Agenda Item	7

Police Authority
25 March 2010

THE ORGANISATIONAL RESPONSE TO THE DEATHS OF MICHAEL POWELL AND LINDA BURT

Report of the Chief Constable

PURPOSE OF REPORT

1. This report has been commissioned at the request of West Midlands Police Authority following the conclusion of the inquests into the deaths of Michael Lloyd Powell and Linda Burt. It is designed to update the Authority of any organisational issues and response following the narrative verdicts[1] reached by the juries in those cases.

THE INQUEST INTO THE DEATH OF MICHAEL POWELL

2. This tragic death of Michael Powell has been subject to extensive and comprehensive scrutiny from a range of authorities;
   - Independent investigation by an external Force supervised by the Police Complaints Authority/Independent Police Complaints Commission (IPCC).
   - A lengthy Criminal Crown Court trial (which resulted in the acquittal of all officers).
   - IPCC consideration of misconduct proceedings under the police (Conduct) Regulations.
   - 6 week Coroner's inquest.

3. The circumstances are also subject to civil claims brought on behalf of family members which are on going. Nevertheless, West Midlands Police has acted, at every opportunity, on organisational learning highlighted by this case and responded to the recommendations subsequently made by the IPCC.

CIRCUMSTANCES OF THE CASE

4. Michael Powell died on Sunday 7th September 2003, whilst in police custody, within the West Midlands Police area. Michael Powell was aged 38 years and lived with his mother in Lozells. His long-term partner lived with their three children at an address in Aston.

5. On the late evening of 6th September 2003, Michael Powell returned to his mother's home where he smashed the windows of a parked motor vehicle causing Mrs Powell to call for the police. Officers arrived and believing that Michael Powell was in possession of a firearm drove their police vehicle at him, knocking him over. Other officers arrived and attempted to restrain Michael Powell using their CS spray and Casco baton.

6. Handcuffs were applied to Michael Powell and he was transported on the floor of a police van to the custody facility at Thornhill Road Police Station where they were met by the Custody Sergeant. Michael Powell was carried into a cell where officers established that he was unconscious. An ambulance was called and Michael Powell was taken to City Hospital where he was pronounced dead.

[1] Narrative Verdict = a verdict available to coroners in England and Wales following an inquest. In such a verdict the circumstances of a death are recorded without attributing the cause to a named individual. Narrative verdicts are now quite common in inquests as they give the jury the opportunity to explain, in their own words, their findings on hearing all of the evidence. A narrative can be in the form of questions which the jury has to answer, or a more free form where the jury can put their verdict in their own words.

SUBSEQUENT INVESTIGATION

7. Northamptonshire Police conducted an investigation under the supervision of the Police Complaints Authority (PCA), subsequently the Independent Police Complaints Commission (IPCC) on their inception in April 2004.

8. The Crown Prosecution Service (CPS) reviewed that inquiry and determined that criminal prosecutions should be undertaken in respect of the conduct of ten officers in this case. The matter was heard at Leicester Crown Court in 2006 which resulted in the acquittal of all the officers on all charges.

9. Following this the IPCC reconsidered the evidence and determined that no officer should face internal disciplinary proceedings under the Police (Conduct) regulations.

THE CORONERS INQUEST

10. After procedural delays, the Coroner's inquest commenced in November 2009 and was heard by the Deputy Coroner for Birmingham and Solihull, Mr Stephen Campbell. The inquest lasted for just over six weeks and was held at Sutton Coldfield Town Hall.

11. The Coroner gave direction to the jury and on Day 30 of the inquest, the following narrative verdict was given by the jury:

Finding One

12. The cause of Michael Powell's death, on the balance of probabilities, was Positional Asphyxia[2].

Finding Two

13. Michael Powell was more vulnerable to Positional Asphyxia because:
    a) Contact with a moving vehicle.
    b) Being sprayed with CS gas.
    c) Being struck by a Casco baton.
    d) Being restrained on the ground whilst suffering a psychosis.
    e) Extreme exertion.

Finding Three

14. Michael Powell was originally placed upon his side in the police van.

    Michael Powell was transported in the van in a position between his front and face down (at an angle.)

    When the Custody Sergeant saw Michael Powell on his arrival at Thornhill Road Police Station, he was on his front.

ORGANISATIONAL LEARNING FROM THE IPCC INVESTIGATION

15. On conclusion of their independent investigation, the IPCC made the following recommendations which resulted in the delivery of learning for the organisation and which formed the basis of the evidence provided to the inquest by Assistant Chief Constable Scobbie;

Recommendation 12.2

16. ***"****It is recommended that a review is conducted of the appropriateness of routine, OCU wide and delayed-start authorisations of Section 60 Criminal Justice and Public Order Act 1994 search authorities. Where particular authorisations are justified, detailed grounds should be recorded."*

[2] Positional Asphyxia = Positional asphyxia, is also known as postural asphyxia, is a form of asphyxia which occurs when someone's position prevents them from breathing adequately.

17. Recommendation adopted. All Section 60 authorities are now recorded electronically fully detailing the grounds and rationale.

Recommendation 12.3

18. *"West Midlands Police should ensure that all staff are aware that there is no facility for medical staff to meet injured or potentially injured persons on arrival at custody. Guidelines should be established to ensure that priority is given to ensuring injured and potential injured persons receive suitably prompt medical assessment, over custody procedures - regardless of their level of compliance."*

19. Guidance and training has been adapted to meet this recommendation.

Recommendation 12.4

20. *"It is recommended that an appropriate partnership policy be developed to meet the needs of a person with evident mental health and physical health needs and to provide more specialist support to police officers called to respond to such an incident. Such a policy should provide for appropriate social services and health service involvement at the time of that response, such that transportation to a custody suite becomes the last resort, rather than the first resort. It is recommended that West Midlands Police engage with the National Health Service to establish suitable facilities for a place of safety and detention under Section 136 Mental Health Act at City Hospital, Birmingham. In light of the research by the IPCC, it is further suggested that formal monitoring arrangements are introduced to oversee a progressive reduction in the use of police stations as places of safety."*

21. West Midlands Police is committed to improving the options/places of safety that are available however; issues can only be resolved with the cooperation and assistance of the relevant Health Service. Considerable effort has been made to improve places of safety provisions as demonstrated with the introduction of a facility in Sandwell.

22. West Midlands Police have been working closely with the Strategic Health Authority to put plans in place to deliver further facilities. Places of safety operations are anticipated to commence in Birmingham, Dudley and Walsall in April 2010, followed by Coventry, Wolverhampton and Solihull. Since the inquest and indeed over the last two years West Midlands Police have been working hard with key partners to develop a better and more fit for purpose response to individuals with mental health problems.

23. The Coroner has issued a report under rule 43 of the Coroners Rules to encourage progress of the relevant parties in this area of health care.

Recommendation 12.5

24. *"It is recommended that basic emergency procedures, such as how to call an ambulance, be incorporated into the training or induction procedures for newly appointed custody staff."*

25. This is now incorporated within relevant West Midlands Police training and guidance to meet this recommendation.

Recommendation 12.6

26. *"It is recommended that the subjects of both positional asphyxia and Acute Behavioural Disorder (Excited Delirium) should be subject of structured input at both initial and refresher training and every officer should be provided with documents that set out the risks and appropriate responses in a simple straightforward format."*

27. This is now incorporated within relevant West Midlands Police training and guidance to meet this recommendation.

Recommendation 12.7

28. *"It is recommended that a review should be conducted of the West Midlands Police vehicle fleet and vehicle allocation to ensure officers have access to suitable vehicles for the safe transportation of*

violent and mentally disordered prisoners. This will then allow the implementation of a ban on the transportation of prisoners on the floor of police vehicles."

29. The force conducts an annual vehicle review and we have increased our provision of sector cell vans which are specially designed to carry detained persons. A policy has been issued in regards to the transportation of detainees.

Recommendation 12.8

30. *"It is recommended that a review should be conducted of the equipment available to front line officers to assist them to safely restrain and transport violent persons, without injury being caused to any person."*

31. The Uniform and Equipment User Group assessed the use of limb restraints which are now standard issue to all frontline officers.

Recommendation 12.9

32. *"It is acknowledged that Centrex training in use of force offers no guidance in the safe lifting or carriage of a prisoner. It is recommended that Centrex should be tasked with producing guidance (with medical reviews) on the safe lifting, carriage and transportation of prone and supine subjects."*

33. This has been raised with Centrex Training, ACPO, APA and the Home Office.

Recommendation 12.10

34. *"It is recommended that in the case of a death in custody, the Independent Police Complaints Commission should take the lead in the provision of all information to the media."*

35. When the IPCC have ownership of an investigation, all media releases are coordinated through their press office.

Recommendation 12.11

36. *"It is noted that in this case the recording of significant witnesses was restricted to civilian witnesses and it is recommended consideration of cognitive interviewing and early recording of witness evidence should also include West Midlands Police staff."*

37. West Midlands Police follow national policy in relation to 'Achieving Best Evidence'.

Recommendation 12.12

38. *"It is recommended that all police radio and telephone recording systems should have the capability of preserving transmissions for an extended period. Ideally this should occur automatically, but where a manual decision needs to be taken, processes must ensure regular consideration of preserving transmissions is made. There must be a sufficient period before transmissions are overwritten to allow the full impact of an incident to be identified late into the proceedings or retrospectively."*

39. The introduction of the 'Airwave' radio system has addressed this recommendation.

Recommendation 12.13

40. *"It is recommended, for the protection of all parties and effective custody performance, television sets and other non-essential audio-visual equipment capable of interfering with the recording of custody activity should be removed from all custody suites."*

41. Force policy prohibits the use of such equipment and audits are carried out to ensure compliance.

Recommendation 12.14

42. *"It is recommended, for the protection of all parties, that custody suite CCTV coverage should cover as full an area as practical and be recorded. In addition overt recording of custody audio activity should be extended beyond the charge room. The adequacy, or otherwise, of custody recording systems should not emerge only in the wake of a Critical Incident. Following this incident it was*

necessary to remove the computer hard-drives from Thornhill Road Police Station to prevent their eventually being overwritten.
It is not acceptable to any party that a lack of replacement equipment should leave any custody without recording facilities following a Critical Custody Incident".

43. A high specification CCTV system is being installed in all custody facilities across the Force.

Recommendation 12.15

44. *"It is recommended that the West Midlands Police Authority should review funding of the force in its obligations a) to secure suitable visual and audio recording facilities in all custody suites, which are sustainable in the event of equipment failure or seizure, b) to maintain an accessible vehicle fleet suitable for the safe transportation of violent or mentally disordered persons and c) to establish suitable places of safety outside of police stations for persons requiring medical assessment who would otherwise need to be taken into custody."*

45. The Police Authority is aware of this recommendation and the recommendations addressed at 12.7 and 12.14 above. Regarding recommendation c) above, West Midlands Police Authority would not have the provisions to fund such facilities nor would they have any legal obligation to do so, however please see the response at 12 .4 above.

Recommendation 12.16

46. *"It is recommended that custody officers are issued with guidance relating to the assessment of apparently unresponsive prisoners prior to accepting them into a cell, to ensure potential medical needs take priority over custody procedures."*

47. This is now incorporated within relevant West Midlands Police training and guidance to meet this recommendation.

Recommendation 12.17

48. *"It is recommended an audit be conducted across the West Midlands Police area to ensure that self-defence and first aid training records are maintained corporately in a timely, accurate, retrievable and accountable manner."*

49. All training is recorded on a computer system which provides an auditable and accountable record.

Recommendation 12.18

50. *"It is recommended West Midlands Police investigate further whether PAVA is a more appropriate incapacitant to be issued to police officers than the current CS incapacitant."*

51. It should be noted that all parties to the inquest and all the medical advice accepted that the use of CS spray was not the cause of Michael Powell's death. The use of PAVA as opposed to CS Spray has been discussed at the Force Health, Safety and Welfare Committee whereby it was decided that West Midlands Police would continue to use CS Spray as there is more knowledge of this product.

52. All of the above recommendations and the response of the Force and Authority were in place before the Inquest and outlined to the coroner. ACC Scobbie's evidence to the Inquest demonstrated how West Midlands Police's service has evolved since 2003 and detailed the force's developments and improvements in policy, training and practice.

ORGANISATIONAL LEARNING FROM THE INQUEST

53. The only organisational learning point from the inquest verdict itself concerned the jury's finding that on the balance of probability, the cause of Michael Powell's death was Positional Asphyxia.

54. The inquest heard a range of expert evidence and views in relation to the cause of Michael Powell's death none of which, with one exception, indicated a particular cause of death. Professor Crane, a Head Pathologist from Northern Ireland was of the opinion Michael Powell

died as a result of Positional Asphyxia. It is apparent that ultimately the jury were persuaded by Professor Crane's view that Positional Asphyxia is potentially capable of being caused when a person is lying on their side. This view was not supported by the other medical evidence provided at the Inquest.

55. The IPCC have noted the narrative verdict and are not progressing any further action in relation to Michael Powell's case.

56. The Association of Chief Police Officers has a national lead for Self Defence and Restraint (ACPO SDaR), Commander Robert Broadhurst of the Metropolitan Police Service. West Midlands Police have shared this narrative verdict and the views of Professor Crane about Positional Asphyxia with ACPO SDaR so that this can be considered as part of the National portfolio. There have been no other recorded police contact deaths within the West Midlands Police force area as a result of Positional Asphyxia.

INQUEST INTO THE DEATH OF LINDA BURT

57. On 27th September 2003, West Midlands Police officers attended the address of the mother of Linda Burt in Erdington, Birmingham after an incident had occurred resulting in a neighbour ringing the police for assistance.

58. On refusing to leave the address, Linda Burt (aged 51) was arrested for a Breach of the Peace[3], handcuffs were applied and she was placed in the back of a police vehicle. When leaving the address and on the way to the custody station, officers noticed Linda Burt was struggling to breath so they stopped their vehicle and moved Linda from the car to lie on the floor. Linda Burt had stopped breathing and officers attempted resuscitation until an ambulance arrived, however Linda Burt had died of a heart attack.

59. The Police Complaints Authority (PCA), followed by the IPCC in April 2004, supervised an independent enquiry into the death of Linda Burt. South Wales Police conducted a thorough and detailed investigation and concluded that officers had no criminal case to answer. Following this, the IPCC considered the case and determined that officers would not face any disciplinary proceedings.

60. The Inquest commenced in October 2009, heard by HM Coroner Mr Aiden Cotter. On 15th October 2009, the jury returned a narrative verdict, determining that Linda Burt died of a heart attack, caused by the combination of a severe heart condition, the stress of the incident and police failures. The jury determined the police failures as:

- The arresting officer was not justified in arresting Ms Burt for a Breach of the Peace.
- Handcuffs should have been applied in the address prior to escorting Ms Burt to the police vehicle.
- An ambulance should have been called at the address rather than once the journey had commenced.
- One officer's First Aid Certificate had expired and when the ambulance arrived it appeared that no officers were monitoring Ms Burt.
- The officers failed to control the scene by allowing a member of the public to place a towel under Ms Burt's head.

POST INQUEST

[3] A breach of the peace is committed whenever harm is done, or is likely to be done to a person, or, in his presence to his property, or, whenever a person is in fear of being harmed through an assault, affray, riot or other disturbance.

61. On release of this narrative verdict, West Midlands Police liaised with the IPCC who agreed that this would not automatically be referred back to them as they had already supervised the case. The IPCC and West Midlands Police agree the narrative verdict did not offer any new evidence and was simply a different interpretation of the information already known.

62. As with the Michael Powell case, the circumstances of the death of Linda Burt, and actions of the officers, have stood intense scrutiny and investigation by the Police Complaints Authority, followed by the IPCC and a full criminal investigation conducted by South Wales Police. The narrative verdict by the jury does not change the position of West Midlands Police in relation to misconduct proceedings against officers; however it does provide the opportunity to develop organisational learning.

63. Police Authority members should note that it is probable that the case of Linda Burt will lead to civil litigation against the force as a letter before action has been received.

ORGANISATIONAL LEARNING FROM THE INQUEST

64. To date, West Midlands Police has not received any formal notification from the Coroner directing recommendations or organisational learning; however West Midlands Police have internally reflected on this case and a full review of all First Aid training has been undertaken by the senior management team within Learning & Development.

65. As with the case of Michael Powell, training and equipment provided to officers has developed since 2003 and records regarding individual officers training are maintained on a computer system providing greater audit and control.

SAFER DETENTION

66. The Safer Detention Guidance is a document produced on behalf of the Association of Chief Police Officers and the Home Office, by the National Centre for Policing Excellence. The guidance identifies the standards expected in the handling of persons who come into police contact.

67. The guidance is aimed at assisting the police service in achieving delivery of targets particularly around the detection of crime, reducing re-offending and increasing public confidence. The document covers in full, risk assessment and management, initial contact on arrest, control and restraint, transportation, detainee care and death and adverse incidents in custody. West Midlands Police is fully Safer Detention compliant.

68. West Midlands Police has established policies and procedures to ensure that deaths and adverse incidents are reported, recorded, investigated and analysed and that the lessons learned are collated, disseminated and implemented. West Midlands Police actively share lessons with other stakeholders and practitioner groups, in order to minimise deaths in custody and reduce the occurrence of adverse incidents. Liaison with local stakeholder groups such as Probation and Court Services is achieved through regular Safer Detention meetings.

69. Safer Detention and risk management remains the priority when determining the future custody model within Programme Paragon and reassurance is given to West Midlands Police Authority that West Midlands Police training, equipment and custody facilities remain safe and adequate for detainee and officers' needs.

CONCLUSION

70. Every death in custody is a personal tragedy for those who are left behind. The deaths of Michael Powell and Linda Burt in 2003 were tragic events that have affected many lives. West Midlands Police continues to learn and develop from any death in custody or near miss to prevent the recurrence of such an incident.

FINANCIAL IMPLICATIONS

71. Legal and other representation costs in relation to the two cases in this report have been incurred by the Authority over a number of financial years and amount to £780k. In addition £350k has been spent in association with responding to recommendations and the Safer Detention programme, along with the CCTV in Custody programme of £3m.

LEGAL IMPLICATIONS

72. In any case where a death appears to have been unnatural, unexpected or to have been caused by violence or neglect; or death occurs in custody or where there has been any recent contact with police or prison authorities, the death must be reported to HM Coroner and unless he can certify that the death was due to natural causes, with or without a post mortem, he must hold an inquest into the death. The deaths of both Michael Powell and Linda Burt required that an inquest be held. The purpose of the inquest is to determine who, how, when and where the deceased came by his or her death and no verdict shall be framed in such a way as to appear to determine any question of criminal liability on the part of any named person or civil liability but clearly both consequences can flow from the Inquisition for those persons and bodies involved. The Chief Constable has a right in the Coroners Act and Rules to attend and be represented at any inquest and is expected and does attend any inquests where his officers have been involved in the circumstances leading up to the death.

73. Both deaths occurred in 2003 and there was therefore considerable delay in the inquests being held in late 2009. Both deaths were subject to substantial police inquiries by outside forces into the circumstances and, in the case of Powell, to a criminal trial and both requiring consideration of disciplinary issues involving officers of West Midlands Police. As related, no officers were convicted and no disciplinary proceedings ensued however these matters led the Authority to agree formally that officers involved should be separately represented from the Chief Constable at the respective inquests through Police Federation appointed lawyers. The family were legally represented by solicitors and experienced barristers (in the Michael Powell case two barristers).

74. There were, in both cases, issues as to the conduct of the inquest with the Coroner, which resulted in several pre-inquest meetings and further delayed the respective starts. In the Michael Powell inquest the representatives of the family of the deceased initiated a judicial review of the Coroners decisions regarding the scope of the inquest and relevant documents to be placed before the jury. The Linda Burt inquest resumed in late September and lasted two and a half weeks. The Michael Powell Inquest commenced in November and lasted approximately six weeks.

75. The jury in these cases give their verdict in the form of basic factual findings and conclusions. That can be in the form of a range of formal verdicts from "natural causes" to "unlawful killing" but also, as here, provide a narrative verdict. They do so following directions from the Coroner who summarises the evidence heard and possible verdicts permitted by law and the evidence. Additionally the Coroner has the power under rule 43 of the Coroners rules to report to appropriate bodies the outcome and any issues that caused or may have contributed to the death and ask them to consider action to prevent the reoccurrence of fatalities similar to that in respect of which the inquest was held. He has done that, as stated above in paragraph 23 above.

EQUALITIES IMPLICATIONS

76. The police service is constantly evolving and reviewing its understanding of equality issues, in terms of how officers make criminal justice decisions which affect all demographic groups in society. It is also understood that the National Health Service faces representations from mental health service users and third sector organisations that clinical decisions made under the Mental Health Act have the ability to disproportionately affect particular demographic groups and need to feature greater consideration of cultural issues. In the response to acute psychiatric emergency, especially where cultural factors and aggression or resistance are being displayed, the potential to criminalise vulnerable people who are ill is in effect.

77. The equality impact of police responses to psychiatric emergency have been much reduced over the last 12 months by agreements between West Midlands Police and a large number of NHS organisations. Such partnership work, which will have the effect of working much closer during the early stages of challenging medical situations, ensures faster access to healthcare providers who can advise and assist on appropriate responses and joint agency management. Research has shown that the occurrence of mental illnesses and attitudes towards service providers are not consistent across demographic groups, therefore equality is best regarded in these circumstances and sensitive, individual response to particular needs during each incident.

78. In the future, the force will achieve greater scrutiny of its mental health detentions and the pathway taken for those arrested, by virtue of improved monitoring arrangements in each area, which will accompany the introduction of health based places of safety. In the long-term, this will allow development of local procedures, improved, targeted training and feedback to operational staff.

RECOMMENDATION

79 To note the update on any organisational issues and response following the narrative verdicts[1] reached by the juries in those cases.

Chris Sims
Chief Constable

CONTACT OFFICER
Name: Gordon Scobbie
Title: Assistant Chief Constable (Citizen Focus)
Tel: (0121)626 5017 Lloyd House Ext: 7800 2017
Email: g.scobbie@west-midlands.pnn.police.uk

BACKGROUND DOCUMENTS

[1] Narrative Verdict = a verdict available to coroners in England and Wales following an inquest. In such a verdict the circumstances of a death are recorded without attributing the cause to a named individual. Narrative verdicts are now quite common in inquests as they give the jury the opportunity to explain, in their own words, their findings on hearing all of the evidence. A narrative can be in the form of questions which the jury has to answer, or a more free form where the jury can put their verdict in their own words.