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.** The Rt Hon Matt Hancock MP - Secretary of State for Health & Social Care **2.** Kit Malthouse MP - Minister of State for Policing and the Fire Service **3.** [redacted] – Chair of the National Police Chief's Council **4.** [redacted] – Chair of the College of Policing **5.** [redacted] - National Ambulance Service Medical Directors **6.** [redacted] – Chair of the Association of Ambulance Chief Executives **7.** James Vaughan - Chief Constable of Dorset Police **8.** [redacted] – Chief Executive of St John Ambulance, provide of the First Aid Manual
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 12th April 2017, an investigation was commenced into the death of Douglas Paul Oak, born on the 4th February 1982. The investigation concluded at the end of the Inquest before a jury on the 22nd October 2019. The Medical Cause of Death was: 1a Combined effects of acute on chronic cocaine intoxication, excitement, exertion, restraint and hyperthermia with terminal bronchopneumonia The conclusion of the Inquest was "Doug came to his death by using cocaine which triggered an onset of paranoia, high levels of adrenaline and sustained

	physical exertion. Recognised as a severe case of ABD which resulted in cardiac arrest and multiple organ failure."
4	**CIRCUMSTANCES OF THE DEATH** On the 11th April 2017 Mr Oak was seen running around the streets of the Branksome area of Poole displaying erratic and frantic behaviour. Dorset Police officers were called to the area and restrained Doug for his own safety and the safety of others. He presented with symptoms of Acute Behavioural Disturbance (ABD) which the Police officers quickly identified. The Police at the scene requested the attendance of an ambulance "on the hurry up" at 16.23 via their radio to the Dorset Police control room. At the time there had been no training given on ABD to the those working in the Police control room, although 2 males working there on that day were also front-line Police officers and had received the training due to that role. A request was made to South West Ambulance Service Trust (SWAST) for an ambulance by the Police control room. The call handler in the Ambulance control room were unaware of ABD and had not been provided with any training. The call handler marked the problem reported as a drug overdose and the ambulance was given a Category 3 prioritisation. Prior to the attendance of the ambulance, Doug went into cardiac arrest at 17.11. The Police officers at the scene began CPR straight away. When the Ambulance control room were informed of the Cardiac Arrest, the ambulance categorisation was upgrade to Category 1 and paramedics arrived at the scene at 17.15. The paramedics continued with life support and whilst on route to Poole Hospital Doug regained spontaneous circulation. Sadly, his condition deteriorated at Poole Hospital and he died the following day.
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. During the iInquest evidence was heard that: i. Acute Behavioural Disturbance (ABD) is a term used to describe the presentation of a spectrum of behaviours, signs and symptoms which create an immediate risk to life, especially at the severe end of the spectrum. It has previously been known as Acute Behavioural Disorder and prior to that Excited Delirium. ii. The signs and symptoms of ABD include: • Excessive strength and exertion • Erratic behaviour • Hyperthermia – high temperature • Sweating • Fast pulse

- Fast breathing
- Acute psychosis with paranoia

iii. The cause of these symptoms and ABD is still being understood but it is most commonly associated with drug use, mainly cocaine and amphetamine, although can be due to other causes including serious mental illness, low blood sugar or a head injury.

iv. There are different levels of ABD, which were described at the Inquest as mild, moderate and severe. Those exhibiting severe symptoms present with the greatest risk of death as there is a risk of cardiac arrest, or death due to organ failure if the symptoms are not controlled. During the Inquest, evidence was given that there is a need to calm the person down in order to treat the underlying cause for the symptoms. This is very difficult, especially with those who present with severe symptoms. The aim is to get the patient to hospital as soon as possible for treatment but this is difficult with a patient who is often violent and struggling against those trying to help.

v. Patients suffering with ABD were described during the Inquest as the most difficult patients to deal with as they will not understand reason or comply with requests. Further they often resist help due to their paranoia. It was explained that the longer the symptoms persist the greater the risk of death.

vi. Evidence was given by [redacted], an expert in ABD, that there are 4 options available to calm a person with symptoms consistent with ABD to enable treatment to be given for the underlying cause, namely:

- De-escalation, eg. talking therapies
- Containment
- Restraint
- Chemical Sedation

It was explained at the Inquest that the first of these, de-escalation is very difficult in those suffering severe symptoms due to their paranoia and erratic behaviour. Containment is also not the easiest way to calm a person down, especially as these people often present with ABD in a public place. Inevitably restraint is used to ensure safety to the patient, those helping or attending upon them and the wider public. With restraint comes risks, as the longer the restraint is used, the higher the risk of death.

Chemical sedation or tranquilisation is often the best way to calm a person suffering with ABD to be able to treat the underlying cause. This is also the best way to transport a patient to hospital in an ambulance. There is however, no national guidance for Ambulance Service Trusts regarding the use of sedation in ABD patients. Sedation assists in enabling a patient to get to hospital

to receive treatment. Without this there are dangers in transporting a volatile patient in an Ambulance or Police vehicle. In the event however, that sedation is not available consideration needs to be given to the best way to get the patient to hospital. Again, there is no national guidance on this.

[redacted], an Advanced Paramedic Practitioner, who provided an expert opinion at the Inquest, in relation to the paramedic care, explained in his report for the Inquest that "rapid chemical tranquilisation is not routinely available to paramedics in the UK" He explained that "paramedics are not prescribers and as such agents which do not form part of routine paramedic drugs needs to be given under a patient group directive".

Evidence was given that only Critical Care or Advanced Practitioner Paramedics can give sedation, and this therefore limits the availability of resources for sedation.

[redacted] explained at the Inquest that in London there is a memorandum of understanding in place regarding the management of ABD and I understand there is a similar policy in the North West of England. He explained that where there is no sedation policy in place, people's lives are being put at risk. There is therefore a need for national guidance to Ambulance Service Trusts on the management of patients with ABD, specifically to deal with sedation. [redacted] explained that he feels there should be a national protocol that allows individual Ambulance Service Trusts to choose the type of sedation drug to use.

Those giving evidence on behalf of SWAST explained that they would welcome national guidance.

vii. There is a lack of awareness generally with ABD. [redacted] also explained that there needs to be a better awareness of ABD and there is no reference to ABD within the First Aid Manual, which I understand is used in first aid training. He explained if ABD was included within the manual, everyone trained in First Aid would be made aware of the condition and the symptoms which would ensure there is a better general awareness and hopefully management and treatment. This could therefore prevent future deaths.

viii. Evidence was given that the College of Policing issued a training package at the end of 2016 to all Police Forces on ABD. The purpose of this was to train all front-line officers. There was no requirement to role this training package out to control room staff and there is still no such requirement.

As at 11th April 2017 those working solely in the Dorset Police control room had not been trained in ABD. They have since been

trained on the condition.

[redacted] has assisted in amending the new ABD training package that was issued by the College of Policing in the summer of 2019. At that time, he recommended that the control room staff also be given training on ABD but there is still no national requirement to do so. [redacted] explained it would be beneficial to have a training package specifically aimed at control room staff.

A number of Police witnesses at the Inquest explained that they thought training with role play scenarios would be helpful and beneficial. Evidence was given by one of the Police trainers, [redacted], that people learn in different ways. Some learn by reading, some by watching, for example videos and some by role play and so the best form of training package for any topic would be to have as many types of learning as you can. He explained to have all types would be the "pinnacle of training" and that scenario based exercises are probably the best. He also explained that it would be of benefit to remind officers of ABD and its consequences regularly and that he would consider implementing an annual reminder in the Police Officer personal safety training.

ix. Evidence was given that at the time of Doug's death, and to date, there is no national guidance on the training of Ambulance staff, both paramedics and control room staff on ABD. Those who were involved in Doug's care on the 11th April had no knowledge of ABD. SWAST have now trained all their staff, even though there is no requirement to do so.

Those giving evidence on behalf of SWAST explained that they would welcome national guidance.

x. In relation to the Ambulance categorisation of calls where a person is suspected as suffering with ABD, there is no national guidance on what prioritisation category such a call should be given. Evidence was given by [redacted] that in London all calls relating to ABD, or their symptoms, are given a Category 1 status, the highest possible status. Since Doug's death, SWAST have adopted a process that where ABD is suspected or a caller provides details of symptoms consistent with ABD, the call is automatically graded as a Category 2 prioritisation and would be referred to a clinician to review to ascertain whether it should receive an alternative categorisation priority.

There is no uniformity across England and Wales and therefore the care and support received depends upon where a patient resides. It is a postcode lottery. This therefore requires national guidance to be adopted to ensure consistent care across England and Wales. Further ABD, especially a severe presentation of symptoms, carries a risk of cardiac arrest and an imminent risk of death. Evidence was given by [redacted] that cases of

suspected moderate to severe ABD should therefore be treated as Category 1 in Ambulance triage prioritisation.

Those giving evidence on behalf of SWAST explained that they would welcome national guidance.

xi. There is currently no joint national guidance between the Police and Ambulance Services on ABD and the management of it. Some areas, such as London, have local memorandums of understanding but evidence was given that it would be beneficial to have national joint guidance to ensure the best care is provided to all patients. In most cases, The Police and the Paramedics are jointly required to treat patients with ABD due to the nature of the presentation and need for restraint or containment, alongside the significant risk to life. They should therefore adopt a joint approach of how to manage those suffering with the symptoms of ABD.

xii. [redacted], a Consultant in Anaesthetics and Critical Care Medicine at Dorset County Hospital, who is also a critical care Doctor on the Dorset and Somerset Air Ambulance, was the Chief Medical Officer for Clinical Governance and tactical medical support for Dorset Police between 2009 and 2017. He explained that Dorset Police was one of the first Police Forces to establish a Clinical Governance Board and that many forces across the country still do not have a Clinical Governance Board as part of their working practice. He explained the benefit of the Board and the input from medical professionals which offer officers the opportunity to seek advice on medical issues easily. He added that the Board can look at first aid issues and training within the Police Force. [redacted] gave evidence that in Dorset the Board oversees the first aid and medical care within the Police and provides a platform of dealing with first aid issues within Dorset Police.

[redacted] explained that from his experience of working in pre-hospital care with the air ambulance and also with the Dorset Police Force, a joint national memorandum of understanding regarding the treatment of ABD patients would be beneficial and there needs to be wider circulation on how to manage ABD.

xiii. The officers at the scene treating Doug requested an ambulance at 16.23 as they identified that Doug was displaying symptoms of ABD and were aware that this was a medical emergency. The Police control room made all contact with the Ambulance control room. They initially tried to contact them via a designated phone line that went unanswered for 11 minutes and eventually spoke to the Ambulance control room at 16.34 when they dialled 999 and the Ambulance call handler answered the call within 2 seconds.

Evidence was given by [redacted], the Executive Medical Director of SWAST that he would expect Police Officers at an incident involving a medical emergency to call 999 rather than request an ambulance through the Police control room. This is due to the fact that more accurate information can be obtained by the Ambulance Service about a patient from the person with them, rather than from a 3rd party not present at the scene. [redacted] also explained that in the SWAST control room 999 calls are answered as a priority over the designated line between the Police and Ambulance control rooms.

Evidence was however given by a number of Police Officers that they are trained to request the ambulance through the Police control room.

There is a policy in place within Dorset Police regarding the Police requesting Ambulance support, but this appears unclear and the evidence of [redacted] was that there would be benefit in redrafting this.

xiv. The Police Officers at the scene attending upon Doug requested an ambulance "on the hurry up". They gave evidence at the Inquest that this meant 'immediately' and a 'grade one' call. The Police control room dispatcher buddy repeated the request to the SWAST call handler that an ambulance was requested 'on the hurry up'. He explained during evidence that he believed in saying this the SWAST call handler would understand an ambulance was needed on the highest priority, namely a Category 1 response. The call handler explained in her evidence however, that she took this to mean an emergency ambulance but that would include any of the top 3 priorities, namely Category 1-3.

Evidence was given that "on the hurry up" is police jargon and training officers gave evidence that the use of such jargon is discouraged, however evidence was given by witnesses that this language is still regularly used within the Police control room.

The use of different language in different control rooms can be confusing and it would be beneficial for staff to be trained on the different processes and language used in different control rooms, so they have a better understanding of each other's roles and communications made. This would avoid confusion in the future which could lead to a future death.

Evidence was also given that cross working between the Emergency Services would be beneficial, for example it would be of benefit if a SWAST Clinician was posted in the Dorset Police control room.

xv. Evidence was given that a number of reports have been issued in the past by Coroners to prevent future deaths in cases where

ABD has been involved in a death. Those reports refer to concerns on training and management of those suffering with ABD. It would appear that although changes have occurred locally in some areas, nothing has been done on a national scale. These concerns need to be raised and addressed on a national basis in order to ensure there is awareness of the symptoms of ABD and a consistent and effective management process in place to reduce the risk of future deaths occurring.

2. I have concerns with regard to the following:

i. There is a lack of awareness generally regarding ABD and I would request consideration is given to the inclusion of the signs, symptoms and management of ABD within the First Aid Manual so that all those trained in first aid are able to deal with a patient presenting with ABD.

ii. There is no joint national guidance on the management of ABD by those who work for the Police and Ambulance Services, both on the front-line and in the control rooms. They are the people most likely to encounter those suffering with ABD and in most cases work together in the management of these patients. Accordingly, I request consideration is given to providing joint national guidance on the management of ABD patients by the Police and Ambulance Services to include:

- the provision of chemical sedation in pre-hospital care
- the training of all paramedics in administering chemical sedation
- the categorisation of Emergency Service calls relating to ABD
- the transfer of an ABD patient to hospital

iii. I believe it is likely there are persons working within Ambulance Service Trusts and Police Forces, whether it be on the front line or in the control room who are not aware of ABD and the serious risk to life it presents. I therefore request that consideration is given to ensuring all those working on the front line, or in control rooms in Ambulance Service Trusts and Police Forces in England and Wales are trained in ABD.

iv. I also have concerns in relation to the frequency of the delivery of the training referred to in (iii) and I therefore request consideration be given to that training being delivered regularly, at least on an annual basis and with a variety of training techniques, including simulation and role play scenarios.

v. Given that the Police and Ambulance Services work very closely in treating and managing a patient with ABD, and other patients who present with life threatening conditions, it is important that they understand each other. It was clear from this Inquest that there is different terminology used by the different services, the meaning of which is not understood by the other Emergency Services. An example of this was the use of the phrase 'on the

hurry up'. Although the confusion regarding this terminology was not found to be causative or contributory to Doug's death, it could be in respect of a future death. I therefore request that consideration is given to the joint national training packages for all Emergency Services, namely the Police Service, Ambulance Service and the Fire Service on the workings within each control room and around the language used in the control rooms.

vi. Extending this point further, evidence was given that there would be benefit in cross working within the emergency services, so for example an Ambulance Clinician working within the Police control room to provide advice. I would therefore request that consideration is given on a national level to cross working within the emergency services.

vii. In relation to the training package that has been provided by the College of Policing regarding ABD, althoug [redacted] has recommended this could be rolled out to control room staff, the package is tailored for front-line staff. I would therefore request consideration is given to a specific training package on ABD being designed and rolled out to those working in the control room environment by the College of Policing together with the Association of Ambulance Chief Executives or the National Ambulance Service Medical Directors.

viii. Evidence was given that Dorset Police have established a Clinical Governance Board which helps to create an awareness of, and improvement in, medical care provided by those working in the Police Service. This is not something adopted by all Police Forces in England and Wales and I therefore request that consideration is given to setting up a Clinical Governance Board in every Police Force in England and Wales.

ix. It was clear from the evidence that there appears to be confusion of when Dorset Police Officers should call 999 directly and when they should request assistance through the Police control room. I would request that there is consideration of the redrafting of the current "Police Requesting Ambulance Support" policy within Dorset Police and specifically when Police Officers should dial 999. In addition, I would request consideration of training be provided by Dorset Police to all Police Officers regarding the use of dialling 999 when contacting other Emergency Services. In doing this I would ask that consideration is given to liaising with the other local emergency services regarding their expectations, especially SWAST.

x. Given the number of relatively recent deaths associated with ABD that have resulted in reports such as this being issued by my fellow Coroners, and the fact that all of the above points I have raised still create a risk of future deaths due to the lack of national guidance and policy, I would request that the concerns I have raised in this report are given immediate attention. I further

	request urgency is taken in responding to this report and taking any action deemed appropriate. This is a sentiment very much echoed by Doug's family, who are very keen to assist the authorities following their tragic loss to prevent any future deaths occurring in similar circumstances to Doug's death. xi. In addition, I would request that those in receipt of this report make the individual Police Forces and Ambulance Services within England and Wales aware of the risks surrounding ABD as a matter of urgency and consider forwarding this report to all Chief Constables and Chief Executives of the Ambulance Services in England and Wales.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 19th December 2019. 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: (1) Irwin Mitchell Solicitors of on behalf of Doug's family (2) The Chief Constable of Dorset Police, Dorset Police, Force Headquarters, Winfrith, Dorchester, Dorset, DT2 8DZ (3) Bevan Brittan LLP, Kings Orchard, 1 Queen St, Bristol BS2 0HQ on behalf of the South West Ambulance Service NHS Trust and Poole Hospital NHS Foundation Trust (4) The Independent Office of Police Conduct (5) NHS Digital I have also sent a copy of my report to the following people who I believe have a sufficient interest in the contents of it: (1) The Rt Hon Dame Elish Angiolini DBE QC (2) Professor [redacted], Chair of the Faculty of Pre-Hospital Care, The Royal College of Surgeons of Edinburgh

	(3) College of Paramedics (4) [redacted], Chair of the Joint Royal Colleges Ambulance Liaison Committee (5) [redacted] (6) [redacted] 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	**Dated** **24rd October 2019**	**Signed**  **Rachael C Griffin**