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. East of England Ambulance NHS Trust** **2. Chief Constable of Essex Police** **3. Association of Ambulance Chief Executives**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 17 August 2022 an investigation was commenced into the death of Scott Darren TAYLOR, aged 31 years. The investigation concluded at the inquest on 31 July 2025. The conclusion of the inquest was a Narrative: Scott Taylor was probably suffering a rare Neuroleptic Malignant Syndrome in the days prior to his death and suffered acute kidney failure that progressed on 12 August with Scott displaying a set of symptoms consistent with an acute behavioural disturbance and complications following cocaine use which involved physical exertion and prone restraint Medical cause of death of '1a Multiorgan Failure and Rhabdomyolysis 1b Complications arising following cocaine use which involved physical exertion and prone restraint with Neuroleptic Malignant Syndrome.
4	**CIRCUMSTANCES OF THE DEATH** Scott Darren Taylor died at Basildon Hospital on 13 August 2022 of Multiorgan Failure and Rhabdomyolysis due to Complications arising following cocaine use which involved physical exertion and prone restraint with Neuroleptic Malignant

	Syndrome. Scott was unwell from at least 10 August 2022 with muscle stiffness, profuse sweating confusion, paranoia , psychosis and had taken cocaine. These symptoms continued on 11 and 12 August 2022. Concerns were raised that Scott required urgent medical attention and may have acute behavioural disorder; he refused to go into the hospital when he was taken there on 12 August. Scott jumped out of a car and ran into a club. Scott was extremely agitated and suffered several collapses with apparent muscle stiffness and was restrained in a prone position by patrons of the club until police arrived. Police were not given accurate information on Scott's behaviour and applied handcuffs and leg restraints and placed Scott on his side with suspected acute behavioural disorder. Police called an ambulance for a medical emergency with active restraint on the floor. Police became increasing concerned that Scott was deteriorating over an 18-minute period when the ambulance was given a category two response. Police decided to convey Scott to hospital that was nearby as a medical emergency. Scott was extremely unwell on admission with noted symptoms of rhabdomyolysis and acute kidney injury and very poor prognosis. Despite treatment Scott continued to suffer rapid deterioration and multiorgan failure. Life support was withdrawn on the evening of 13 August 2022.
5	**<u>CORONER'S CONCERNS</u>** 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) East of England Ambulance NHS Foundation Trust (EEAST)** a. Members of the public were restraining Scott Taylor on arrival of the police who quickly became concerned that Mr Taylor was exhibiting signs of Acute Behavioural Disturbance and made an emergency call to the ambulance service. The police, during the 999 call, were put on hold on three occasions by the ambulance service and became increasingly concerned about Mr Taylor's deteriorating condition over an 18 minute period and confirmation that this remained a Category 2 call despite active police restraint with suspected Acute Behavioural Disturbance. Police decided to 'scoop and run' and urgently convey Mr Taylor to hospital due to the severity of their concerns. The EEAST Standard Operating Procedure requires escalation to Category 1 where there is active restraint, but this is not linked to Acute Behavioural Disturbance and remains unclear and may continue to cause confusion during triage by contact call handlers. b. The East of England Ambulance NHS Trust provide ambulance services across 6 counties and that also includes police/healthcare professionals reporting Acute Behavioural Disturbance and active

police restraint. There is concern that there is a different response applied and that this discrepancy between Category 1 and Category 2 responses is significant and could affect the survival of patients. Evidence heard from police trainers and expert witnesses is that Acute Behavioural Disturbance has a high rate of fatality and requires an urgent response, particularly where police officers with training in this condition are reporting to ambulance service and with active restraint.

c. The EEAST updated training on Acute Behavioural Disturbance, active restraint and reports received from police and correct coding remains confusing with the policy and training handouts in December 2023 with discrepancies between those who are sectioned and those who are not. Persons confirmed with Acute Behavioural disturbance and in active police restraint being coded as Category 2 and those in the same circumstances and 'sectioned' will require a Category 1 response. The difference appears to be one related to the Mental Health Act and not the presentation or clinical requirements of the person.

d. The EEAST documents continue to use the term 'Excited Delerium' interchangeable in some of the training materials and this may lead to confusion with contact handlers triaging calls.

(2) Chief Constable of Essex Police

a. Whilst it was not causative of Mr Taylor's death, there appears to be a discrepancy in the training for Police Officers and Special Constables in the potential recognition and actions for Acute Behaviours Disturbance. Special Constables are a valuable resource for police forces and may often be first on scene as in this case and should receive the same training in the potential recognition and alert of potential life-threatening conditions.

b. Whilst it would not have changed the outcome for Mr Taylor, arm and leg restraints were not removed by police officers in this case when it was understood that Mr Taylor was unconscious and when Mr Taylor was being conveyed to hospital. Police officers who gave evidence were not clear that this was a requirement of the policy.

(3) Association of Ambulance Chief Executives

a. It was agreed in evidence that the set of symptoms consistent with Acute Behavioural Disturbance amount to a medical emergency with a significant mortality risk. The evidence was that the Association of Ambulance Chief Executives set the Categories nationally that dictate the required classification for ambulance response to emergencies, however in some ambulance localities the required response is allocated Category 2 and in others Category 1. This

	means that there is not a national standard for response Acute Behavioural Disturbance with active restraint.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 March 2026. 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: • Family • Care Quality Commission • Expert Witness 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	[redacted] **2 February 2026** **HM Area Coroner for Essex Sonia Hayes**