THEMES FROM THE INDEPENDENT ADVISORY PANEL (IAP) ON DEATHS IN CUSTODY REVIEW OF RULE 43 REPORTS, NARRATIVE VERDICTS AND INVESTIGATIONS REPORTS WHERE RESTRAINT WAS IDENTIFIED AS A DIRECT CAUSE OF CONTRIBUTORY FACTOR IN THE DEATH.

Background

1. At the Ministerial Board on the 4 March 2010, Board members supported the IAP recommendation to undertake a review of the Coroner Rule 43 Reports, narrative verdicts and investigation reports relating to those deaths where the use of restraint was identified as either a contributory factor, or direct cause of death. The IAP believes that these reports contain a large amount of learning, which could be disseminated across the custodial sectors. Board members were particularly keen to identify trends in the reports in relation to ethnicity, mental health and learning disabilities/difficulties.

2. The IAP wrote to the Prisons and Probation Ombudsman (PPO), Care Quality Commission (CQC) and to individual Coroners to access copies of these reports. Unfortunately, due to confidentiality restrictions, the IAP was unable to view the original investigative reports from the Independent Police Complaints Commission (IPCC). Instead, they provided a detailed analysis of 16 restraint cases between 1998/99 and 2008/09, where restraint was directly linked to the death, as well as an analysis of six further cases where the use of restraint *may* have contributed to the death[1].

3. The Faculty of Forensic and Legal Medicine at the Royal College of Physicians had initially expressed an interest in contributing to this review although after exploring the scope of their work we agreed that it was not sufficiently aligned at this stage. This paper provides an overview of the key themes and suggestions for the next steps to be taken by the IAP.

Summary of Themes Identified in Restraint Related Deaths

4. The themes and issues highlighted below are based on examination of 29 individual deaths in custody. These have been drawn from the summary analysis of 22 IPCC

[1] The IAP would like to note that the identification of these six cases was reliant on searching the free text IPCC database; therefore, there may be more than the six additional cases identified by the IPCC.

cases, and the seven reports from the PPO, HM Coroners Rule 43 Reports and narrative verdicts and Mental Health Act Commission Post Inquest Reports to which the IAP had access. Some of the information was validated against press reports.

Characteristics of the Deceased

- There were 28 male deaths and one female death.
- In six of the cases, positional asphyxia was listed as either a primary or secondary cause of death.
- Acute behavioural disorder or excited delirium was listed in six of the cases.
- Nine individuals were from Black and Minority Ethnic (BME) groups, with six individuals classified as Black, one as Asian and two as Mixed Ethnicity. 17 were classified as White, with the ethnicity of the remaining three individuals unknown.
- The most common reasons for arrest were for public order offences (seven cases) and for assault (five cases).

Drugs and Alcohol

- In nine of the cases, drugs and alcohol were listed as factors[2] on their case files.
- All known drug factors were connected to illicit drug use, with cocaine, cannabis and amphetamines all listed on their case files.

Mental Health Issues

- In 12 of the cases, individuals had mental health problems at the time of their death. Five individuals had been diagnosed as suffering from schizophrenia and two individuals were diagnosed with paranoid schizophrenia.
- Five individuals had been restrained whilst being detained by the police under Section 136 of the Mental Health Act (MHA)[3].

[2] For the IPCC's analysis, they looked at 'factors' on the individual's case. These could be any issues identified by the arresting officer, custody officer / staff, information held on the Police National Computer (PNC), information on the custody system and reason for arrest.

[3] Section 136 of the Mental Health Act gives the police powers to remove a person who appears to be suffering from mental health disorder and *"who is in immediate need of care or control"* from a public place to a place of safety, usually to a police cell or hospital emergency ward.

Restraint Techniques, Training and Guidance

- In three of the cases, there were concerns that the restraint techniques were not always carried out in accordance with those taught on training courses. In two of those cases, the restraint was being administered by staff that were not appropriately trained to administer such techniques.
- In seven of the cases, the reports contained concerns around the lack of staff awareness concerning the dangers associated with positional asphyxia and to a lesser extent, acute behavioural disorder, during the restraint incident.
- In three of the cases, concerns were highlighted at the delays between the incident of restraint and the arrival of an emergency ambulance or doctor.
- In three of the cases, serious concerns were raised about the use of the prone position as a restraint technique and the prolonged period of time this was used. The independent inquiry into the death of David 'Rocky Bennett', a patient who was detained under the MHA who died in 1998 after being restrained, was published in February 2004. In the report, significant concerns on the use of the prone position were highlighted.
- Of particular concern to the IAP is that inquests held in 2008 into the deaths of Kurt Howard who died in 2002 and Azrar Ayub and Geoffrey Hodgkin who both died in 2004 highlighted that the lack of restraint training and staff knowledge was a contributory factor[4]. Worryingly, in the latter two cases, deaths followed use of the prone position for restraint, and they occurred after the findings of the Bennett inquiry had been published.

5. This workstream is undertaking a parallel piece of working, reviewing the medical theories and research relating to restraint related deaths. It is hoped that the findings from this review will enable the IAP to identify whether the restraint training packages used by each of the custodial sectors adequately mitigate the medical risks related to restraint and to make necessary recommendations to improve restraint practices.

Learning Disabilities and Difficulties

- In the reports made available to the IAP, there was nothing to indicate that any of the individuals had learning disabilities or difficulties. One PPO case provides information from the bereaved family stating that the detainee had been vulnerable. There are a number of reasons for the lack of information as to whether the

[4] The Mental Health Act Commission (2009) *Coercion and Consent – Monitoring the Mental Health Act 2007-2009:* 211.

individuals had learning disabilities. In some cases this information would never have been recorded by the custody sector.

- The review of the medical theories and research relating to restraint related deaths has identified that three individuals, detained under the MHA, had a learning disability at the time of their death. These cases will be discussed in more detail in the final report of the review, which is due to be presented at the Ministerial Board in October 2011.

Conclusion and Next Steps

6. This work highlighted that 12 individuals included in the review had mental health problems at the time of their death. Of particular concern to the IAP is that in two of these deaths, the use of prone restraint was noted with significant concern in their inquests. The deaths of Azrar Ayub and Geoffrey Hodgkin in 2004, both patients detained under the MHA, occurred after the recommendations from the Rocky Bennett inquiry were made public. The Department of Health, as a result of this inquiry is still exploring legislative routes to develop accredited training packages and techniques for use across mental health trusts.

7. The IAP would like to re-iterate the importance of an accredited training package being developed to address ongoing concerns on the use of restraint in a mental health setting. Rocky Bennett died in 1998 and the initial recommendations from his death were made in 2003. Since then, there have been four deaths, where restraint was identified as a cause of death of patients detained under the MHA.

8. The IAP is also concerned about the number of individuals from Black and Minority Ethnic (BME) group where restraint was either a direct cause or contributory factor in their death. The IAP will analyse data to identify whether restraint is used disproportionately on individuals from BME groups across all sectors.

9. The findings from this work, will inform the development of a series of common principles for the use of restraint, which it is hoped custodial sectors will adhere to as a minimum. The aim of these principles will be to bring about an improvement in operational practices across the custodial sectors in order to reduce the number of restraint related deaths in the future. These principles are due to be presented to the Ministerial Board on Deaths in Custody in February 2012.