**[This PDF contains several articles regarding the RESTRAINT ASPHYXIA DEATH of KURT HOWARD. They are presented in REVERSE order; from the MOST CURRENT (June 28th's Jury's verdict), to LEAST CURRENT; as of the date of this PDF file's creation and posting: June 30, 2008.]**

**http://www.thisissouthwales.co.uk/displayNode.jsp?nodeId=161389&command=displayContent&sourceNode=161372&contentPK=20970054&moduleName=InternalSearch&formname=sidebarsearch**

this is swansea.co.uk
At the heart of all things local

Evening Post

# RESTRAINT DEEMED EXCESSIVE BY JURY

JASON EVANS
JASON.EVANS@SWWMEDIA.CO.UK

Date : 28.06.08 **[June 28, 2008]**

A Mumbles-born man who died after being held face down on the floor at Cefn Coed Hospital for three-quarters of an hour died due to excessive, prolonged restraint, a jury has decided. Kurt Howard, a man with a history of drug taking and mental health problems, suffered a cardiac arrest while being restrained by four members of staff in the Tegfan Ward - but it took 20 minutes for paramedics to be called.

In their verdict the jury of seven men and three women highlighted a series of failings and mistakes in the care Mr Howard received prior to his death.

They also said that the face-down, or prone, restraining position as had been used on the 32-year-old had not been part of hospital training or policy at the time of the death, but was "in accordance with the practice at Cefn Coed Hospital".

Coroner Phillip Rogers read the seven-page verdict on behalf of the jury, and said the cause of death had been: "Excessive, prolonged physical restraint, face down on the floor in a confined environment, suffering acute behavioural disturbance in a background of chronic psychosis brought on by a history of illicit drug taking."

Mr Howard had been in and out of Cefn Coed for more than a decade prior to his death, and had been diagnosed with drug-induced psychosis.

On June 17, 2002, he appeared before Swansea Magistrates Court on a public order charge after an incident at Sizzles Caf?? in Swansea High Street, and on an assault charge after he had struck a police officer.

He was bailed to Cefn Coed Hospital, and while there was sectioned under the Mental Health Act because of his deteriorating condition and non-compliance with treatment.

In the detailed verdict - which recorded the events of June 29, the day Mr Howard died - the jury said there had been two periods of restraint.

In the first, which lasted around 30 minutes, Mr Howard was restrained on a bed. His behaviour was described as violent and aggressive and he assaulted a member of nursing staff.

All the staff involved in this initial restraint were appropriately qualified.

The second period of restraint lasted around 55 minutes, about 45 minutes of which was on the floor.

Three members of staff, all fully qualified in restraint techniques, were initially involved in holding him down but they were subsequently joined by a fourth staff member, a senior nurse, who was not fully qualified.

The inquest into Mr Howard's death lasted almost five weeks and heard testimony from dozens of witnesses.

It was delayed for six years partly because of two separate police investigations, neither of which led to charges being brought.

Speaking after the verdict Mr Howard's father-in-law, Robert York, said the family had been let down by systematic failings in the health care system, and had been misled as to what had happened on the day his son died.

"There have been massive failings in Cefn Coed Hospital in training and policies," he said.

"It is not just the policies that need changing, but the culture.

"This was a vulnerable young man who needed to be properly cared for."

He also expressed concern that staff involved in the death were still at work. Astrid Coates, the solicitor acting on behalf of Mr Howard's family, said: "We have waited six years to find out the truth of what happened to Kurt.

"The jury's verdict is a damning indictment of the care Kurt received in Cefn Coed Hospital.

"Kurt was a vulnerable young man with mental health problems who was let down by Swansea NHS Trust."

The successor body to the Swansea trust is the Abertawe Bro Morgannwg University NHS Trust.

In a statement, the trust said it would need time to consider the verdict in detail and it would be inappropriate to comment on it.

The statement went on: "The trust would like to take this opportunity to again express its condolences to Mr Howard's family for their loss.

"Mr Howard's death occurred six years ago in 2002, and there have been many changes in procedures and policies since that time.

"A series of actions were put in place by the former Swansea NHS Trust following an internal review in 2002 after Mr Howard's death.

"They concentrated on more robust violence and aggression management training, and tighter procedures.

"A clear system of checks was set up to ensure regular staff training and awareness-raising were undertaken.

"When restraint is used now, the circumstances are reviewed in all cases to ensure best practice is shared with staff and lessons learned.

"The trust also acknowledges that procedures around reporting unexpected deaths to police were not robust enough six years ago, and there are now firm and clear rules in place."

==========

**http://www.thisissouthwales.co.uk/displayNode.jsp?nodeId=161389&command=displayContent&sourceNode=161372&contentPK=20970174&moduleName=InternalSearch&formname=sidebarsearch**

this is swansea.co.uk
At the heart of all things local

Evening Post

## 8 FATAL MISTAKES LED TO TRAGEDY

JASON EVANS
JASON.EVANS@SWWMEDIA.CO.UK

28 June 2008 **[June 28, 2008]**

An inquest jury has highlighted eight fatal mistakes and errors which combined to lead to the death of a psychiatric patient. Kurt Howard, aged 32, died after being restrained face down on the floor of his room by four male nurses at Cefn Coed Hospital in Swansea. **[Unfortunately, this reporter neglected to IDENTIFY the "8 Fatal Mistakes" highlighted by the jury. Perhaps he'll do so in a later "article."]**

His family spoke out after the jury reached its verdict, accusing the former Swansea NHS Trust, and the system, of "routinely failing him in life and death".

**[Yeah! That's IT! That's the entirety of this "article"!]**

==========

http://www.thisissouthwales.co.uk/displayNode.jsp?nodeId=161389&command=displayContent&sourceNode=161372&contentPK=20812486&moduleName=InternalSearch&formname=sidebarsearch

this is swansea.co.uk
At the heart of all things local

Evening Post

# NURSE ACCUSED OF 'HIDING EVIDENCE' IN KURT HOWARD CASE

EMMA JUDD
EMMA.JUDD@SWWMEDIA.CO.UK

Date : 07.06.08 **[June 7, 2008]**

A Senior NHS nurse was accused of getting rid of vital evidence and covering up the circumstances of a mental patient's death, when she gave evidence at an inquest.

Former duty nursing manager Petrina Thomas was in charge at Cefn Coed Hospital at the time of 32-year-old Kurt Howard's death on June 29, 2002.

She was giving evidence yesterday for the second day at an inquest into his Mr Howard's death.

The Mumbles-born patient died while under restraint in his room in ward five of the facility, known as Tegfan ward.

Three of the nursing staff involved in his restraint have also been accused of trying to cover up the details of events leading up to his death.

A fourth, Paul Hunt, was due to begin his evidence yesterday afternoon.

On Thursday, Leslie Thomas, the barrister working on behalf of Mr Howard's family, accused Mrs Thomas of being "part and parcel" of a cover-up involving her and the four nursing staff.

Yesterday, he leveled 11 accusations of her omitting to fill in forms correctly, washing Mr Howard's body and his room to eradicate forensic evidence of alleged wrongdoing, and colluding with her staff to cover up their actions in restraining Mr Howard in the face-down position, including a failure to record bruising to Mr Howard's face. **[Unfortunately, this article's reporter entirely failed to identify the evidence offered by Mr. Thomas supporting these accusations, OR the testimony offered by the accused to refute the charges.]**

Mrs Thomas, who is now clinical nurse manager at Tonna Hospital in Neath, vehemently denied the allegations.

"I haven't got anything to cover up," she said yesterday. "

Barristers Mikhael Puar, working on behalf of the four nursing staff, and Robert Francis, representing ABM University NHS Trust, joined Leslie Thomas in focussing on discrepancies in Mrs Thomas's witness statement.

She said at around 7.30am she was paged to request extra staff be sent to ward five, known as Tegfan,

because of an incident on the ward. She arrived to find Kurt Howard being restrained in the prone position on his bedroom floor. She told the inquest she assessed the situation and thought Mr Howard was at no risk of harm.

She and staff nurse Steve Parsons spoke for around five minutes about Mr Howard and the incident.

Mrs Thomas said she checked on Kurt again, and he was still under restraint in the same position.

From there, she went to the next-door detox ward and had a cup of tea with staff there for around 10 minutes.

Then she went back to Tegfan and by that time Mr Howard was making his bed along with nursing support worker Paul Hunt, she said.

"I was quite surprised," she said.

From there she headed to Ward E, and was then called out to ward A.

By that time, she said, it was around 9am and she got an emergency call that there had been a cardiac arrest on Tegfan ward.

She arrived there, she said, to see Kurt Howard on the floor of his bedroom, turning blue.

She took over CPR, but had to break off some time later as she was overcome with nausea. She said the ambulance had been called, and a crew arrived, but Mr Howard was pronounced dead at 9.46am.

Other staff have said that Mr Howard was restrained on his back, on his bed during the first restraint, the one witnessed by Mrs Thomas.

They said it was during a second restraint that Mr Howard either dragged them off the bed and onto the floor or fell.

But Mrs Thomas said the staff told her that they put Mr Howard on the floor in the prone position on purpose.

"They couldn't manage him, he was all over the place," she said.

The other staff also claimed that he "went limp" at around 9.25am - not 9am as Mrs Thomas suggested.

"I would suggest you have made several mistakes in relation to your evidence," said Mr Puar.

When Mr Francis informed her the ambulance was called at 9.31am, he asked her if she still thought she arrived on the ward at 9am.

"No, if that's the case, if the ambulance was called at 9.31am, then no," she said.

The inquest resumes on Monday.

==========

http://www.thisissouthwales.co.uk/displayNode.jsp?nodeId=161389&command=displayContent&sourceNode=161372&contentPK=20800991&moduleName=InternalSearch&formname=sidebarsearch

this is swansea.co.uk
At the heart of all things local

Evening Post

# 'ADRENALIN CAUSED PATIENT'S DEATH'

[No Author/Reporter name published.]

Date : 05.06.08 **[June 5, 2008]**

A Surge of adrenalin caused a mental patent's heart to stop, an inquest has heard.

Professor John Vann Jones said that Kurt Howard died suddenly after a period of "extreme emotional upset".

He said the physically healthy 32-year-old was one of 20 per cent of people who die suddenly from cardiac arrest, who have no history of heart disease or any evidence of heart damage.

But he said: "It has long been recognised that otherwise healthy people can die suddenly after a prolonged period of extreme emotional upset."

The inquest has heard how Mr Howard was restrained twice on the day of his death.

During the first restraint he was injected with Haloperiodol, an anti-psychotic drug, as well as Lorazepam, a calming drug.

And during the second restraint, Mr Howard was restrained first on his back, then, after a period of time, he fell from his bed to the floor, and ended up being restrained in the face-down, prone position.

The court has heard how he was struggling throughout the 55-minute restraint, up until the last minutes.

Prof Vann Jones said: "It is not difficult to imagine that the situation could deteriorate into ventricular fibrillation and cardiac arrest."

He said that Haloperidol, mixing with the adrenalin caused by the stress of the situation, could have had dangerous consequences.

"I suspect the combination is what proved lethal here," he added.

Prof Vann Jones said that is could be neither proved nor disproved that the face-down position could have had an effect on the situation. **[Clearly, Prof Vann Jones isn't familiar with restraint asphyxia pathophysiology.]**

Instead, he said, it was the act of being restrained against his will that produced the adrenalin - the fight or flight hormone - that speeds up the heart.

"That would be very stressful," he said.

Professor Vann Jones said the time between the heart going into arrhythmia - abnormal rhythm - and death, would have been a matter of seconds, and it was unlikely that Mr Howard could have been resuscitated.

A witness giving evidence before Professor Vann Jones this morning, nursing support worker Royston Mulland, said Mr Howard seemed to calm down between five and seven minutes before he died. **[It is far more likely than not, that Mr. Howard's "calm" period occurred after he entered respiratory arrest, and just prior to (or coincident with) his heart stopping – meaning that five to seven minutes of "calm" behavior expired prior to his restrainers noticing that he was dead!]**

Professor Vann Jones said this period would have reduced the risk of Mr Howard suffering cardiac arrest. **[Again, Prof Vann Jones clearly isn't familiar with restraint asphyxia pathophysiology.]**

"I would have thought there was nothing to indicate it was coming," he said.

The inquest has also heard written evidence from nursing support workers Christopher Davie ( and Anthony Fry.

==========

http://www.thisissouthwales.co.uk/displayNode.jsp?nodeId=161389&command=displayContent&sourceNode=161372&contentPK=20783265&moduleName=InternalSearch&formname=sidebarsearch

this is swansea.co.uk
At the heart of all things local

Evening Post

## 'NO MEDICAL REASON FOR PATIENT'S DEATH'

EMMA JUDD
EMMA.JUDD@SWWMEDIA.CO.UK

Date : 04.06.08 **[June 4, 2008]**

A Number of factors contributed to the death of a physically healthy 32-year-old man, an inquest has heard. Dr Derek James was giving evidence yesterday into the death of Mumbles-born Kurt Howard (pictured left) at Cefn Coed Hospital on June 29, 2002.

Mr Howard was being treated at the hospital for drug-induced psychosis, which he had been suffering from for more than a decade.

Dr James said that he could find no medical reason for Mr Howard's death during the post mortem examination of his body, some days after he died.

Dr James described it as a "sudden death during the physical and chemical restraint of a man suffering acute behavioural disturbance, in a background of psychosis, with treatment".

He said it is a historic fact that people with mental health problems were more susceptible to sudden death, termed lethal catatonia. **[Dr. James is clearly a witness being paid to provide testimony that will exonerate those who restrained Mr. Howard, and an individual who has no apparent**

**understanding of restraint asphyxia pathophysiology.]**

Dr James also said there had been studies carried out on cocaine abusers in the US who had suffered similar, unexplained deaths.

He said the fact Mr Howard was restrained at the time of his death was a factor, as was his history of drug abuse, the tranquillising medication he had been injected with an hour before, the stress his body was under, his psychotic behaviour and a blow to the head he had received from another patient the day before.

He discounted the possibility that Mr Howard could have died because of positional asphyxia - a condition caused when the body is positioned so not enough air can get into the lungs.

He said had that happened because pressure had been put on the chest or lungs, tiny haemorrhages called patichiae would have covered his upper body, but they were absent, he said.

**[This is blatantly *false* testimony. Were Dr. James a legitimate forensic pathologist (someone actually qualified to provide testimony as to cause of death), he would know that *absence* of post mortem petechiae does NOT "rule out" asphyxial death! See: http://www.charlydmiller.com/LIB04/2000petechiaereview.html and http://www-medlib.med.utah.edu/WebPath/FORHTML/FOR125.html among *many other* forensic references regarding petechiae.]**

Mr Howard had around 33 different marks on his body, according to the barrister for his family, Leslie Thomas.

Mr Thomas had asserted that some of the marks were caused when Mr Howard was assaulted by the nurses restraining him.

But Dr James said the wounds on Mr Howard's body - bruising to the legs and arms, as well as facial grazes, a black eye and a bruise in front of the ear - could have been caused during restraint, using normal pressure, and during resuscitation. **[Once again, Dr. James is clearly a witness being paid to provide testimony that will exonerate those who restrained Mr. Howard.]** A second expert witness called to give evidence yesterday, Dr Andrew Bleetman, gave evidence on how dangerous the prone restraint is to a patient.

"Prone restraint, when applied safely by staff trained to do so, places no significant risk of death," he said.

But the court has heard that the nurse and health workers involved in restraining Mr Howard were untrained in prone restraint, or in turning those who had landed or fallen onto their faces.

Dr Bleetman said untrained staff trying to turn him onto his back, in a room measuring 9ft 4ins by 10ft 9ins would be "challenging, if not impossible".

He added that if the breathing was limited even slightly, in any kind of restraint, it could contribute to heart arrhythmia and from there to cardiac arrest. He also said that patients can continue to shout loudly up to the moment of cardiac arrest, in the body's last effort to save itself.

Barrister Robert Francis asserted that if the patient was shouting, it was proof that any tranquillising drug

they may have been given was not working. The inquest is due to continue at Swansea Guildhall until early next week.

---

**USE YOUR BACK BUTTON** To Return To Wherever You Came From
***OR*** Use the Following Links:

Return to the Restraint Asphyxia LIBRARY:
http://www.charlydmiller.com/RA/RAlibrary.html#2008HowardVerdict

Go to the Restraint Asphyxia Newz Directory:
http://www.charlydmiller.com/ranewz.html

Go to **CHAS' HOME PAGE:**
http://www.charlydmiller.com

**Email Charly at:** c-d-miller@neb.rr.com

Those are hyphens (dashes) between the "c" and "d" and "miller"