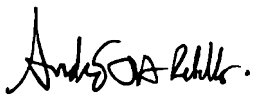
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 National Police Chiefs' Council** Chair - [redacted] 1st Floor, 10 Victoria Street London SW1H 0NN [redacted]
1	**CORONER** I am Andre REBELLO, Senior Coroner for the coroner area of Liverpool and Wirral
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 30 August 2017 I commenced an investigation into the death of Gary WILLIAMS aged 56. The investigation concluded at the end of the inquest held from 8th to the 25 November 2021. The verbatim conclusion of the Jury at the inquest from was that:* *"Based on the medical evidence we find that Mr Gary Williams acute behavioural disturbance in the early hours of 18th July 2017 was a result of an episode of Ictal Automatism due to temporal lobe epilepsy.* *Based on the evidence given, we heard that the furniture had been rearranged in the garden and a trail of blood was left. We find that Gary had been injured prior to the police arrival at Bardon Close.* *We find that the householder of [redacted] was reasonable in calling the police to the incident happening at her front door about 3 am on the 18th of July 2017. We find that the householder was alerted to knocking on her front door at 3 am, she opened the door after applying the security chain and was confronted by her neighbour Gary Williams, She noted he was completely naked and was trying to gain entry. Gary then tried to remove the security chain, and was saying "we need to be together". Over concerned for safety she shut the door. She considered getting Gary a dressing gown given concerns of Gary's well-being. After the door was closed the banging intensified which caused the householder to feel threatened of a potential assault and the welfare of her elderly mother, who was also a resident of the household. This then prompted a 999 call to request police and ambulance. Gary's behaviour continued to escalate with banging to punching then changing to pounding. This lead to a vase inside the house to fall and smash, which them prompted a second 999 call as the incident became more threatening.* *Police arrived on the scene around 10 minutes of the first 999 call.* *In consideration of the action of Police at [redacted] on the 18th July 2017. We find that the police actions were as followed: Tactical communications (i.e. "its the police stop"), ("get on your knees"). These were unsuccessful. One officer then deployed pava spray which had no effect on Gary.* *Due to the this and Gary's aggressive behaviour towards police, the three police officers deployed the use of batons. Each of the three officers delivered several baton strikes. We understand this to be in accordance with their training and consideration of the NDM*

	(National decision making model). However in our judgement the combined number of strikes was inappropriate. *Due to continued escalation and ineffective previous actions, Gary was then then forcibaly restrained by way of a headlock. Handcuffs were applied to the front by other officers.* *Due to further agitated behaviour leg restraints were then applied to protect the officers and Gary.* *Mr Williams was then carried out of the garden to a grass verge at the front of the house, the handcuffs were then repositioned to the rear as witnessed by a neighbour.* *Gary was then moved from the grass verge into the bulk head area of a police carrier by several officers whilst awaiting the arrival of medical proffessionals. Whilst in the police carrier theire is evidence via body cam which shows Gary to be agitated, still restrained and trying to be calmed by officers. We therefore consider the action of the Police reasonable at this time.* *At approximately 03.45 hours Gary was place on a stretcher and was taken to the ambulance.* *We have found that the actions by the police were reasonable in the circumstances known to them at the time.* *From the evidence available at the time we found there was no alternative course of action. A Police officers oath is to protect people and property first before considering the reason for the given circumstances.* *We find the actions of the police officers both in the ambulance and at the Royal Liverpool hospital on the 18th July to 26th July 2017 were reasonable in assisting therapeutic support to Gary, and his continued restraints. However their was a lack of detailed information passed on during hand overs to the medical teams. This is evidenced by insufficient information recorded which omitted key factors, in relation to use of restraints/use of force and mechanism of injuries during Gary's arrest.* *We find that due to Gary's condition, He did not have the capacity to consent to treatment, therefore we find the treatment given to Gary in the circumstances was reasonable. We find the treatment administered to Gary was appropriate considering the balance of risk. This treatment included being admitted to ICU on the morning of the 18th July following sedation and a CT scan which showed up clear. Gary spent a period of 10 days in critical care, three of which were under Anaesthesia, whilst continually being assessed. During this time he received 9 doses of preventative anti-coagulant medication to help reduce any risk of blood clots forming. There was no aspect of care delivered that was not appropriate or necessary. However some communication during Gary's time at the Royal hospital between departments was lacking due to inconsistencies and omissions within reports and notes from the medical staff.* *In relation to the cause of death, we find this to be:* *1a Pulmonary Thromboembolism (caused)* *1b Deep Venous thrombosis* *2 Ictal automatism due to temporal lobe epilepsy* *We find that the pulmonary Thromboembolism was causes at least in part, that is more than minimally, negligibly or trivially by the following:* *B. Injuries and bleeding sustained in a entering the back garden of* [redacted]. *C: Restraint and baton strikes by the police in effecting his arrest and detention.* *D : Therapeutic support in critical care - including restraint, sedation, anaesthetic, ventilation, peripheral venous access, central venous line access ext.* *From the medical evidence from medical staff and experts theire is no direct link that Temporal lobe epilepsy causes the pulmonary Thromboembolism, however this was the catalyst that lead to the incident that occurred on the 18th of July 2017 and the subsequent chain of events.* *We find that Gary Williams was certified as having died at 18:50 on 28th July 2017 at his sisters home* [redacted]. *given all the circumstances known at the time when intervention was possible we find that Gary Williams death was not preventable."*
4	**CIRCUMSTANCES OF THE DEATH** As set out in the Narrative Conclusion above The cause of death being found as:

	I a Pulmonary Thromboembolism **I b Deep venous thrombosis** **2. Ictal automatism due to temporal lobe epilepsy**
5	**CORONER'S CONCERNS** During the course of the investigation, my inquiries revealed matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Gary Williams suffered from Temporal lobe epilepsy. He was a retired police officer who was a very friendly and polite gentleman, when not unwell. He had previously had absences. However, nothing that can compare with the events in the eleven days before his death on the 28th July 2017. On the 18th July 2017 he suffered from an extreme acute behavioural disturbance, described as what appeared to be a psychotic delusional state in which affray and violence to life and property was demonstrated. This was Ictal automatism due to temporal lobe epilepsy. A neurologist explained at the inquest that he felt sorry for the police, as they did not know the patient or with what they were dealing. He explained that there was no way to rationalise with some in this state - they are like a zombie and though they do not feel pain the use of PAVA, baton strikes and restraint will be responded to by the person's fight and flight instincts. It is important to approach such a person with calm. In a neurological ward, it can take four experience health care professional and a fifth to sedate to deal with such a presentation. There is no treatment as such for this presentation just sedation and if necessary critical care support until the person has recovered. This condition is not part of the college of policing training materials with regard to use of restraint. You may consider that it would be helpful to include it in the minimum of 12 hours future mandatory annual restraint refresher training undertaken by all officers. In this case, officers, members of the public and health care professionals were distressed and exhausted but fortunately officers, healthcare professionals and the public did not suffer permanent serious or fatal harm.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **21st January, 2022**. 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 **Gary Williams - Family** **Merseyside Police** **Gary Williams' GP** **Liverpool University Hospitals NHS Foundation Trust**

	I have also sent it to **Independent Office for Police Conduct** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 26/11/2021**  **Andre REBELLO** **Senior Coroner for** **Liverpool and Wirral**