REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Director General National Crime Agency Bramshill Hook Hampshire RG27 0JW

1 CORONER

I am André Rebello, Senior Coroner, for the area of Liverpool

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 13th March 2012, I commenced an investigation into the death of **Antony HUGHES**, Aged **27**. The investigation concluded at the end of the inquest on 9th December 2013.

The conclusion of the inquest was

la Cocaine Toxicity with Excited Delirium

Mr Hughes died from a drug related death

4 CIRCUMSTANCES OF THE DEATH

On Sunday 26th February 2012 Antony Hughes went with friends to London on the occasion of Liverpool F.C. playing in the 2012 League Cup final. He returned to Liverpool in the early hours of Tuesday 28th February 2012. During the trip he consumed large quantities of alcohol, cocaine and non-prescribed valium. The effects of the substances consumed had an adverse effect on his mental health which was witnessed by him stating that people were after him. During the early evening of the 28th February 2012 he alighted from a taxi in Liverpool Road Huyton and was witnessed running in and out of the traffic on East Prescot Road. This behaviour alarmed members of the public who contacted the emergency services. Mr Hughes was unwell, paranoid and anxious and he entered the garden on the East Prescot Road, kicking at the door causing alarm to the occupants. Police officers attended and approached Mr Hughes. He was apprehended and restrained by police officers to prevent harm to himself and to protect the public. He was handcuffed behind his back initially face down. This was a fast moving dynamic incident involving a very agitated and unwell man. Despite the best efforts by the police officers to move him onto his side to an approximate recovery position, Mr Hughes was making involuntarily movements making it difficult to hold him in one position. An ambulance team arrived and assisted by the police put him back into the recovery position to facilitate examination. Mr Hughes was moved to the ambulance where an attempt was made to gain intravenous access. During this attempt Mr Hughes

suffered an arrest. Cardio-respiratory resuscitation was commenced and Mr Hughes was appropriately rushed to the Royal Liverpool University Hospital Emergency department where advanced life support was available. In spite continuation of resuscitation efforts he was certified as having died at 20.53. Post mortem analysis of blood revealed Cocaine at 1.5 milligrams per litre, Benzoylecgonine greater than 5 milligrams per litre, Diazepam at 0.060 milligrams per litre and desmethyldiazapam at 0.015 Milligrams per litre. There was no evidence of asphyxia and it is more likely than not Anthony Hughes was experiencing excited delirium as a result of cocaine use. His paranoid and agitated stressful state is more likely than not to have elevated catecholamine levels which are likely to have exacerbated the cardio-toxic affects of cocaine until exhaustion/containment calmed Mr Hughes down.

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. —

During the course of this inquest, though there is no criticism of the action of police officers (or paramedics), it was apparent that police officers were unaware of the term excited delirium at the time of the incident. Coincidentally it was found that the officers acted in an appropriate manner given the presentation before them. However, in different circumstances training with regard to awareness of excited delirium might make a difference. I have now received evidence from Merseyside Police from DCI

that there was implemented via an online training package (Breeze Package) a new Personal Safety Training package which includes awareness slides on excited delirium. All officers must present a knowledge check certificate when attending annual personal safety training. This package was based upon a similar package already available to South Wales Police Officers. It is appreciated that Chief Constables independently run their own forces to the requirements of the police Commissioner's however I would be grateful to hear whether this awareness training in excited delirium is now standard across England and Wales Constabularies.

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 3rd February 2014. 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.

COPIES and PUBLICATION

8

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

Mr Hughes' family Merseyside Police North West Ambulance Service and
The Coroners' Society of England and Wales

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.

André Rebello
Senior Coroner for the
City of Liverpool

9th December 2013