	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [REDACTED], Metropolitan Police Service, Broadway, London, SW1H 0BG 2. [REDACTED], Chief Executive Officer, London Ambulance Service, 220 Waterloo Road, London SE1 8SD
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** This report arises from the death of Mr **Kevin Clarke**, who died aged 35 on 09.03.18 at Lewisham Hospital [REDACTED]. I opened an inquest into the death on 28th March 2018, which was concluded on 9th October 2020. The delay in writing this report is occasioned by three matters: The complexity of proceedings led to several applications by interested persons for extensions to the period to make submissions (the family submission ran to 40 paragraphs). Secondly the senior coroner was engaged in another jury inquest at the time the submissions were completed. Thirdly the Covid-19 pandemic created unprecedented pressures on the coroner's service. The staffing was substantially below establishment and ill equipped to cope with the surge in deaths, which reached a peak of 40 on one day. This led to the senior coroner commissioning support from the First Aid Nursing Yeomanry and personally directing triage and case managing new death reports for seven weeks. The jury recorded the medical cause of death as 1a Acute Behavioural Disturbance (ABD) (in a relapse of schizophrenia) leading to exhaustion and cardiac arrest, contributed to by restraint struggle and being walked. They returned a long critical narrative conclusion.

4	**CIRCUMSTANCES OF THE DEATH** Mr Clarke was a 35 year-old black man with complex mental health problems. On 9 March 2018, he was found by police officers in a disturbed state. He was restrained prior to being taken to an ambulance. While in the ambulance but still handcuffed, he was found to be in cardiac arrest, which proved to be fatal. The narrative conclusion included these relevant extracts: The police officers' decision to use restraint was inappropriate because it was not based on a balanced assessment of the risks to Mr Clarke compared with the risks to the public and police. Supervision was not appropriate as his vital signs were not monitored; there was lack of attention to what Mr Clarke was saying due to radio cross talk and opportunities to release restraint were missed. The paramedic failed to conduct a complete clinical assessment on her arrival and failed to provide appropriate clinical advice on conveyancing to the police and these amounted to a failure to provide basic medical care. There were not adequate dynamic risk assessments by the paramedical staff together with the police officers. There is no evidence of police and paramedics considered the length of time he had been restrained or his position during conveyance, the fact that none spoke up or spoke out about either of these concerns is indicative of the lack of a dynamic risk assessment by the police and paramedics together. The absence of adequate initial and subsequent dynamic risk assessments before and during conveyance meant that the changing and increasing risks to Mr Clarke were not appropriately considered. This led to unsuitable choices, which ultimately increased his exhaustion. While police and paramedics offered a range of conveyance options they were not based sufficiently on his clinical needs and seemingly prioritised speed over safety. The way that Mr Clarke was moved from the playing fields was inappropriate. Forcing him to stand up and walk added to considerable extra strain on his body. The position in which he was conveyed including being bent forward with the back of his head held down by the hood and the elevated positions of his arms impaired his breathing and increased the stress on his body.

5	**CORONER'S CONCERNS**

The **MATTERS OF CONCERN** are as follows.

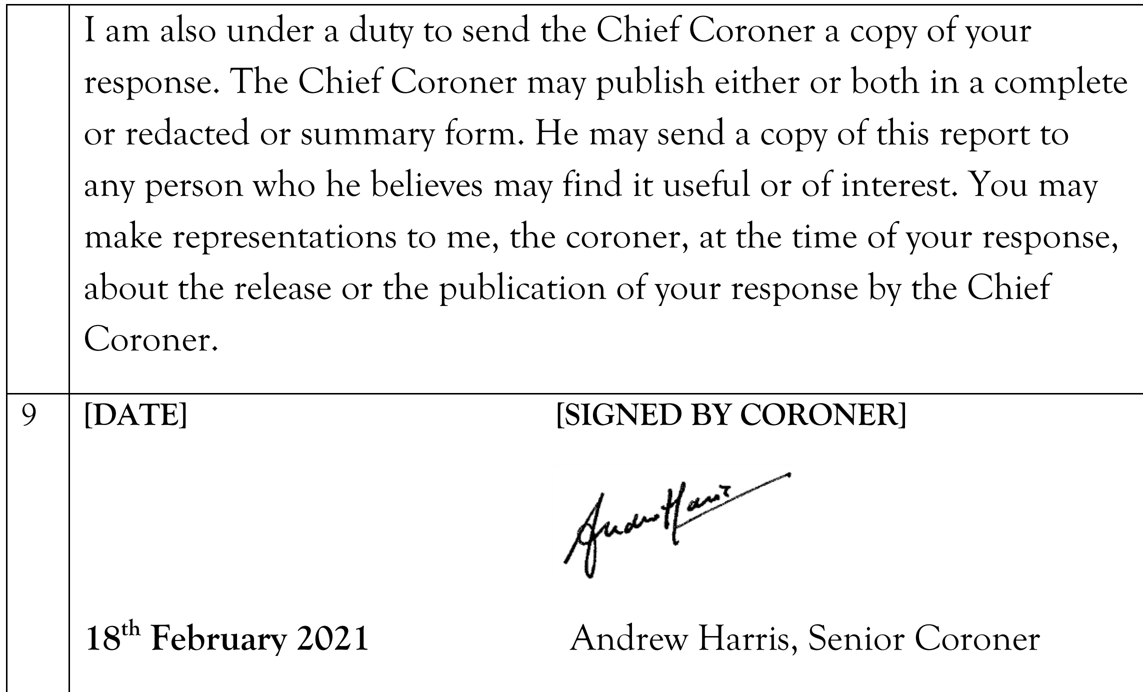
1. Evidence was adduced that the police officer training programmes are run by a specialist in officer safety, the core being Officer Safety Training, and another module being Emergency Life Support (ELS) and a bolt on of ABD Training. The focus of ELS is upon action in the event of a cardiac arrest, so that there is little attention to given to health and safety of the detainee in non-emergency situations and an inadequate input by health professionals. It is illustrated by the officer who said that he had not been taught how to measure vital signs as part of monitoring a detainee. The expert consultant physician who viewed the video of restraint observed a highly abnormal fast breathing rate, but none of the officers had noticed this at the time.

2. Despite organization protocols and the MoU there was a conspicuous lack of leadership, risk assessment or challenge on health and safety of the detainee by the paramedic, who appeared to have insufficient seniority or experience to know what to do in a detention situation. Equally there was a lack of expectation or request by police for her input and advice. My expert physician opined that if the detainee was to be moved, he wouldn't recommend standing him and walking him, which would make things worse. Yet the paramedic recalls no professional dialogue between police and paramedics about the critical conveyance decision, says she left it to them to decide, although preferring a safer method and then later changes her evidence.

3. The protocols of the MPS require a Safety Officer to monitor the detainee's health and safety in restraint situations. Evidence heard suggested that this was either not carried out or was ineffective. No officer challenged the decision to cuff the detainee when he started to get up and the Safety Officer at the time agrees he did not consider whether his illness made the decision unreasonable, as laid out in ACPO guidance. An officer agreed that the risks of restraint to the detainee were not balanced against the risks to everyone from not restraining. The Safety Officer at the head changed several times, making any monitoring of trend difficult and for a critical period the

	most inexperienced officer was the Safety Officer, who was unaware of the benefits of looking at gums or nails. At the time he was escorted, the Safety officer agreed that the face could not be observed as it was hidden by a hood. The risks are further augmented by the MPS submission that it is not always possible to identify a safety officer in all incidents. 4. There was serious inadequacy of supervision. The initial scene was managed by "collective leadership", where decision making seemed to emerge without discussion. An experienced serjeant who arrived after the initial restraint, alleged she had conducted a risk assessment, without getting an adequate briefing on the circumstances of his restraint. She was unable in questioning to identify any situation in which restraints should be released due to the length of restraint, unless directed by a paramedic or emerged from mania. She asserted that she knew that whatever her officers had done prior to her arrival, she could trust that they made the right decision. The steps that have been taken by the MPS and LAS have begun to address the concerns, but do not provide sufficient assurance of mitigation of risks to the lives of future detainees. Whilst policies and corporate commitments have acknowledged the challenges and agreed approaches, the dominance of the primacy of police officer safety in comparison with the attention to detainee health officer training and the weaknesses in leadership and supervision of both police and ambulance service staff in managing challenging incidents continue to create future risks to lives.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the evidence given in the inquest about the circumstances of this death and are in a position to mitigate or prevent future deaths: The Metropolitan Police Service The London Ambulance Service.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday, April 14th 2021. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [REDACTED] tel: [REDACTED] and [REDACTED]
8	**COPIES and PUBLICATION** I am also copying this report to the interested persons: [REDACTED] Solicitors for the Family from Saunders Law [REDACTED], Solicitor for Jigsaw from BLM Law [REDACTED] Solicitor for Police Officers from Reynolds Dawson Solicitors [REDACTED] Claims and Litigation Manager for SLAM (South London Maudsley) The Secretary of State for Justice is copied into this report for two reasons. Firstly a lengthy submission by the family urged me to write to all stakeholders to review their response to the [REDACTED] Report, citing [REDACTED] recent assertion that she had not seen detailed report of progress against each of her 100 recommendations. I have not accepted that submission, as the evidence related to this was not specifically heard during my investigation, and I do not consider this Regulation 28 Report a suitable vehicle for instigating such a review. Secondly this inquest has had high publicity and been the subject of a TV programme and the matter of police conduct in restraint of ethnic minority detainees is of high public interest. I thought it courteous to bring concerns to his attention. I also copy this to the Royal College of Psychiatrists, the Royal College of Emergency Medicine, who may have a professional interest and to my expert witness, [REDACTED], Professor of Emergency Care, West of England University.



	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.
9	**[DATE]** **[SIGNED BY CORONER]** **18th February 2021** Andrew Harris, Senior Coroner