ANNEX A

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:** **1. Mr John Adler, The Chief Executive, Leicester University Hospitals NHS Trust**
1	**CORONER** I am Martin Gotheridge, Assistant Coroner, for the coroner area of Leicester City and South Leicestershire
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 23 August 2012 I commenced an investigation into the death of Rafal Delezuch. The investigation concluded at the end of the inquest on 23rd January 2015. The conclusion of the inquest was that Mr. Delezuch died from Amphetamine induced delirium in association with prolonged struggle.
4	**CIRCUMSTANCES OF THE DEATH** Early in the morning, from about 06.00 onward, the patient was seen to have been acting in a bizarre manner in the Highfields area of Leicester, including knocking on doors and exhibiting symptoms of paranoia. The police were called. The patient voluntarily got into the back seat of a police car, but then became agitated and the officer attempted (without success) to subdue him by use of his captor spray. 3 other officers eventually attended the scene and the patient was restrained and detained under S.136 M.H.A. and taken to L.R.I. in the back of a police van.
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. – (1) Although the Trust had a policy for Restraint for dealing with aggressive patients, it became clear from the witnesses from the Trust who gave evidence, that many of the staff in the Emergency Department (including the Senior Registrar in charge of the case) were either wholly unaware of the Policy or unaware of, and had no training in, the application of the policy.

	(2) It also became clear that the Senior Registrar was not familiar with the dangers of prolonged restraint of a patient in the prone (face-down) position (3) When it was decided that the patient was in need of rapid tranquilisation then: a) A supply of Lorazapam from the manufacturer was apparently not available and no policy appeared to have been devised for the priority use of any limited supply of Lorazapam within the Trust and there was no awareness amongst the clinicians of the availability of alternative medications b)The possibility of a licensed product or of the alternative of Promethazine does not appear to have been pursued. The importance of quick-acting drugs, for the purpose of rapid tranquilisation did not appear to have been fully appreciated. (4) Although the NICE guidelines were printed off and consulted in dealing with the rapid tranquilisation, a reference there to the fact that diazepam was "not recommended" was overlooked.
	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 by way of appropriate policies, and above all ensuring training so that all members of the clinical staff are aware of those policies. Also a review of medecines that should be maintained in ED for use when Rapid tranquilisation is necessary may help to avoid future deaths.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th March 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 Bhatt Murphy (solicitors for the family) and to Weightmans (solicitors for the Police) 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	**[DATE] 27th March 2015** Martin Gotheridge