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Commissioner's report following the IPCC investigation into the circumstances surrounding the death of Patrick Gaughan in Hertfordshire.

Introduction

This is a summary of the report into the death of Mr Patrick Gaughan on 8 June 2007, following restraint by officers from Hertfordshire Constabulary.

Patrick Gaughan was a 31 year old resident of Ridgeview Lodge, a hostel, in London Colney, St Albans Hertfordshire. He had been there since October 2006. He was a popular resident of the hostel who was widely referred to as "loveable rogue." A fellow resident said: "He'd do anything for you. If somebody was unhappy he'd cheer you up, just his presence." He was known at the hostel to like a drink and occasionally use drugs, but this had not caused any problems.

On 8 June 2007, at about 22.50, two Police Community Support Officers (PCSOs) were at the hostel, conducting enquiries about a missing person. While they were speaking to the duty manager, a resident came in reporting loud noises from Patrick's room. The duty manager opened the door, and saw the room "completely trashed", with Patrick lying on the floor naked, sweating and with blood on his forehead. One of the PCSOs called for an ambulance and a police unit to attend. He also entered the room and spoke to Patrick, trying to calm him down.

Two police officers arrived some minutes later, followed closely by the ambulance. The ambulance crew described Patrick as thrashing around violently. They tried to carry out tests for hypoglycaemia but he was kicking out and tried to bite one of the crew. The two police officers and PCSOs then restrained Patrick, holding his arms and legs and protecting his head. He continued to thrash about so handcuffs and leg restraints were applied, so that the ambulance crew could administer an injection. The restraints were removed after the injection appeared to calm him down.

He was then taken by ambulance to Barnet General Hospital, but en route his condition deteriorated and he was pronounced dead at the hospital at 1.10am.

Patrick's room was contained as a potential crime scene by Hertfordshire Constabulary. The IPCC was promptly informed and decided that it would carry out an independent investigation. Deputy Senior Investigator Clare Brookes was appointed to lead the investigation.

Patrick's family were not informed of his death until 10.20am on 9 June 2007. The delay in notifying Patrick's next of kin of his death was due to a number of factors: officers' failure to confirm Patrick's identity (despite available evidence), resources being focused on securing evidence relating to Patrick's death (with consideration to the possibility that this may have been suspicious) and identification of, briefing and deployment of an experienced Family Liaison Officer to meet with the family. This delay has caused the family considerable anxiety and exacerbated their grief.

Terms of reference

1) *To investigate the circumstances surrounding the police contact with Patrick Gaughan on 8th June 2007by:*
   a) *assessing the actions of the police officers and PCSOs against national and local policies and procedures, specifically:*
   b) *reviewing the actions, training and authority of PCSOs relating to the use of restraint.*
   c) *assessing whether the use of restraint on Mr Gaughan was appropriate, proportionate and necessary, taking into account any concerns from Mr Gaughan's family that any officer used excessive force;*

2) *To assist in fulfilling the state's investigative obligation arising under Article 2 of the European Convention on Human Rights by ensuring as far as possible that:*
   a) *the full facts are brought to light and any lessons from the death are learned (this will include collecting and analysing forensic evidence);*
   b) *the investigation is independent on a practical as well as an institutional level.*

3) *To consider and report on whether any criminal or disciplinary offence may have been committed by any police officer or member of police staff involved in the incident, and whether relevant local and national policies/guidelines were complied with.*

4) *To consider and report on whether there is any:*
   a) *learning for any individual police officer or member of police staff; or*
   b) *organisational learning for the police service, including whether any change in police policy or practice would help to prevent a recurrence of the event, incident or conduct investigated, or whether the incident highlights any good practice that should be disseminated.*

The investigation

Following Patrick’s death, extensive enquiries were carried out. Over fifty witness statements were obtained, including from residents and staff at the hostel and the ambulance crew.

Background to Patrick Gaughan

Patrick's family describe Patrick as having a drug problem for many years. They say that Patrick abused cocaine which induced paranoid fits which caused him to sweat and have violent agitated tendencies with a distrust of all people apart from family members. Records in relation to Patrick feature a number of incidents in which his manner and behaviour are similar to those exhibited on the night of his death. During previous incidents he had to be restrained for his own protection and to allow him to receive treatment.

Actions of PCSOs

The two PCSOs were both trained in first aid and Staff Protection, which includes tactical communication, unarmed defence tactics, use of force and awareness of positional asphyxia and acute behavioural disturbance. Unlike police officers, PCSOs are not issued with public protection equipment.

They decided to accompany the duty manager to Patrick’s room when she went to check on him. Although it was not within their remit to deal with public order matters, they were concerned about leaving a lone female to go to a potentially dangerous incident. One of them tried to calm Patrick while the other spoke to the ambulance service. They also called for police back up and later assisted the police officers in the restraint.

Restraint

Following the arrival of the ambulance crew, the senior police officer present, a Sergeant, made the decision that Patrick should be restrained for everyone’s safety including his own. She felt they had no choice but to use restraints to try to save his life, as he clearly needed medical treatment and to be taken to hospital. The officers say they were aware of the risks of “positional asphyxia” so they placed him in the recovery position as soon as restraints were applied. Three of the officers considered the possibility that he was suffering from excited delirium (which can follow a drugs overdose) but from their perspective the ambulance crew were in charge.

Subsequent investigation

A post mortem was conducted by Home Office Pathologist Dr Fegan-Earl on 9 June 2007. He noted signs of medical treatment, as well as superficial injuries consistent with witness accounts of the incident. There were no features to suggest blows from any form of baton nor was there any evidence of significant restraint. Samples were provided for toxicology analysis and reviewed by Professor Forrest, a recognised expert in the field of

medical and forensic toxicology and chemistry. Toxicology revealed extremely high levels of benzoylecognine (cocaine metabolite), consistent with cocaine abuse.

Professor Forrest concluded that death was likely to have been due to the cardiac and metabolic consequences of agitated delirium produced by cocaine toxicity. He commented that restraint did not seem to have been a factor, and that the prognosis for a patient in this condition would at best have been guarded. Even with optimal treatment Patrick may not have survived.

Patrick Gaughan's family commissioned further work from Professor Crane. His preliminary report agreed with Dr Fegan-Earl but he also commented that restraint could have been a factor in Patrick's death. He stated that: "Clearly the sooner the condition of agitated delirium was recognised and the appropriate treatment given the better the prognosis but even early diagnosis of the condition does not preclude a fatal outcome."

Review of the restraint techniques employed

Any death following police restraint is a matter of public concern. The IPCC considered it appropriate to examine in detail the justification for the level of force used by the officers, whether this was in accordance with their training, and whether any other techniques might have been more safely used in the circumstances. Evidence was sought from the officer responsible for officer safety training in Hertfordshire Constabulary. In addition, an expert from the National Policing Improvement Agency (NPIA) was commissioned by the IPCC to consider the actions of the officers, specifically in relation to their initial use of physical restraint, the use of handcuffs and leg restraints.

Both experts concluded that the officers acted in accordance with their training. The use of restraint was solely to facilitate medical treatment. In commenting on their actions, the NPIA expert commented that they were acting on the medical advice available.

The role of the ambulance service

At the request of the IPCC, the actions of the ambulance crew who treated Patrick were subject of a clinical review by the East of England Ambulance Service NHS Trust. It was the general consensus of the panel that the crew managed the patient extremely well in very difficult circumstances and to a high standard of care. Patrick was believed to be suffering from hypoglycaemia (low blood sugar) which is a potentially fatal condition. He was given an injection of Glycogen. Although not necessary in this case the injection was harmless. When Patrick failed to respond as expected he was taken to hospital.

Family and police liaison

The IPCC appointed a Family Liaison Manager for Mr Gaughan's mother, who was also represented by a solicitor. They were kept informed during the investigation. The family were concerned that Patrick may have been assaulted by the officers and that excessive force may have been used to restrain him. Patrick had survived previous drugs overdoses where police had been called to restrain him and they felt that he would have survived if the police had responded differently. As a result of the family's concerns the IPCC commissioned a forensic expert to examine the officers' batons and to analyse the blood patterns found in Patrick's room. These examinations showed no evidence that Patrick had been hit or struck with a baton and witnesses confirmed that Patrick had an injury to his forehead before the officers entered the room.

The officers involved were treated as witnesses and co-operated fully with the investigation. They were kept informed during its course.

Conclusion

It is apparent that Patrick Gaughan was acutely unwell when first seen by the police, who immediately called for an ambulance.

Police officers are taught that where someone is suffering from excited delirium they should be treated as a medical emergency and taken to hospital as soon as possible. In this case they immediately called for an ambulance. When the ambulance arrived their priority was for the ambulance crew to assess him. As Patrick was attempting to hurt both himself and them, it was necessary for officers to restrain him for any treatment to be administered, and indeed, to take him to hospital. The officers were controlled and professional in the manner in which they did so and the techniques they used were appropriate in the circumstances. Whether or not restraint was a factor in Patrick's death, it is clear that all attempts at restraint were solely in the interests of Patrick's welfare.

There is no evidence that any officer or member of police staff committed any offence in their restraint of Patrick Gaughan. There is evidence of good practice in the way the Sergeant took control of the situation. Despite Patrick having attempted to assault police and ambulance crew he was not arrested and continued to be treated as a medical emergency.

Excited delirium is a rare condition. The police were, in this case, more familiar with possible symptoms of excited delirium than the ambulance crew, however they deferred to the ambulance crew in their medical assessment. Training of ambulance crews on this specific condition would enable the emergency services, when working together, to have a joint understanding and familiarisation which would better support the progress made by police forces in training their officers to recognise the condition.

The delay in notifying Patrick's family of his death was deeply unfortunate. Although not deliberate, a delay in these circumstances can significantly affect a family's confidence in the police. We note that Hertfordshire Constabulary have since apologised to the Gaughan family. We have also recommended that notifying a family should be given a much higher priority in these circumstances.

Deborah Glass **Commissioner**	**Clare Brookes** **Deputy Senior Investigator**

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