REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** **SIA** **Health and Safety Executive**
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West 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.
3	**INVESTIGATION** On the 15th day of September 2011 I opened an investigation touching the death of Michael Roger Stuart Lawrence, who died aged 35 years on the 8th September 2011 in ITU at St Thomas's Hospital. The inquest was concluded on the 27th Day of October 2015 at Westminster Coroner's Court, sitting at the Royal Courts of Justice. The medical cause of death was recorded as: 1(a) *Hypoxic- Ischaemic Brain Damage* *(b) Cardiac Arrest occurring in association with Prone Restraint and Struggling and Underlying Myocardial Fibrosis.* How, when and where and in what circumstances the deceased came by his death: *On 01/09/2011, Mr Lawrence attended O'Neil's Bar, Wardour Street, W1. At around 21:45 he entered the stage area, refused to move and so Door Supervisors were called. He again refused to leave, reacted violently and was restrained. He was carried to the exit, soon after which he was no longer resisting, however restraint continued.* Conclusion of the Coroner as to the death: *He suffered a cardiac arrest due to a combination of restraint, struggle and underlying heart damage, shortly after 22:11. This was not recognised nor was appropriate help sought for his condition until just as the police arrived at approximately 22:26 hours. He was then resuscitated at the scene by police and the LAS and a return of circulation was achieved. Despite this, he died at St Thomas's Hospital as a result of brain damage sustained at the time of the arrest.* *Even if he had been resuscitated at the time of the arrest, his death is highly unlikely to have been averted.*

4	**CIRCUMSTANCES OF THE DEATH** Following evidence taken at the inquest I was satisfied that the door supervisors, despite being licensed and trained to SIA standards were not appropriately conversant with the risks of positional asphyxia to a person restrained prone. I understand that there is a rolling programme to address any shortfalls in knowledge in this area, as licences of Door Supervisors come up for renewal. There was and is no requirement for door supervisors to be trained in anything but very basic first aid and particularly not in CPR. Once Michael was brought to the exit it was clear that he was under control and yet prone restraint continued. The deterioration in his condition went unrecognised for some time and no medical aid was sought or CPR started for more than 10 minutes. I was satisfied that this was due to a relative lack of training and practical experience of the Door Supervisors. Whilst a trained first aider was present on the premises he was elsewhere at the material time and his help was not sought when Michael became unwell and arrested. Much of the restraint at the exit was out of clear view of CCTV. Evidence was taken from the SIA and experts in restraint, as well as multiple witnesses. I understood from the evidence that the SIA training still does not address CPR although the training specification contains a long and detailed list of potential medical concerns that Door Supervisors should have regard to when restraining a person, including matters such as signs of head injury or other neurological condition, that suggests an expectation that the Door Supervisors should have the ability to recognise complex conditions with no medical training. The training specifications specify that Door Supervisors call for help from the resident first aider or LAS as required, which must be correct, but without any requirement that the Door Supervisors be trained in recognising difficulties in airway, breathing and circulation that they would receive as part of CPR training. It is my understanding from the expert evidence that in police restraint it is now recommended that one person is assigned to monitor the welfare of the person being restrained and that all officers, as first responders, are trained in CPR.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – (1) That Door Supervisors, although they are potential "first responders", are not required to be trained in CPR and as such may not be able nor be trained to recognise difficulties in airway, breathing or circulation. As such, and as occurred in this case, the necessity for CPR to be administered is not recognised promptly, increasing the chance that the life of person who arrests may be lost. (2) That restraint may occur out of direct CCTV sight, so that opportunities for lessons to be learned are lost, despite most venues where Door Supervisors are employed being likely to have CCTV. Perhaps consideration should be given to venues designating a "restraint area", which has been identified by Health and Safety considerations as an appropriate area and is fully CCTV covered. (3) That when restraint is carried out by door supervisors, the designated first aider, trained in CPR, for the venue should be present to monitor the welfare of the person being restrained and so be available to give medical assistance and or call for medical assistance to the restrained person or others involved should such be required.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to identify the concerns relevant to their own areas of responsibility.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th December 2015. 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 :  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	**3rd November 2015.** **Dr Fiona Wilcox,** **HM Senior Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London** **SW1P 2ED**