In the South London Coroner's Court
Inquest touching the death of Olaseni Lewis

Report to Prevent Future Deaths
(*Coroners (Investigations) 2013 Regulation 28)*

	THIS REPORT IS BEING SENT TO: 1. The Commissioner of the Metropolitan Police 2. Chief Executive, South London and Maudsley NHS Foundation Trust
1	**CORONER** I am Selena Lynch, Senior Coroner for the coroner area of South London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi_20131629_en.pdf
3	**INVESTIGATION and INQUEST** On 13th September 2010 Dr Roy Palmer commenced an investigation into the death of Olaseni Lewis 23. The investigation concluded before me at the end of the inquest on 9th May 2017. The conclusion of the inquest was that Mr Lewis died from hypoxic brain injury caused by restraint in association with acute behavioural disturbance. The jury recorded a narrative conclusion, (set out on the attached sheet and summarised in paragraph 4 below)
4	**CIRCUMSTANCES OF THE DEATH** Mr Lewis developed symptoms of an acute psychotic illness and was taken to the Maudsley Hospital in South London. Later the same day he was admitted to Gresham Ward at Bethlem Royal Hospital as an informal patient. He became agitated and was restrained by healthcare staff, detained under the Mental Health Act, and given medication. Hospital staff requested police assistance. Police officers placed Mr Lewis in handcuffs and took him to a seclusion room. Mr Lewis became agitated and fearful, and resisted efforts to leave him in the seclusion room. Officers restrained him but were unable to gain control. Leg restraints were applied and additional officers attended, but control was not achieved until eventually Mr Lewis became unconscious and suffered a cardiac arrest. The jury concluded that the Hospital Trust failed to meet training targets, that there was a lack of communication between police and medical staff, that the restraint was prolonged disproportionate and unreasonable, that police failed to follow their

	training to administer basic life support, and that medical staff failed to respond to the medical emergency.
5	**CORONER'S CONCERNS** 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. – (1) The court was told that officers are not expected to read Standing Operating Procedures and the Officer Safety Manual, and there is little "required reading" or ready reference for police officers regarding restraint techniques and dangers. (2) Officers had been taught about Acute Behavioural Disturbance (ABD) but most did not recognise that Mr Lewis was suffering from ABD. The training on ABD appeared unnecessarily complicated and was not fully understood by officers. They incorrectly assumed that it was a formal diagnosis of some sort and that healthcare professionals would be able to recognise and treat the condition. An expert psychiatrist indicated that the description might be helpful for police in the community, particularly when the condition is caused by drugs, but it causes difficulty when police and mental health services work together and where the underlying cause is related to mental illness. The question that arose was whether it is necessary to attach a label at all. It might be more easily understood if officers are taught that people who resist restraint and appear to be suffering from mental illness may not respond as expected, and are therefore more vulnerable to die suddenly during restraint. (3) Police were taught that prolonged restraint was dangerous, but had no idea what "prolonged" meant, and were left to use their own judgement. They also seemed to think that prolonged restraint referred to time spent in a prone position and that as long as the detainee was held on his/her side the danger was ameliorated or removed. The pathological and psychiatric expert evidence clearly indicated that restraint in any position can lead to sudden death in patients who are highly agitated. The jury found that the police training was inadequate in its definition of "prolonged restraint" for people exhibiting signs of ABD. (4) Police officers were given no advice or training what they could or should do if control was not achieved within a given period of time. (5) There was no training or understanding about the respective roles and responsibilities of healthcare and police staff. There was (and still is) no Memorandum of Understanding.

	(6) The jury concluded that medical staff requested police assistance due to a lack of trained and physically able medical staff. The Trust had a policy for closing wards or placing them in special measures when training levels fell below a given level, but this was not followed and there was a lack of clarity around who was responsible for assessing compliance
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23rd August 2017. 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 Chief Coroner and the following Interested Persons The family of Olaseni Lewis Health and Safety Executive Independent Police Complaints Commission Separately represented Bromley police officers I have also sent it to College of Policing INQUEST Secretary of State for Justice Secretary of State for Health Care Quality Commission who may find it useful or of interest. 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
	DATE 28 June 2017 **SIGNED BY CORONER** Emma Lynch