Regulation 28: Prevention of Future Deaths report

[redacted]

	THIS REPORT IS BEING SENT TO: **1.** [redacted] **Metropolitan Police Service (MPS)** **6th Floor, New Scotland Yard** **Victoria Embankment** **London SW1A 2JL**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 25 March 2021, I commenced an investigation into the death of [redacted], aged 44 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest that death was drug related. I recorded the medical cause of death as: 1a complications arising from cocaine intoxication.
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of 18 March 2021, [redacted] took cocaine and went to a friend's home. He demonstrated features of acute behavioural disturbance (ABD) and police were called. They recognised this as a medical emergency and sought an ambulance, but [redacted] arrested before the ambulance arrived. With police assistance paramedics achieved a return of spontaneous circulation, but [redacted] died in hospital 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.

The police officers who attended [redacted] acted quickly. They:

- restrained him carefully and safely;
- sought to protect his airway;
- supported his head;
- recognised a medical emergency and potential ABD;
- requested an ambulance;
- looked for a defibrillator;
- responded to an emerging situation and continued to monitor;
- moved [redacted] to a better location;
- sought additional information that might be of assistance in the resuscitation by running a police national computer (PNC) check, looking for a medical alert amongst [redacted] belongings and searching the bathroom where it appeared he may have taken drugs;
- noted that he was hot and removed his thick jacket to try to cool him down;
- eventually moved to cardiopulmonary resuscitation (CPR); and
- flagged down the ambulance when it arrived in the street.

This was all the more commendable because three out of the four officers were probationers, including the officer who entered the property first and took the lead. The response was described by the Home Office pathologist who gave evidence as exemplary.

However, there were two other aspects of the resuscitation that I want to bring to your attention to help with organisational learning.

1. What was particularly challenging for the officers was knowing when to move [redacted] to the floor and when to commence CPR.

   [redacted] was in peri arrest/arrest for probably around three and a half minutes before CPR was commenced. Although earlier CPR would not have changed the outcome for him, it might for another casualty.

   The intensive care consultant giving evidence at inquest articulated his view of the point at which [redacted] was in peri arrest.

	He recognised that this was a difficult call to make, but told me that if in doubt about such an arrest situation, first aiders should move straight to CPR. I am aware of the work the MPS has undertaken to improve the first aid training of its front line officers. The recognition of the deteriorating patient is notoriously difficult, sometimes even in a hospital setting. However, given that it is a difficulty I have seen recur for the MPS, it seems to me that it would benefit from further consideration. 2. Whilst the officers worked well as a team in many respects, it seemed to me that there could have been more focus on pro-active support from those not directly monitoring [redacted] vital signs. For example, the experienced officer who initially held down [redacted] legs and then later stood close by, would have assisted further if he had been asked. However, because he was confident in his colleagues' abilities he did not act as what would have been a very useful pair of eyes. He did not provide that focused consideration of a situation that can be so useful when other members of the team are very busy with immediate tasks. I heard at inquest about the MPS training to speak up, speak out in such a situation. I know that the MPS trains on the value of a helicopter view from a secondary safety officer. However, it seemed to me that this was not completely embedded within the frame of reference of the officers attending. It is not about criticism of one's colleagues, it is about remaining active in the resuscitation. I am wary of recommending a counsel of perfection but, as this is an issue I have observed on previous occasions, I feel I would be failing in my duty if I did not raise it with you.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 4 September 2023. 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 following. • [redacted] wife of [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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 other 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 05.07.23 *ME Hassell*