REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive of the College of Policing
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 25 July 2022 an investigation into the death of Kevin Michael Cashin was commenced. The investigation concluded at the end of the inquest on 20 June 2024. The jury found that the medical cause of death was 1a) hypoxic brain injury and haemothorax 1b) post cardiac arrest syndrome 1c) out of hospital cardiac arrest due to restraint in association with drug induced psychosis and metabolic acidosis. The jury returned a narrative conclusion.
4	**CIRCUMSTANCES OF DEATH** In the early hours of 20 July 2022, officers from Greater Manchester Police received a call from Kevin Cashin asking that police attend his home address as he had concerns that people were coming to his home with guns. Kevin was experiencing an extreme episode of Acute Behavioural Disturbance due to having ingested a significant amount of cocaine. When the police officers arrived, Kevin had barricaded himself into his bedroom. The officers made efforts to engage with Kevin and to reassure him that they were there to help him. Without warning, Kevin opened a first floor bedroom window and dropped onto an area of loose slate at the front of the house. Kevin was immediately restrained by officers and once handcuffs were secured, he was sat up and supported in a seated position so that his airways were kept open. Kevin began to deteriorate and stopped breathing. He was resuscitated and transferred to Salford Royal Hospital where Kevin was diagnosed with an unsurvivable hypoxic brain injury. He died later that morning.
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 MATTER OF CONCERN is as follows:- The Court heard from an expert in pre-hospital emergency medicine and anaesthesia who had viewed the officers' body worn footage which covered events from their arrival at the scene to Kevin's transfer to hospital. The expert's evidence was that Kevin had been unconscious at the point that he was placed in the seated position following the restraint. The expert also gave evidence that Kevin was in cardiac arrest for a period of six and a half minutes before this was recognised by the officers and chest compressions commenced. The Court heard of a number of factors that had hindered earlier recognition of Kevin's cardiac arrest. (1) The officers did not understand what agonal breathing was or how to recognise it. This included an officer who had completed the enhanced first aid training required to undertake Public Order Medic duties. Their focus had been on the fact that they could see Kevin's chest moving and they had not appreciated that his gasping was an indicator of breathing difficulties.

	(2) The Court heard that the effect of a cocaine induced Acute Behavioural Disturbance episode meant that Kevin's agonal breathing was at a faster rate than is typical and would have looked more like regular breathing. (3) The Court heard that there is generally a lack of knowledge on how to recognise when a person is going into a cardiac arrest. The officers had placed reliance on their observation of Kevin's chest movements and their belief that they could feel his pulse. They had interpreted his lack of muscle tone, facial movements, poor colour and failure to respond to verbal prompts as signs of the effects of drug intoxication rather than indicators that he was in the early stages of cardiac arrest. (4) It was the opinion of the expert that the most effective way to train responders in recognising agonal breathing and on how to identify when a person is going into a cardiac arrest is through the use of video footage rather than solely power-point presentations. (5) The Court is concerned that the above is not currently covered in the curriculum for First Aid Learning Programme delivered to all police officers or the Enhanced First Aid Skills delivered to those officers in high risk roles and to public order medics.
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 **16 August 2024** I, the Area 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 namely:- • The family of the Deceased • Chief Constable of Greater Manchester Police • North West Ambulance Service • Independent Office of Police Conduct 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 from. 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.
-	Date: 21 June 2024 Signed: