Re : Terrence Arthur Albert Smith Deceased

Regulation 28 Report to Prevent Future Deaths

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South East Coast Ambulance Service NHS Foundation Trust (in relation to paragraph 5 A and B below),** **2. NHS England / NHS Digital (in relation to paragraph 5 A below),** **3. Joint Royal Colleges Ambulance Liaison Committee (in relation to paragraph 5 C below),** **4. Mitie Care & Custody (Health) (in relation to paragraph 5 D below),** **5. Teesside University (in relation to paragraph 5D below),** **6. The Chief Constable of Surrey Police (in relation to paragraph 5 E and F below), and** **7. The College of Policing (in relation to paragraph 5 E below).**
1	**CORONER** I am Richard Travers, HM Senior Coroner for the coroner area of Surrey.
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** I commenced an investigation into the death of Terrence Arthur Albert Smith who died on 13 November 2013 aged 32 years. The investigation concluded on 24 January 2019 after I had conducted an Inquest, which began on 12 February 2018 and was completed on 5 July 2018, and a subsequent hearing for evidence relevant to the prevention of future deaths which ran from 21 to 24 January 2019.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death of Terrence Smith (referred to at the Inquest as "Terry") were as follows : On the evening of 12 November 2013 Terry was at his parents' home when he began to behave in a bizarre manner. He had taken amphetamines and he showed signs of agitation, suffering hallucinations and paranoia, incoherence, some aggression, and overheating and he demonstrated extreme strength. He ran from the premises and stood outside, shouting at the sky, wearing only his underwear. It was established at the Inquest that Terry was displaying "textbook" signs and symptoms of the condition known as Excited Delirium or Acute Behavioural Disturbance ("ED/ABD") and that he continued to do so until he collapsed approximately two hours later. The evidence at the Inquest also established that ED/ABD is a medical emergency. Judging that he needed medical help, Terry's parents telephoned 999 and asked for the attendance of the ambulance service. The South East Coast Ambulance Service ("SECAMB") call handler did not identify that Terry was suffering ED/ABD. She dispatched two Emergency Medical Technicians and asked for Surrey Police to attend. The first two police

officers in attendance approached Terry and he ran away. They chased and caught him, restrained him on the ground, applied handcuffs, and detained him under section 136 of the Mental Health Act 1983. Further police officers arrived and, because Terry was resisting restraint, he was restrained by about six police officers, leg restraints were applied, and a spit hood was placed over his head.

The police officers and Emergency Medical Technicians learned that Terry had taken drugs and they were handed a white powder which had been found in his bedroom. The Police Sergeant who was in attendance alerted the other police officers present to the possibility that Terry was suffering Excited Delirium but the police officers stated in evidence that their training had not made them aware that the condition constituted a medical emergency. The two Emergency Medical Technicians had received no training at all on ED/ABD and did not recognise that Terry was suffering the condition or that he was in a state of medical emergency.

The police decided that Terry should be taken to and detained at a police station rather than a hospital Accident and Emergency Department. The two Emergency Medical Technicians did not question this, even though they had not been able to examine Terry sufficiently to form a view as to his medical needs.

The police placed Terry on the floor of the caged area of a police van, still restrained by handcuffs and leg restraints and wearing the spit hood. They transported him to Staines Police Station, arriving at 22.59 hours. A short time later, whilst still in the van, Terry was arrested for possession of a Class A drug.

The Custody Sergeant approved his detention and he was then carried in to the station by six officers and placed on the floor of a cell. Throughout his time in the cell Terry was restrained by at least six police officers or custody staff and he resisted that restraint with extreme strength. Throughout, he remained in leg restraints and the spit hood, but his handcuffs were removed and replaced with a body cuff. Terry continued to be largely incoherent but he stated that he "could not breathe" 13

times.

Whilst in the cell and under restraint Terry was seen, for less than two minutes, by a Forensic Medical Examiner who informed the Custody Sergeant that he needed to go to hospital because of a cut on his foot and because he had taken drugs. The doctor did not mention ED/ABD although he was aware of the condition and knew it was a medical emergency.

At 00.13 hours on 13 November 2013 (one hour 14 minutes after arriving at the station) the police officers carried Terry from the cell back to the police van, where they again placed him on the floor of the caged area in order to take him to hospital. Terry was restrained in the caged area of the van by three police officers, with the body cuff, leg restraints and the spit hood still in place. Shortly afterwards, Terry stopped breathing. He was subsequently taken by ambulance to St. Peter's Hospital where he died later that day.

The medical cause of death was found to be :

Ia Multiple hypoxic organ failure
Ib Cardiorespiratory collapse
Ic Amphetamine-induced excited delirium in association with restraint.

The jury's conclusion as to the death was that :

Narrative Conclusion
The Deceased died as a result of an amphetamine-induced Excited Delirium in association with :

1. A serious failure by those who owed a duty of care (to the deceased), to recognise the signs and symptoms of Excited Delirium as a medical emergency. There was also a failure to find out more about Excited Delirium after the term had been raised.
2. A failure to carry out an adequate assessment (of the deceased) at any stage.
3. Inadequate training of those who owed a duty of care, with a serious failure to check their learning.

	4. Prolonged and excessive restraint, and a failure to understand that the resistance to the restraint (by the deceased) was leading to an ongoing depletion of oxygen and an increased level of adrenaline and that this was speeding up the effects of the Excited Delirium in his body. **Neglect** The death was contributed to by Neglect. **Other Contributory Causes** The death was caused or more that minimally contributed to by the failure on the part of Surrey Police to : 1. Ensure that all response and custody officers and staff were sufficiently trained in relation to Excited Delirium. 2. Treat Terry as a medical emergency. 3. Take Terry to hospital from Douglas Road [home address]. 4. Assess sufficiently or at all his fitness to be detained at Staines Police Station prior to his detention there being authorised. 5. Ensure that Terry was taken to the Accident and Emergency Department of the hospital, prior to 23.45 hours on the 12th November 2013. 6. Monitor and consider sufficiently or at all the length of time for which Terry was under restraint and his response to it, prior to 23.45 hours on the 12th November 2013. 7. Consider his containment rather than restraint at Staines Police Station, prior to 23.45 hours on the 12th November 2013. 8. Have in place an adequate policy in relation to the management of those detained under section 136 of the Mental Health Act 1983.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern, some of which have now been addressed. However, in my opinion there is a risk that future deaths will occur unless action is taken in respect of the matters which have not yet been addressed or sufficiently addressed. In the circumstances it is my statutory duty to

report to you.

A. To : (i) The South East Coast Ambulance Service NHS Foundation Trust and (ii) NHS England / NHS Digital

The **MATTER OF CONCERN** is as follows :

1. Call Handling : Emergency calls for an ambulance are triaged by SECAMB's call handlers using a tool known as NHS Pathways which is produced by NHS England / NHS Digital. The tool is designed to enable the non-clinical operator to assess the urgency of a call, to recognise a medical emergency, and to categorise SECAMB's level and speed of response. The version of NHS Pathways currently in use is version 16 which does not enable operators to recognise potential ED / ABD and respond accordingly. I was told that it is intended that version 17 will do so but this is not yet in use. My concern is that, unless and until it is in use, there will continue to be a failure by call handlers to recognise ED/ABD and respond appropriately.

B. To : The South East Coast Ambulance Service NHS Foundation Trust

The further **MATTERS OF CONCERN** are as follows :

1. Call Handling : I was told that, whilst waiting for version 17 of NHS Pathways, SECAMB has provided its call handlers with guidance (by way of a "Hot Topic") that a call from the Police or a Health Care Professional stating that a patient is suffering ED/ABD should be given a category 2 response. I was also told, however, that SECAMB's call handlers have no discretion when using NHS Pathways which must be followed precisely. I have three concerns about the current situation. First, there appears to be a contradiction between the call handlers being told they have no discretion when using NHS Pathways and their being given

additional guidance for certain calls. This contradiction could cause confusion. Secondly, the guidance given in the "Hot Topic" is concerned only with calls from the Police or an HCP in which ED/ABD is identified. Currently, therefore, there is no provision for identifying the condition in calls from the Police or an HCP which do not expressly mention ED/ABD or in calls from the public (meaning the call from Terry's family would still not be recognised as a call relating to ED/ABD, even today). Thirdly, the "Hot Topic" does not guide the call handlers to ask whether the patient is under restraint. If a patient suffering ED/ABD is under restraint this could add to his risk of sudden death and this information could affect the proper categorisation of the response to the call.

2. Training of Clinical Staff : I was told that in 2016/17 SECAMB sought to address the absence of training of its clinical staff b providing some "key skills" training in relation to the condition of ED/ABD and its management, but that it was only in 2018 that it introduced a specific training package on the condition. I have two concerns about this training package. First, its content is potentially confusing in that (a) it refers to the condition of ED/ABD as "controversial" (when it is not) and (b) it links ED/ABD to patients detained under section 136 of the Mental Health Act (which a patient suffering ED/ABD will not necessarily be). Secondly, to date the training has been given to only about 150 out of about 650 front-line response staff (and out of a much higher number of all employees who should be trained). I was told that there are plans to create an e-learning package to aid faster delivery, but this has not yet been created.

3. Conveyance Policy : The Joint Surrey Police, Sussex Police, Kent Police and South East Coast Ambulance Service NHS Foundation Trust Conveyance Policy is currently being re-drafted but I have concerns about the current and draft proposed versions I was shown. Both versions indicate that a patient suffering ED/ABD (or other life threatening conditions) should not be conveyed to hospital by police vehicle under any circumstances or unless a

series of 11 conditions are satisfied. Some of the 11 conditions could take some time to satisfy and some are dependent on the presence of SECAMB at the scene (which could be subject to delay). I am concerned that the policy could prevent a patient who is suffering a medical emergency being conveyed to hospital as soon as possible, and by police vehicle if necessary, and could result in a fatal delay in the provision of life-saving treatment.

4. Data Gathering and Auditing : I am concerned that SECAMB is not currently monitoring accurately the incidence of cases of ED/ABD in the regions it covers. A witness told me that she believed there were very few incidents (under ten a year) and that they were all apparent from the data gathered. On the basis of the evidence heard at the Inquest it seems unlikely that there are very few incidents given that SECAMB cover three large counties with a total population of over 4 million people and given the much higher incidence in other areas. Further, there were at least two incidents of ED/ABD (from 2018 and 2019) referred to in evidence which had not been captured at all by SECAMB's data gathering.

5. Senior Management Awareness : I was told by the Chief Executive Officer of SECAMB that he was not aware of Terry's death and SECAMB's involvement in it, nor of the issues arising at the Inquest, until very shortly before being required to give oral evidence at the Regulation 28 hearing. Given the length of the Inquest and the seriousness of the issues arising in relation to SECAMB (including their failure to recognise that Terry was suffering ED/ABD and to ensure he was treated as a medical emergency and taken to an Accident and Emergency Department), I am concerned that there is no system in place to ensure that such matters are drawn to the attention of the most senior management in a timely manner so as to ensure there is strategic planning for the prevention of other deaths.

C. To : Joint Royal Colleges Ambulance Liaison Committee

The **MATTER OF CONCERN** is as follows :

1. I was told that although the London Ambulance Service has provided out of hospital rapid tranquilisation of patients (such as may well be needed by a patient suffering ED/ABD) for some years, SECAMB will not do so until a national protocol or guidance has been issued by JRCALC. In those circumstances, whilst I understand that work on the production of such guidance is being undertaken, I am nevertheless concerned that none is yet in place.

D. To : (i) Mitie Care & Custody (Health) and (ii) Teesside University

The **MATTER OF CONCERN** is as follows :

1. Although it was clear from the evidence that, as a provider of Forensic Medical Examiners to custodial settings, Mitie Care & Custody (Health) has in place thorough systems for the recruitment and monitoring of staff, I am concerned about aspects of the training currently being provided in relation to ED/ABD. I was told that this training is being delivered in conjunction with Teesside University and I was provided with a copy of the training materials. I am concerned about the following within the training materials :

   (a) Under the heading "What causes Death in Excited Delirium ?" there follows a series of six slides dealing with positional asphyxia when a patient has been "hogtied". A later slide, headed "Hypoxia The last nail in the coffin?", suggests that hypoxia is an element in what causes death from ED/ABD. In fact, the evidence provided to me at the Inquest established that ED/ABD and positional asphyxia are two entirely separate and quite different conditions. Death from ED/ABD can result even though there is no asphyxiation or hypoxia. Whilst many patients suffering ED/ABD in a custodial setting may well be

under restraint (although they will not necessarily be), it is of real importance that FMEs (and all involved) understand that there is a risk of sudden death from ED/ABD whatever the patient's position, whether or not there is restraint, and whether or not there is hypoxia. The evidence I heard showed that it is vital that it is understood that the risk of death from ED/ABD comes from the condition itself, which can be exacerbated by restraint and resistance against the restraint, no matter what the sufferer's position. On the basis of the current training material, students may be misled in to thinking that a patient is not at risk of death as long as the position in which he is being restrained is not causing him asphyxiation (which was the thinking of the officers restraining Terry), and that they will fail to understand that there is a risk of death from ED/ABD whatever the sufferer's position under restraint and even if he is not being restrained at all.

(b) The material suggests that FMEs should encourage the use of minimal force and minimal restraint and the use of de-escalation techniques, but it makes no reference to encouraging the containment rather than restraint of the patient.

E. To : (i) The Chief Constable of Surrey Police and (ii) The College of Policing

The **MATTER OF CONCERN** is as follows :

1. Training : It is clear that Surrey Police now ensure that all officers and staff receive training in relation to ED/ABD and its management, including the fact that it is a medical emergency. I was provided with a copy of the current training material and told that it was, to a very large extent, reflective the material provided by The College of Policing's National Curriculum, Module 5. I have two concerns :

(a) I am concerned that the material includes reference to ED/ABD

being "controversial" when this is not the case. A number of the officers who restrained Terry stated in evidence that they believed the condition was "controversial". The inclusion of this reference continues the risk that trainees are misled into doubting the existence of ED/ABD and this may result in their failing to recognise or accept a presentation of ED/ABD.

(b) I am concerned that, within the training material, the guidance in relation to ED/ABD is closely linked to the guidance in relation to positional asphyxia. The evidence provided to me at the Inquest established that ED/ABD and positional asphyxia are two entirely separate and quite different conditions. Death from ED/ABD can result even though there is no asphyxia. Whilst many of those suffering ED/ABD may well be under restraint (although they will not necessarily be) it is of real importance that police officers and staff understand that there is a risk of sudden death from ED/ABD whatever the sufferer's position and whether or not he is under restraint. It is vital that it is understood that the risk of death from ED/ABD comes from the condition itself, which can be exacerbated by restraint and resistance against the restraint. On the basis of the current training material, there is a risk that students may be misled in to thinking that there is no risk of death as long as there is no positional asphyxiation (which was the thinking of the officers restraining Terry).

F. To : The Chief Constable of Surrey Police

The further **MATTERS OF CONCERN** are as follows :

1. Mental Health Guide : Surrey Police's Mental Health Guide addresses ED/ABD only in bullet point form alongside reference to Positional Asphyxia. The conditions are separate and different and the absence of a separate sheet addressing ED/ABD alone could mislead those reading the Guide in to thinking that the conditions are necessarily connected.

	2. Conveyance Policy : The Joint Surrey Police, Sussex Police, Kent Police and South East Coast Ambulance Service NHS Foundation Trust Conveyance Policy is currently being re-drafted but I have concerns about the current and draft proposed versions I was shown. Both versions indicate that a patient suffering ED/ABD (or other life threatening conditions) should not be conveyed to hospital by police vehicle under any circumstances or unless a series of 11 conditions are satisfied. Some of the 11 conditions could take some time to satisfy and some are dependent on the presence of SECAMB at the scene (which could be subject to delay). I have two concerns : (a) I am concerned that the policy could prevent a patient who is suffering a medical emergency being conveyed to hospital as soon as possible, and by police vehicle if necessary, and could result in a fatal delay in the provision of life-saving treatment. (b) I am concerned that the content of this policy is inconsistent with the training I was told is given to police officers, namely that they may convey a patient to hospital by police vehicle if the use of an ambulance is not an available or practical option, and as long as the conveyance is approved by a senior officer.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above 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 by 18 April 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 and to the others listed below who may find it useful or of interest : [redacted] The Independent Office of Police Conduct The Secretary of State for Health Dame Elish Angiolini (Author of Review of Deaths in Police Custody) Members of the Jury. 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	**21st February 2019** **Richard Travers**