Regulation 28: Prevention of Future Deaths report
Michael James SWEENEY (died 18.04.11)

	THIS REPORT IS BEING SENT TO: **1. Metropolitan Police Service** **2. London Ambulance Service**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 20 April 2011, an investigation was commenced by my predecessor into the death of Michael James Sweeney. The investigation concluded at the end of the inquest on 18 September 2013. The jury concluded that the cause of Mr Sweeney's death was an **accident**. They said as follows. **The failure in the time delay getting Michael Sweeney medical assistance/care had the impact that resulted in over exertion during Michael's struggling and being restrained.** They gave his medical cause of death as: **1a acute toxic effects of cocaine** **2 restraint and struggling in association with acute behavioural disturbance.**
4	**CIRCUMSTANCES OF THE DEATH** Michael Sweeney died after taking cocaine on a recreational basis. He was a sporadic user of the drug. At post mortem examination, ten times

	the usual recreational level was found in his blood. Following the cocaine ingestion, Mr Sweeney entered a public house with a knife. He was extremely agitated. The Metropolitan Police Service was called and officers attended shortly thereafter. Police officers almost immediately identified Michael as being unwell, suspecting that he was suffering from what had been described in their training as excited delirium. They correctly categorised his condition as a medical emergency and asked police control to arrange for an ambulance to be sent. Police control contacted ambulance control. London Ambulance Service categorised the call as C1 Amber, rather than Red One or Red Two. At the time, there were no paramedics located in the ambulance control room (who could have recognised the seriousness of the condition and upgraded the call), but that has since changed. The combination of the categorisation of the call and the demand upon the service meant that an ambulance was not sent within the target time. Twenty minutes after police first asked for an ambulance, they took the decision to transport Mr Sweeney to the Royal London Hospital in a police van. Once at hospital, police officers, medical and nursing staff were very challenged by the situation. Mr Sweeney remained violently agitated, and demonstrated extraordinary strength in trying to hurt himself and resisting efforts to help him. He was restrained prone until sedation was effective and was then turned over. Unfortunately, he arrested within a minute and then died less than two hours later.
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. Police officers had clearly been trained in the condition described to them as excited delirium. The training was effective in facilitating their understanding of Mr Sweeney's condition as a medical emergency. However, this term is not widely used in this country, and neither ambulance, nursing nor even some of the medical staff had heard of it in April 2011. It would be possible to give ambulance and hospital personnel an

	understanding of the term excited delirium. However, given that this describes a medical condition, it seems more logical for the police to follow health services in this, rather than the other way round. Moreover, although it did not happen in Mr Sweeney's case, there could be situations where a person exhibits extreme agitation that is not related to an acute drug psychosis. There is the potential for an organic cause to be missed because of reliance on that term as an apparent diagnosis. Extreme agitation can be caused by conditions such as a bleed on the brain, sepsis from infection (e.g. meningitis), or a diabetic coma. From the evidence I heard, the safest and most effective way to deal with a person exhibiting such an acute behavioural disturbance seems to be simply to use the term "extreme agitation". This describes the constellation of symptoms without purporting to diagnose the cause. 1. Such an approach would require the Metropolitan Police Service simply to amend the training it currently delivers, to describe the condition as "extreme agitation" rather than "excited delirium". 2. The take home message that the condition is a medical emergency should still be part and parcel of the training, in just the way it is now. 3. This training would also need to be delivered in some form to police control staff, so that they recognise the importance of the term when an officer uses it, and pass this on to the ambulance service. 4. Finally, it would require London Ambulance Service to amend its protocols and training to recognise extreme agitation as a medical emergency and prioritise appropriately.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 November 2013. 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 following. • The Chief Coroner of England and Wales • The Chief Medical Officer of England • The College of Emergency Medicine • The Nursing and Midwifery Council • [redacted] brother of Michael Sweeney • [redacted] partner of Michael Sweeney • [redacted] A&E consultant, Royal London Hospital • [redacted] forensic pathologist 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 23.09.13