Restraining Police Restraint

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Death in police custody

- 1,160 people died in police custody in England and Wales between 1990 and 2020, out of a total of 1,777 police-related deaths in that period.
- By contrast, there were 75 police shootings between 1990 and 2020.
- So most police-related deaths are deaths in custody.

Source: INQUEST

What is positional asphyxia?

- Identified in the late 1980s/early 1990s as a potential cause of death.
- Often occurs where the deceased has been placed in the prone position, namely on their front, with hands handcuffed or bound behind the back.
- If a person is held for a sustained period and particularly if they are exhausted, this additional effort may prove too much and they may succumb and die as a result of a reduction in oxygen in the blood.
- Higher risk if the person is large/has a large stomach, and if they are drunk or under the influence of drugs.

Key signs of positional asphyxia

- Gurgling or gasping sounds
- Cyanosis (the face turning blue)
- Passivity
- Hypervigilance
- Verbal complaints of being unable to breathe

'Acute Behavioural Disturbance' or 'Excited Delirium'

- A controversial cause of death.
- Not found in the DSM-V or ICD-10 as a distinct diagnosis.
- Lipsedge (2015) questions whether it is a sufficient cause of death in its own right.
- Key signs: delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent and bizarre behaviour, insensitivity to pain, elevated body temperature, tachycardia, incoherent speech or shouting, inappropriate removal of clothes and superhuman strength

The Angiolini Review (2017)

" This report argues that police practice must recognise that all restraint has the potential to cause death. Recognition must be given to the wider dangers posed by restraining someone in a heightened physical and mental state, where the individual's system can become rapidly and fatally overwhelmed...

Currently there is no consistency of training in restraint techniques across the 43 police forces in England and Wales. There should be mandatory and accredited national training for police officers in restraint techniques and supervision of vital signs during restraint, with appropriate refresher training for officers. There should be national consistency in approaches to the use of force. In addition, the ability to de-escalate circumstances which may lead to a physical or violent encounter should be paramount in the skills set of the individual officer.

National policing policy, practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk."

Unlawful killing verdicts

- Must be murder, manslaughter or infanticide not sufficient if the killing was unlawful in some other sense (*R (Wilkinson) v HM Coroner for Greater Manchester South District* [2012] EWHC 2755 (Admin)).
- Previously the criminal standard of proof, but now (since 2020) the civil standard (*R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46).
- The main relevant types of unlawful killing:
 - Unlawful act manslaughter
 - Gross negligence manslaughter

Unlawful act manslaughter

- A defendant is guilty of this sub-category of manslaughter if they intentionally do an act which is unlawful and dangerous which inadvertently causes death (*DPP v Newbury* [1977] AC 500 HL).
- It is not necessary to prove that the unlawful and dangerous act was aimed at any person, or in particular the person whose death was caused (*R v Mitchell* [1983] QB 741 CA).
- Neither is it necessary to prove that the defendant knew that their act was dangerous and unlawful (*Newbury*).
- For an act to be unlawful within the meaning of this rule it must be criminally not merely civilly wrong (*R v Franklin* (1883) 15 Cox CC 163)

Unlawful act manslaughter

- As for dangerousness, this is determined objectively. The act must be such that all sober and reasonable people would inevitably recognise that it must subject the other person to at least the risk of some harm, even if not serious harm (*R v Church* [1966] 1 QB 59).
- So the key elements are:
 - an unlawful and dangerous act
 - which results in the death of another
 - which was committed intentionally
 - by one or more persons if they act together in a joint enterprise.

Gross negligence manslaughter

- The key ingredients are set out in *R v Adomako* [1995] 1 AC 171:
 - The existence of a duty of care (based on ordinary principles of negligence) owed to the deceased;
 - A breach of that duty of care;
 - The risk of death (not just the risk of serious injury) was a reasonably foreseeable consequence of the misconduct;
 - The breach caused the death, and
 - Having regard to the risk of death involved, the misconduct was grossly negligent so as to be condemned as the serious crime of manslaughter.

Meaning of 'negligence' and 'gross negligence'

- The ordinary principles of negligence apply.
- The duty owed by a professional is to exercise the skill, care and diligence of a competent professional of the same rank and with the same professed specialisation. Their 'incompetent best' is not good enough.
- For negligence to be 'gross negligence' it must be 'truly exceptionally bad' – a question of fact for the jury.
- See *Adomako*; *R v Misra* [2005] 1 Cr App R 21; and *R (Dawson) v HM Coroner for East Riding and Kingston upon Hull* [2001] Inquest LR 233.

Who holds the police to account?

- No successful prosecutions of police for murder or manslaughter in respect of deaths in police custody.
- Police are investigated by the Independent Office for Police Conduct (IOPC) (formerly the Independent Police Complaints Commission (IPCC)) – but bereaved families are often dissatisfied with their investigation.

Race and restraint: the elephant in the room

"Taking all that we have heard and read into account we grapple with the problem. For the purposes of our Inquiry the concept of institutional racism which we apply consists of:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.

It persists because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease."

-The Stephen Lawrence Inquiry

"...despite much seeming and some very real progress, public discourse about racism is still as childish and supine as it ever was. Where we do discuss race in public, we have been trained to see racism – if we see it at all – as an issue of interpersonal morality. Good people are not racist, only bad people are. This neat binary is a great way of avoiding any real discussion at all."

- From "Natives: Race and Class in the Ruins of Empire", Akala, 2019.

"We need to hold those responsible to account because Thomas" life and death needs to matter. It has been truly heartbreaking to witness Thomas' hideous end, we can only imagine how dreadfully frightening it would have been for him and we will never recover from this; we can never forget and we feel almost as much victims of this as Thomas was. But to have some good come of it, some accountability, some change in policy, some shift in Police attitudes towards vulnerable people, would go some way towards our healing."

-The family of Thomas Orchard

Examples of state-related deaths 1990present

- Police-related: Joy Gardner, Christopher Alder, Richard O'Brien, Ibrahima Sey, Roger Sylvester, Mikey Powell, Sean Rigg, Kingsley Burrell, Thomas Orchard, Thomas Orchard, Douglas Oak, Leon Briggs, James Herbert, Sheku Bayoh, Kevin Clarke.
- Prison and youth custody : Denis Stephens, Kenneth Severin, Alton Manning, Omasase Lumumba, Gareth Myatt.
- Deportation: Jimmy Mubenga.
- Mental health settings: Rocky Bennett, Olaseni Lewis.
- And the recent death of Mouyied Bashir in Wales, restrained and put in handcuffs and leg restraints when his family called the police after he was having a MH crisis, one of two deaths of people of colour in the last six weeks.

"Our son, Seni, died because of the prolonged restraint in which he was held down by police officers while he was a patient in a mental health hospital: they held him face down, shackled with his hands in two sets of handcuffs and his legs in two sets of restraints. They held him down like that, in a prolonged restraint which they knew to be dangerous, until he went limp. And even then, instead of treating him as a medical emergency, they simply walked away, leaving Seni on the floor of a locked room, all but dead. That is how we lost our beloved son."

-The parents of Olaseni Lewis

Are the police accountable?

- Over 1700 deaths in police custody or following police contact since 1990.
- 10 prosecutions of police officers, all of which ended with acquittal or the collapse of the trial.
- The security contractors who killed Jimmy Mubenga were also acquitted at trial.

The barriers to justice

- Inequality of arms
- Misinformation, pathologisation and demonization of the deceased
- Narratives of 'drug addict', 'mentally ill' and 'gangster'
- Use of ABD/ED to deflect blame away from police officers

Have things really changed?

- Roger Sylvester died as a result of police restraint in 1999. In 2003 the inquest found that restraint was the cause of his death and that he was unlawfully killed. A lengthy Preventing Future Deaths report was produced by the coroner.
- Police forces became increasingly aware of the issues of ABD and positional asphyxia. There was another review into mental health and restraint by the MPS in 2004 making another 26 recommendations.
- Yet in 2018 Kevin Clarke, a Black man in mental health crisis, died as a result of police restraint. His inquest in October 2020 found that the restraint was inappropriate and contributed to his death.
- The same thing keeps happening we have known about this problem since the 1990s and people are still dying.

Possible solutions

- A 24/7 mental health emergency response service, to replace police as the first responders for people in mental health crisis.
- More funding for community mental health services, rather than policing and imprisonment.

"We have to cling onto hope otherwise they've won indefinitely and that cannot be right because the evidence is so compelling. It's traumatizing for any family and I don't think that ever goes away. We understand that our loved ones will never come back. What we want is for it to not happen to another family. What we want is really effective change."

-Marcia Rigg, sister of Sean Rigg