	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. Legal representatives of the Interested Persons (see Box 8) 8. IPCC
1	**CORONER** I am Sam Faulks, assistant coroner, for the coroner area of Teesside
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 13.10.14 I resumed an inquest into the death of Kirk William Williams, aged 26. The investigation concluded at the end of the inquest on 06.11.14. The conclusion of the inquest was the cause of death was Ia Excited Delirium and II Coronary Artery Atheroma and Left Ventricular Hypertrophy. The narrative conclusions of the jury were elicited via a questionnaire. In summary it was found that it had been inappropriate for police officers to have taken Kirk Williams to a police station when he was detained. He should have been taken to hospital instead. The jury considered that Kirk Williams would have been accepted and treated in accident and emergency. However, the jury were unsure as to whether such treatment would have saved his life.
4	**CIRCUMSTANCES OF THE DEATH** On 17.04.11 Kirk Williams was seen running around fields adjacent to the Moorhouse Estate, Stockton-on-Tees. He had ingested a number of drugs including, alcohol, cocaine, 'M-cat', MEC and PVP. He had divested himself of all of his clothing and was exhibiting bizarre, aberrant and very agitated behaviour. It took 4 police officers to restrain Mr Williams, apply handcuffs, leg restraints and secure him in a police van. A total of 6 police officers were in attendance in the field. One officer, it is accepted, stated that Mr Williams should be taken to hospital. The dilated pupils, agitated state, intense heat and aberrant behaviour caused that officer to consider that Mr Williams may be suffering from a condition known as 'Excited Delirium'. The other 5 officers did not accept that the local hospital (University Hospital North Tees) would accept such an unpredictable and aggressive patient. Because those officers were content that there would be medical staff at the local police station (Middlehaven or Middlesbrough police station,) they decided that Mr Williams should be taken there. Having been taken into Middlehaven at 12:04pm, custody officers were advised by the locum forensic medical examiner at 12:19pm to have Mr Williams taken to hospital. Paramedics arrived at 12:29pm and following a cardiac arrest at 12:49pm Mr Williams was taken to James Cook University Hospital at 13:13 hours. Following extensive treatment, Mr Williams died at 14:32 hours. The pathology evidence was that Mr Williams died of Ia Excited Delirium and II Coronary Artery Atheroma and Left Ventricular Hypertrophy.
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) Police officers in Cleveland doubtless receive training about Excited Delirium and now understand in a way that they perhaps previously did not that the condition should be treated as a 'medical emergency' which thereby requires the detainee's attendance at a hospital. (2) Some police officers still consider that notwithstanding that they may be faced with a medical emergency, A&E departments will not treat violent or aggressive patients. (3) The various consultants that gave evidence are clear that they will treat violent patients provided that (a) treatment is warranted and (b) they are provided with sufficient assistance from either or both the police or security staff. (4) It therefore follows that there is a mismatch in perception and expectations between Cleveland police officers and local A&E staff. (5) There did not appear to be a sufficiency of understanding within Cleveland Constabulary about how and whether detainees may be treated at A&E departments. (6) Further or alternatively, the insufficiency in understanding lies with A&E consultants and their perception of what type of patients will be accepted and allowed to be treated in their departments. (7) There does not appear to be a dialogue between Cleveland Constabulary and local A&E departments to address these particular misunderstandings or misconceptions. (8) There does not appear to be any memorandum of understanding or guideline to cover aggressive detainees in police custody being taken to A&E departments. (9) Without a fuller understanding of the true position, police officers will continue to be faced with the perennial dichotomy of whether to take an aggressive medical emergency detainee to an A&E department for treatment or to a police station to prevent self harm or harm to others.
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 09.01.15. 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' representatives, namely those acting for the family, Cleveland Constabulary, former [redacted] NEAS, JCUH and Tascor (formerly Reliance). I have also sent it to the IPCC who may find it useful or of interest. 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	**14.11.14**