ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Department of Health** 2. [redacted] **Chairman of the Association of Ambulance Chief Executives** 3. [redacted] **(ACPO Lead, National mental health working group)**
1	**CORONER** I am Louise Hunt, senior coroner, for the coroner area of Birmingham and Solihull
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 12th April 2011 I commenced an investigation into the death of Kingsley Burrell, aged 29. The investigation concluded at the end of the inquest on 15th May 2015. The conclusion of the inquest was a narrative as per the attached record of inquest.
4	**CIRCUMSTANCES OF THE DEATH** On 27th March 2011 Kingsley Burrell was detained under S136 of the Mental Health Act following an incident at the Hayer Supermarket in Birmingham. Mr Burrell had claimed he and his son were threatened by men with a fire arm. CCTV from the shop did not confirm such an event. Mr Burrell had to be restrained for the S136 detention. He was taken to a place of safety at Oleaster hospital where he remained for over 4 hours. During this time he was restrained by officers. Mr Burrell was spitting at officers. After a mental health assessment Mr Burrell was detained under S2 of the MHA and taken to Meadowcroft psychiatric intensive care unit based at the Mary Seacole hospital in Birmingham. On 30th March 2011 at around 5.15pm, Mr Burrell became aggressive and threatened staff. As a result 4 police officers attended and Mr Burrell was restrained with handcuffs to the rear and leg restraints. During the restraint he had been hitting his head on the floor which caused a cut to his left eye. He was also spitting at officers. Mr Burrell was sedated with an intramuscular injection. Arrangements were made to take Mr Burrell to a seclusion room at another hospital. An ambulance was called which had an emergency medical technician and a trainee emergency medical technician as crew. The ambulance staff decided to take Mr Burrell to A&E for his eye to be treated. He was then to be taken to the seclusion room at the Oleaster hospital. During the journey to A&E, Mr Burrell remained in restraints and was strapped to an ambulance trolley. 2 police officers travelled with him in the back of the ambulance with the trainee emergency technician. No mental health nurse travelled with Mr Burrell. On arrival at the A&E department, he came out of sedation and became aggressive and was spitting. His eye was sutured whilst he remained under restraint by the police officers, one of whom was straddling his legs on the A&E trolley to keep him still. Mr

Burrell continued to spit. As a result the trainee emergency medical technician placed a blanket over Mr Burrell's head. Mr Burrell was still restrained and on an ambulance trolley with straps applied. This was seen on CCTV.

Mr Burrell was taken to the seclusion room by ambulance staff and the 4 police officers. Once in the seclusion room the restraints were removed but the head covering remained in place. The police and ambulance staff left the seclusion room and mental health staff were observing Mr Burrell through a viewing window. No physical checks had been undertaken on Mr Burrell. At the start of seclusion at 19.50, Mr Burrell's respiration rate was noted to be 7. At 20.05 it was noted to be 4. CPR was started at 20.18. The first defibrillator had no pads so a second was requested. Staff incorrectly attempted to use a nebuliser mask to provide oxygen. The ambulance service records the 999 call at 20.21 and were at the patient's side at 20.28. Mr Burrell was then taken to Queen Elizabeth Hospital where he died on 31st March 2011. The total period of restraint and struggle against restraint was 2 ½ hrs.

The jury at the inquest found that:

- Mr Burrell was suffering from an acute behaviour disturbance on the 30th March 2011.
- The covering applied to Mr Burrell's head remained in place from A&E to the time when he suffered his cardiac arrest in the seclusion room and that this contributed to his death.
- Periods of restraint were unreasonable and contributed to his death.
- Delay in instigating resuscitation contributed to his death.
- Neglect contributed to Mr Burrell's death.

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: –

(1) Medical evidence at the inquest confirmed that Mr Burrell was suffering from acute behaviour disturbance. As a result he continued to struggle against restraint. Patients with this condition are at risk of death through prolonged restraint and struggle against restraint. Most training in relation to restraint deaths focuses on positional asphyxia. Position in this case was not a major consideration. It was clear from the inquest that there was a lack of understanding of how to treat someone with an acute behavioural disturbance. Minimising the period of restraint is key. West Midlands Police have undertaken considerable work and training of staff concerning this condition. My concern is that this has not be rolled out nationally and therefore many other forces will not understand the implications of this condition and how best to treat it. I suggest contact is made with Chief Inspector Russell at WMP for full information on the changes made in the West Midlands area.
(2) The West Midlands area now have a crisis team that works with people who are in a mental health crisis. This involves a mental health worker and ambulance crew working together with the Police to try to help patients with acute mental health disorders. My concern is that this is not a national system. Chief Inspector [redacted] at West Midlands Police can provide full details of the scheme.
(3) This case has resulted in a multi-agency review of how patients are managed between the services when crisis occurs. A new conveying of patients policy has been devised. Critically police now only attend a mental health ward if there was a patient who is threatening staff or there is disorder on the ward. My concern is that this is not reflected nationally. Chief Inspector [redacted] at West Midlands Police can provide full details of the policy.

[redacted]

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisations 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 15th July 2015. 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 Interested Persons [as per the attached list. 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	**20th March 2015**