rule 43' reports to the SIA by Coroners concerning the training of door supervisors on restraint and asphyxia.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 August 2014. I, the Assistant Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none"> 1.  2.  3.  4.  5.  <p>I have also sent it to HM Coroner for North West Wales and to the British Security Industry Association who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted</p>

	<p>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.</p>
9	<p>2 July 2014</p> <p>..... Karon Monaghan QC Assistant Coroner</p>