

PCA

POLICE COMPLAINTS AUTHORITY

SAFER RESTRAINT

Report of the conference held in April 2002
at Church House, Westminster

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Foreword

by Chris Mullin MP, Chairman of the Home Affairs Committee

I welcome this report.

Although in this case the police service is in the spotlight, many of the issues raised are also relevant to the prison service and to special hospitals, indeed to any organisation whose staff or officers might be called upon to control and restrain people.

Forcible restraint is an emotive subject. The death of someone either in custody or in the process of being taken into custody always arouses strong emotions and rightly so. If that process has also involved restraint, questions will be asked – again, rightly so – about the amount of force used; the type of restraint used; how long the person was restrained and ultimately, whether the police actions were justified.

It is difficult to measure the effect of such incidents on the families and friends of the victim. But the damage goes much further. Regrettably, a disproportionate number of people who die in custody or specifically following restraint are from minority ethnic groups, which inevitably leads to allegations of racism.

The investigations into these deaths are time-consuming and expensive and, with the best will in the world, the outcome rarely, if ever, proves satisfactory to the relatives of the deceased. Public confidence in the police, the Crown Prosecution Service, the Police Complaints Authority itself and in our wider institutions is damaged.

The issues involved in restraining someone are rarely straightforward. Many of the victims were, by common consent, behaving badly. They may have been under the influence of alcohol or drugs. The police officers involved have to make split-second decisions about how to deal with difficult, possibly dangerous people, in stressful circumstances. If they get it wrong, they may have to live with the consequences for the rest of their lives.

Everyone understands that this is difficult territory. It is easy to be wise after the event but that is, in effect, what we have to be. One of the themes that emerged very strongly throughout the conference is that we must learn from previous experience, not just from the deaths themselves but from the near misses too. In 2000/01, there were 5,211 assault complaints against the police, 164 of them serious, any one of which might have resulted in a death.

We must learn the lessons in the police service, in the prison service, the immigration service, in special hospitals and in the private security industry. We must learn them nationally and locally, across government departments and throughout the justice system. And we must learn them quickly to enable us to devise standards and practices that apply to all those agencies whose staff and officers may be in confrontation with a member of the public, in whatever setting or circumstances.

Introduction

by Sir Alistair Graham, Chairman of the Police Complaints Authority

The Police Complaints Authority has been concerned about deaths in police care or custody for a long time. Every one of our annual reports since 1994 has raised this as a headline issue and deplored the extent of the problem, the number of deaths involved as well as each individual tragedy.

We have been making recommendations for change for more than five years. In 1996, we recommended the use of CCTV in cells. In 1998, we called for better custody officer training. We organised a major conference, also in 1998, involving police, doctors, government departments and the voluntary sector, which produced an agenda for action - *Deaths in custody: reducing the risks*.

Much progress has been made – there has been a 50 per cent reduction in deaths in the past three years – but we continue to make reducing the figures top priority. No death in these circumstances is acceptable.

Some of the most distressing and high profile cases in recent years have been those in which the detainee has died following police restraint. In May 2000, we organised a seminar involving American and British pathologists, which resulted in PCA guidance for police on how to treat people showing extreme states of behavioural disturbance or distress – *Policing Acute Behavioural Disturbance*.

This current report and the conference on which it is based are further signs of recognition that the issue of safer restraint in particular must be placed at the forefront of any discussion about deaths in custody. They are also signs of an increased awareness of and focus on the Human Rights Act, particularly Article 2 outlining the state's positive duty to protect every individual's fundamental right to life.

The conference brought together experts from the police service, the prison service and the special hospitals to exchange best practice in situations where there is no alternative but to restrain detainees, either for their own safety or for the safety of others.

It also heard moving and valuable contributions from others directly involved in the issues, either as people who had experienced restraint, relatives of victims of restraint-related deaths or those that represent them as lawyers or campaigners.

The aim of the conference was to identify the risks to detainees of particular forms of restraint and to seek safer options. The aim of this report is to act as a catalyst to ensure that the trend of a fall in the number of restraint-related deaths continues. It attempts to distil the concerns, knowledge and experience of speakers and delegates on the day.

It also provides a list of their strong recommendations both for preventing restraint-related deaths and for investigating such incidents when tragically they do occur, in a way that is open, accountable and transparent and takes into account the feelings, responses and needs of the friends and families of the victims.

The lessons to be learned can also be usefully applied to other individuals, institutions and organisations increasingly involved in restraining people – immigration officers; private security firms detaining asylum seekers or employing

doorkeepers and of course, a whole new category of law enforcer created by the Police Reform Bill – the community beat officers.

Restraint-related deaths – definition and numbers

Under Section 3 of the Criminal Law Act 1967, a police officer has the authority to use reasonable force to make a lawful arrest or to counter a genuine threat of assault, whether on themselves or on another person. In deciding what is reasonable force, the officer must determine whether the force is necessary or reasonably believed to be so and whether it is proportionate to the wrong it seeks to avoid.

Restraint may be used during arrest, for example where an individual is trying to escape or resist arrest, or while they are in custody, for example if an individual becomes violent, tries to escape or to harm themselves.

A death is deemed to be restraint-related in cases where an individual becomes seriously ill while physically restrained and dies at the scene or some time later.

Such incidents are typically associated with a chase and/or a violent struggle. They may involve the use of manual restraint or, in police cases, of batons, CS spray, handcuffs and other equipment (in extreme cases, firearms) or a combination of some of these. The most commonly used method is a combination of manual restraint and handcuffs.

In some cases, it appears officers may have injured the deceased by accident, for instance by falling on them during a struggle. In other cases, other factors alongside police actions may have contributed to the individual's death, such as the presence of alcohol, drugs or some physical medical or psychiatric condition. These detainees are more vulnerable to the impact of restraint.

Nevertheless, suspicions may arise of excessive force, inappropriate or dangerous use of restraint or at least, a failure of duty of care by police (or prison or mental health services officers and staff). This is particularly the case if they held the person in an unsafe position, such as face down and prone, for any length of time. Where neither post-mortem examination nor toxicological and other tests reveal any clear reason for death, it may be argued that the physical restraint either contributed to the sudden death or caused it.

Thankfully, restraint-related deaths within the police service are now rare, accounting for a very small percentage of total deaths in custody. Work by the Police Research Group suggests that they amount to 1.4 deaths for every one million people arrested over a seven year period – that is, around two or three deaths a year.

Nevertheless, in 2000/02, there were 5,211 assault complaints against the police, 164 of them serious, any one of which might have resulted in a death.

Restraint-related deaths among black and minority ethnic groups

Restraint-related deaths may be rare but there are still too many. More worrying is the proportion of victims who are black or from minority ethnic groups, which exceeds their proportion in the general population. This pattern, first established in the 1980s, has continued into the 1990s and beyond.

In the two and a half years from April 1998 to September 2000, the ethnicity of the 129 people who died in police care or custody was:

- White – 105 (81%)
- Black – 9 (7%)
- Asian – 6 (5%)
- Other – 9 (7%)

In 1998-99, there were nine restraint-related deaths – six of the victims were white, three were black. In 1999-2000, there were six deaths – five of the victims were white, one was Asian.

It is these cases in the main that cause the greatest public concern and have the highest profile – Joy Gardner, Brian Douglas, Shiji Lapite, Richard O'Brien, Wayne Douglas and Ibrahim Sey, to name just some of those who have died in recent years.

The disproportionate numbers of black and minority ethnic victims are not confined to the police service. They are also to be found in the prison service (for example, Kenneth Severin, Alton Manning and Dennis Stevens) and in mental health services (for example, Rocky Bennett and Orville Blackwood). Between 1991 and 1995, Inquest records six deaths within the prison service from control and restraint; five out of the six people who died were black. Between 1985 and 1998, the Institute of Race Relations records the deaths of 15 black people in psychiatric hospitals – six of whom died after injections and one after being restrained.

Inevitably, there are allegations of racism, which damage relationships between services and communities, reducing public confidence and leading to anger and mistrust.

In particular, there is a feeling that this over-representation among certain groups has led all three services to seek and promote medical theories and alternative explanations for the deaths in terms of a racial predisposition or susceptibility to die rather than anything to do with the force used against the deceased.

A number of people believe that by ascribing stereotypical characteristics of extraordinary strength and dangerousness to black people in particular, the services are attempting to blame the victims for their own deaths because of their pathological condition or personal choice. A young black man called Rocky Bennett died in 1995 at a secure mental health unit after five or six nurses restrained him. In the nurses' statements about the incident, they described Mr Bennett as 'big', 'excessively strong', having 'the worst case of mental illness' they had ever seen and as 'animalistic'.

Medical issues

There is a marked lack of consensus among pathologists and other medical practitioners as to the precise cause of death in many restraint-related cases. In some recent high profile instances, PCA investigators were seeking up to five separate medical opinions.

Among the most controversial conditions relating to these deaths are postural or positional asphyxia and acute exhaustive mania also known as excited delirium.

Positional asphyxia

This refers specifically to a recognised cause of death resulting from a body position that interferes with a person's ability to breathe. What is contentious is whether this term can be applied in a range of restraint-related deaths, for example where an individual is held down or placed in a prone position and restricted in their movement – either because their hands are cuffed behind them or because someone is on top of them, holding them down.

Some medical practitioners and others cite the following as cases in which positional asphyxia contributed, to a greater or lesser extent, to the victim's death:

- In 1993, Joy Gardner was restrained by police and immigration officers, handcuffed, placed in a body belt, gagged with tape – Mrs Gardner died of suffocation.
- In 1994, Richard O'Brien was restrained face down with his hands cuffed behind his back.
- In 1996, Ibrahima Sey was handcuffed, sprayed with CS and restrained in the prone position by more than a dozen police officers.
- In 1995, in a secure mental health unit, Rocky Bennett was restrained face down in the prone position for up to half an hour at a time by five or six nurses.
- In 1997, Glenn Howard was held in a reverse bear hug for up to four minutes, face down with an officer across his legs. Mr Howard asphyxiated after inhaling vomit and fell into a coma.
- In 1995, in the prison service, Kenneth Severin and Dennis Stevens were both restrained in the prone position. The latter was also held in a body belt for 24 hours.

'Excited delirium'

Some pathologists however, feel the term positional asphyxia is misused in many of these cases. They believe that the proper diagnosis is excited delirium, which can, they say, be caused by drugs, alcohol, a psychiatric illness or a combination of these. Someone suffering from it may ignore pain and continue to struggle against restraint beyond the normal point of exhaustion.

Whatever the terminology used, the PCA believes that restraining someone in the ways described above, particularly for any length of time, can pose severe risks as can leaving a detainee unattended in any position that might restrict their breathing.

Even if the position itself does not present a danger, the detainee may be suffering from a physical medical or psychiatric condition or the effects of alcohol or drugs, which combined with the restraint, could make them more vulnerable.

Mental illness and acute behavioural disturbance

Restraint appears to be used more often where an individual's mental state or what is known as acute behavioural disturbance is a factor. It also appears that a similar negative imagery informs their treatment as it does that of black people – 'mad, bad and dangerous to know'. It is perhaps not surprising then that people with mental health problems or psychiatric disorders are also over-represented among the victims of restraint-related deaths.

There is also a feeling that within the mental health setting, medication itself can be used as an improper and potentially lethal form of restraint, particularly if given in unlawfully high doses.

Neck holds

Far less contentious as a factor in restraint-related deaths are neck holds that can cause asphyxia or other serious physical problems.

Those who have died after being restrained in this way include Clinton McCurbin in 1987, Oliver Pryce in 1990 and asylum seeker Shiji Lapite in 1994.

The PCA has repeatedly made its concerns clear about the dangers of neck holds and, although in some people's opinion long overdue, issued its first set of guidance in 1993. This was followed by Association of Chief Police Officers (ACPO) guidance in 1994 and Metropolitan Police Service (MPS) guidance in 1996. Further ACPO guidance was issued in 1999 and neck holds are now discouraged in the current police self-defence training.

Concerns about equipment

Certain pieces of equipment are used by the police in particular, usually in combination with manual restraint. These include handcuffs, batons, CS spray, body belts and, in extreme cases, firearms.

In some instances the design, in others, the improper or unjustified use of equipment can give rise to concern.

Batons

The old-style police truncheon was perceived to be ineffective and is not now used. However, forces throughout the country are using a wide variety of US-designed batons. A number of these appear to bring a greater risk of injury, particularly when blows to the head are involved.

In 2000/01, the PCA investigated 291 assault complaints involving batons. The baton least likely to lead to complaints is the MPS straight baton. Ways of using the new side-handled baton in particular are so complex that officers need regular refresher training to use it properly. This is borne out by PCA research, which suggests that those forces providing the most frequent training appear to have the lowest levels of complaints.

There are also instances of batons being misused as instruments of aggression rather than control and restraint. Indeed, there are incidents caught on CCTV showing officers assaulting members of the public. In 1995, for example, Brian Douglas died as a result of a baton blow to the head, which fractured his skull. There is also a belief that officers are not properly alert to the possible signs and symptoms of head trauma following such a blow.

CS spray

CS spray was introduced in 1996 in the hope that it would reduce the need to use batons. So far, this does not appear to be the case although the number of assaults against police officers has fallen.

Indeed, CS spray itself is the subject of numerous assault complaints alleging excessive and/or unjustified use – the PCA investigated 409 cases in 2000/01. Although many forces do not monitor how often their officers use CS spray, PCA research suggests that one in 20 uses leads to a complaint. The year 2000/01 also saw the first case of an officer being convicted and imprisoned for causing injury by excessive and unjustified use of CS spray.

CS spray featured in a small number of restraint-related deaths although there is no evidence to suggest that it was the direct cause of death.

Moreover, CS spray is often ineffective on people with mental health problems or people who have been drinking alcohol and it is more dangerous when used at short range. Some forces are now looking at alternatives such as synthetic pepper sprays.

Handcuffs

In 2000/01, the PCA investigated 1,048 cases of alleged improper use of handcuffs causing unnecessary harm such as bruising or redness around the wrists. This can occur when rigid handcuffs are not properly fitted or double-locked or if the detainee struggles.

VIPERS

In September 2000, Sussex Police introduced VIPERS – the Violent Person Emergency Restraint System – after a three-month trial in 1999. Once fitted, detainees cannot lash out but are still able to walk unaided. No officers or detainees were injured during the trial period and there were no complaints about the device either during its trial or its first six months of use. It also appears to have the potential to reduce serious injuries.

ERB

In March 2001, Northamptonshire Constabulary began force-wide training with the alternative to VIPERS, the American-designed Emergency Restraint Belt (ERB). The belt had come through a three-month trial successfully, without public complaint and is used by 500 police services in North America. The advantage of ERB for officers is that there is no possibility of getting free from it. The disadvantage is that detainees with their legs strapped find it very difficult to walk.

The PCA expects police officers to exercise caution when using both VIPERS and ERB until this new equipment has been extensively tested in practice. It will monitor the use of both methods as well as any complaints from the public.

Firearms

Although not the main thrust of the conference or this report, firearms are, of course, the ultimate means of restraint. Police shot and killed two members of the public in 2000/01 and injured five others. The police service is constantly looking for less lethal alternatives. To be effective, such options must be capable of incapacitating an individual immediately with minimum long-term effect. However, with regard to ultimate force there is, unfortunately, no such thing as a non-lethal alternative.

Less lethal alternatives – Baton gun and rounds

Baton guns are now being introduced – currently 36 forces have them. Since February 2002, five men have been arrested after baton gun rounds were deployed. So far, no one has suffered a serious injury.

Less lethal alternatives – Taser

The Taser is an electric rifle that fires two barbs connected to it by a high-voltage wire. Once contact is made with the subject, it begins discharging a metered and pulsed current through their body, causing involuntary muscle spasms and severe loss of motor control. Its limited range would appear to make it appropriate for only a narrow range of situations. (The Association of Chief Police Officers announced that trials of the Taser would begin in five police forces in April 2003.)

The human rights perspective

The Human Rights Act 1998 came fully into force in October 2000, incorporating into UK law the provisions of the European Convention on Human Rights (ECHR).

The change is of great significance when judging standards of policing and the Act creates a new mechanism – in addition to present criminal, civil and disciplinary procedures – for making individual police officers, their organisations and practices accountable. Police forces must be seen to act in ways that are lawful, necessary, proportionate and non-discriminatory.

Particularly important in the context of this report is Article 2 of the Act – the right to life, the most fundamental of all civil and political rights. It says that the state has a positive duty in law to protect the lives of everyone in its jurisdiction. It goes on to stress that any force used must be ‘no more than absolutely necessary’.

The responsibility of the state in this regard is total – it is no defence against an Article 2 violation for an institution or public authority to say that the problem lay elsewhere or to ‘scapegoat’ individual officers. The issue is not restricted to the specific circumstances or individuals directly involved in a death – it covers also all those within an agency who are responsible for planning, preparation, training and protection as well as the government departments that oversee those agencies.

The Act requires thoroughness. In relation to restraint-related deaths, it applies to codes of practice, training courses and manuals, procedures and so on and even perceived attempts on the part of senior managers or other leaders to avoid the issue. If the state, in all or any of its manifestations, has realised that there is a problem and understood the nature of that problem but has failed to deal with it adequately, there will be a violation of Article 2 if that failure subsequently leads to a death.

The right to life is crucial and it requires us to explore alternative remedies or methods before using those that we know to be dangerous.

In other words, it is everyone’s responsibility to do their utmost to protect the right to life of all those people whose lives the state has taken control over, in custody or institutions and who are more dependent on the protection of the state than most of the rest of the population.

Approaches to control and restraint

The Prison Service

The Safer Custody Programme is an attempt at an all round, proactive approach to reducing violence in prisons and thus reducing the need to resort to physical restraint of prisoners.

It aims to change the culture of the service to one that is constructive and supportive, encouraging good staff-prisoner and prisoner-prisoner relationships, designing out risks and making prisons generally safer places to be. The challenge is to do this within the context of a rising prison population and an increasing number of prisoners with mental health needs.

In keeping with this programme is an emphasis on exploring all other options before resorting to physical intervention, in the belief that 'the use of force is unpleasant, undignified and dangerous to all involved and to be used only as a last resort'.

To that end, the prison service encourages officers to think about why people behave violently and requires them to try to anticipate and recognise the symptoms of anxiety and agitation that might precede violent outbursts. Part of the training officers undergo is in verbal persuasion and negotiation and other de-escalation techniques to defuse tension and prevent loss of control.

Nonetheless, there is a recognition that the use of force through control and restraint remains very much part of the business of the prison service.

It is close-quarter restraint, rather than incidents of concerted indiscipline by a number of prisoners, for example riots or rooftop protests, that poses the greatest risk to all concerned. In these instances, officers are taught that force used must be the minimum necessary and that it must be reasonable and proportionate.

The control and restraint techniques used by the prison service are well established and well known to all staff, through initial and refresher training. They include ideas and standards since adopted by other organisations, including colleagues in mental health services.

Techniques centre around the three-man team, which can be deployed only with the proper authority and with a fourth person, senior in rank, supervising. The fourth officer is responsible for assembling, briefing and debriefing the team, making sure each member has had the appropriate training, and for bringing in any necessary help such as medical support. The senior officer does not take part in the restraint itself but he or she is responsible for looking out for signs of distress or trauma and is ultimately accountable for the way the incident is managed.

When the intervention is a planned one, for instance in a cell, a member of health care staff must be present to give the supervising officer clinical advice, which must be acted on immediately. Officers are specially trained to restrain people in confined spaces such as cells and to be able to negotiate difficult areas such as doorways and stairs.

Control and restraint is well established as the prison service's most effective last resort option. Nevertheless, the service is working with colleagues in the police and mental health services, continually looking at alternatives to the use of force.

Mental health services

As with the prison service, control and restraint in medium secure units as well as high secure units such as Broadmoor Hospital is seen very much as a last resort.

It fits within a wider context of care of patients in which disruptive behaviour is managed and minimised and in which they can learn alternative methods of expressing themselves. In some medium secure units in particular, emergency responses are formulated as part of an individual's care plan, both within and outside the clinical setting.

Again in common with the prison service, staff across the mental health environment are trained to prevent and manage violence and aggression. They learn to recognise signs and signals and interpret body language. And they are taught to use a variety of non-physical interventions such as verbal de-escalation techniques or simply giving a patient the time and space to calm down on their own.

They receive awareness training covering the human rights perspective as well as cultural, gender and sexuality issues. They also receive training in medical conditions. The challenge here is in helping some staff such as nursing assistants who may have very little knowledge of mental health issues to understand the psychological factors that might be at work – helping them to appreciate how a patient with, for example, a schizophrenic illness, may think about the world and what is going on.

But again, control and restraint is sometimes necessary as it is in the prison service, from where both high and medium secure units have adapted some of their techniques and codes of practice. However, there appear to be no national standards across the NHS as a whole, with each individual Trust setting its own.

At Broadmoor Hospital, for example, instructors from their in-house Control and Restraint Centre provide minimum mandatory training, including breakaway techniques and refresher training for all staff who have contact with patients. In particular, all ward-based nurses and rehabilitation therapy staff go on a five-day control and restraint course, which includes training on the three-man team model.

All training modules are underpinned by contemporary theoretical aspects and modified to account for changes in policy, procedure, legislation and ethical considerations. Courses are based around a control and restraint manual, similar to that used in the prison service, which sets the standard. Training records are kept for all staff and these are fed into quarterly reports to senior management.

Medium secure units, on the other hand, do not have their own control and restraint centres or in-house instructors. They receive their training from external organisations such as National Control and Restraint Services (NCRS), which is one of the largest suppliers of training to the healthcare sector. Where a Trust employs NCRS, training is mandatory for all staff, including those in administration, who might come into contact with patients.

Continual reporting and auditing are a vital part of procedures in both high and medium secure units as are immediate debrief and review of the issues following a critical incident.

In liaison with the Department of Health and other government departments and agencies, NCRS also has some responsibility for bringing together best practice and working on setting national standards. Most recently, senior ministers at the Home

Office and the Department of Health have asked the prison and police services to work with healthcare colleagues to review strategies and share ideas about managing violence in mental health settings.

The Police Service

The police service shares a certain amount of common ground with the prison and mental health services with regard to restraint.

It too views the use of force as a last resort. Indeed, ACPO guidance makes clear that: "Before resorting to the use of force, police officers should use all other methods to achieve the desired outcome of a situation."

It is also clear from the legal standpoint that officers' use of force should be reasonable, necessary and proportionate and that each individual is accountable to the law for his or her actions. The police service shares the same focus on the human rights aspects of the issue and the view that no death in these circumstances is acceptable.

It uses many of the same control and restraint techniques used in the prison and mental health services. And it is working both on its own and with them to continually review these techniques, learn lessons from experience and find alternatives wherever possible.

On the other hand, the context in which the police operate is very different to that of the other two services.

The nature of their role as an emergency service means that they are often dealing with crises and unpredictable circumstances. They are usually the first port of call, often the first to arrive and accept the responsibility to act as gatekeepers, dealing perhaps with medical or mental health emergencies until other agencies arrive.

The environment in which potentially violent incidents unfold is not controlled in the same way as it is in either prison or mental health settings. The events are spontaneous, the dynamics unknown and officers usually have very little time to assess a situation and plan a response. The challenges they face are particularly difficult when the behaviour of those they confront is affected either by mental illness, psychiatric disorder or by the consumption of drugs or alcohol.

Moreover, officers may have conflicting priorities. At the same time as they have a duty of care towards the individual, they are also required to protect the public – and themselves – from harm.

In some instances then, restraint will be necessary but the police service is striving to make it a safer option by following five main steps:

1. Informed by a working group on self-defence and restraint, ACPO establish clear national policy; individual forces set their policies within this framework.
2. Best practice and procedures are set out in a personal safety manual, the national guidance for all forces and officers.
3. Training is based on the manual and supplemented by first aid training.
4. Equipment is tested, approved and recommended to support best practice, tactics and procedures.
5. Use of force is continually monitored and best practice and procedures reviewed and reformed as necessary in order to continue to minimise risk.

Training is the key to turning policy into action on the ground. Beyond the fundamental principle that they must always act within the law, officers are taught conflict resolution. The model moves through a structured approach to threat assessment that enables officers to choose an appropriate response including a level of force. They are also taught to continually reassess the threat so that they can de-escalate or escalate the use of force as necessary.

At one end of the continuum of force, an officer's presence is often enough to defuse a situation. ACPO guidance emphasises the importance of good communication. Officers' training in verbal de-escalation techniques is underpinned by many of the same elements found in prison and mental health services training – body language interpretation, cultural awareness and an understanding of certain medical conditions, particularly associated with acute behavioural disturbance or the consumption of drugs or alcohol. It is important that officers do not make any assumptions and thereby overestimate the threat.

Where communication, negotiation and the threat of using equipment such as CS spray fail, containment of the individual is the next option. Ultimately, at the other end of the continuum of course, is the use of force. The challenge is to ensure that 130,000 officers dealing with 1.25 million acts of restraint a year apply that restraint properly and safely.

The police service is responding to criticism and striving to minimise risk, continually evaluating techniques and keep officers' training up to date in terms of best practice and the human rights context. The personal safety manual, for example, devotes a chapter to acute behavioural disturbance, its possible causes and implications and the signs and symptoms to identify risk factors. Positional asphyxia and the dangers of restraining someone in the prone position for too long are covered in similar detail. The manual also clearly states that neck holds carry inherent risks and are not acceptable.

Officers' equipment is also kept up to date and comes into use only after it has been subjected to rigorous medical scrutiny and evaluation. The police service continues to look for safer alternatives including less lethal alternatives to firearms.

Ultimately, there is an understanding that public scrutiny and public confidence are vital to policing by consent and that the police must exercise force ethically, lawfully, proportionally and with sensitivity if they are to retain that consent.

Conference recommendations

Preventing restraint-related deaths

A coherent approach

There is an urgent need for a more coherent approach to the issue of safer restraint with co-ordination and collaboration between government departments and across services, nationally and locally. In particular, there must be more uniformity across the services in the application of restraint.

Standards and sanctions

The conference recommends that clear national standards be set for the prevention and management of violent situations, that the application and maintenance of those standards are closely and carefully monitored and that sanctions should be enforced where standards are not met.

Reinforcing the message

Such standards and sanctions should be used to focus the minds of senior managers and other leaders within the different agencies on their responsibilities under the Human Rights Act, particularly Article 2 – the right to life. Moreover, they should be used to reinforce the message to staff and officers on the ground that there is no place for ‘macho men,’ that restraint is to be used only as a very last resort and that use of force should be always lawful, necessary and proportionate.

Joint working group

To ensure a coherent approach, the conference also believes that some form of joint body or working group should be established to formalise and encourage inter-agency co-operation and planning, to share and disseminate information and best practice and to continue to look for methods of safer restraint.

Operational issues

Among other aspects, joint planning should cover operational issues on the ground. These might include, for example:

- the introduction of warning markers about detainees who may be particularly at risk due to a medical condition, psychiatric disorder or drug or alcohol consumption;
- the need for specialist restraint teams within the police service when they are called to deal with people showing signs of acute behavioural disturbance – members might include paramedics and/or doctors and civilian counsellors;
- the need for continual reporting of incidents and auditing of management of incidents; and
- the vital importance of debriefing following a critical incident.

Drugs

People who are very agitated should not be given powerful phenothiazine drugs – the interaction is dangerous. If drugs have to be used, resuscitation equipment should be available and its use planned beforehand.

Learning lessons

A strong theme throughout the conference was the importance of learning the lessons of past experience. Acknowledging past mistakes and accepting

responsibility were felt to be fundamental to the process of reconciliation and regaining public confidence.

More research

To that end, there is a need to revisit cases of restraint-related death, to re-examine coroners' recommendations at inquest and to study not only the fatalities but also the 'near misses' of the past. This work could usefully inform further detailed academic research into restraint-related deaths, which is currently seriously lacking. In particular, there is a need to understand the physiology of these deaths to enable agencies to frame prevention and treatment strategies.

National training standards

The conference calls not only for national standards in the application of restraint but also for national training standards across the services, covering both quantity and quality. The conference recommends the establishment of an inter-agency group to share best practice and, working with the Health and Safety Executive, to set and monitor standards for the validation of training modules and courses.

Minimum requirements

National standards should require mandatory minimum training, regular retraining and annual refresher training, the keeping of individual training records and regular audits of courses and reviews of guidance manuals to ensure material is up to date and reflecting current best practice.

Course content

Specifically, training should cover as standard:

- fundamental principles with regard to the lawful, necessary and proportionate use of force;
- the human rights perspective and duty of care;
- cultural awareness to combat racism and stereotyping;
- psychological factors – understanding the causes of violence, recognising potential violence and interpreting body language;
- threat assessment, including medical risk assessment;
- conflict resolution, including verbal de-escalation, communication and negotiation techniques;
- the unacceptable nature of some forms of restraint, for example neck holds;
- the proper use of restraint equipment such as batons, CS spray and handcuffs;
- the dangers of some forms of restraint, for example positional asphyxia, and the need for restraint to be brief;
- monitoring a restrained person and recognising warning signs of trauma or distress;
- medical conditions, psychiatric disorders and associated risk factors;
- drug or alcohol consumption and associated risk factors;
- basic first aid;
- resuscitation as a planned event;
- mental health issues and legislation, including the need for early intervention and referral to other agencies;
- the need for immediate reporting and critical incident debrief.

Investigating restraint-related deaths

Facing up to the issues

If we are to seriously challenge the problems addressed by the conference and this report, we must be willing to face up to the issues. Government departments, the justice system and the PCA as well as senior managers and leaders within the different agencies must be prepared to accept responsibility and be seen to be doing so.

The Independent Police Complaints Commission

Investigations into restraint-related deaths must be robust, independent and transparent. The conference welcomes the development within the Police Reform Act that will introduce a new system for independent investigations into deaths in custody through the Independent Police Complaints Commission.

Delays and secrecy

Further, the conference hopes that within this new system, the delays, secrecy, defensiveness and insensitivity that have dogged a number of investigations into restraint-related and other deaths in custody in the past are dispensed with. A lack of openness hinders policy change and we cannot learn the lessons we need to learn under these conditions.

Involving families

The conference recommends that the families of victims be involved as far as possible in investigations. Their responses and experiences must be taken into account and they must be provided with the appropriate emotional and legal support to enable them to take part in the process.

Disclosure of evidence

The conference also recommends that evidence and other material should be disclosed to families or their representatives properly and at an early stage. Moreover, families should be apprised quickly of any findings from internal inquiries or tribunals and told what action is to be taken as a result.

Saying sorry

Being accountable and accepting responsibility is not the same as taking the blame. Whether there is evidence of wrongdoing or not, families should receive a swift and genuine apology from senior officers or managers.

Learning lessons

Once again, we need to learn the lessons and to learn them quickly. Notwithstanding the comment above about cutting delays, some investigations can take years. The conference therefore recommends the introduction of a mechanism to pick up the lessons at an earlier stage, perhaps even while the investigation is ongoing. These ideas could then be fed into a national body with inter-agency representation without jeopardising any subsequent criminal or disciplinary action.¹

¹ Such a national committee has been set up under the chairmanship of Ken Jones, Chief Constable of Sussex Police and with a secretariat provided by the PCA.

Coroners' recommendations

It may be that there is a role for either a full and independent public inquiry into every death in custody or for a standing commission to look at each case. Currently however, the only public scrutiny of restraint-related deaths occurs during the inquest. The conference recommends the introduction of a mechanism to monitor coroners' recommendations and to ensure that these are disseminated and acted upon across the agencies.

'Near misses'

We can learn not only from the fatalities but also from the 'near misses'. The conference recommends thematic inspection of these cases by Her Majesty's Inspectorate of Constabulary (HMIC) and a mechanism to ensure that lessons learned are disseminated and acted upon across the agencies.

Summary of conference recommendations

Preventing restraint-related deaths

1. There should be a more coherent approach at all levels to the prevention of restraint-related deaths and more uniformity across the services in the application of restraint.
2. National standards should be set for the prevention and management of violent situations supported by monitoring and backed by sanctions.
3. Leaders, senior managers, staff and officers should understand their responsibilities under Article 2 of the Human Rights Act – the right to life – and recognise that restraint is a last resort.
4. A joint body should be set up to facilitate inter-agency co-operation in continuing to look for methods of safer restraint.
5. Joint planning should cover operational issues on the ground, including warning markers about detainees, specialist restraint teams and systems of reporting, auditing and debriefing.
6. Phenothiazine drugs should not be given to agitated people. If they are, resuscitation should be planned for in advance.
7. All agencies and services involved in the formulation and application of control and restraint techniques should acknowledge past mistakes and learn the lessons of experience.
8. There should be more research into restraint-related deaths, in particular aimed at understanding their physiological causes.
9. An inter-agency group should be established to work with the Health and Safety Executive on the setting and monitoring of national tri-service training standards in the application of restraint.
10. National training standards should cover quality and quantity of courses as well as auditing and reviewing of individual training records, courses and guidance manuals.
11. As a minimum, training should cover:
 - legal principles and human rights issues;
 - cultural, psychological and medical factors;
 - threat assessment and conflict resolution;
 - unacceptable forms of restraint;
 - dangers of restraint;
 - use of equipment in restraint;
 - first aid and resuscitation;
 - referral; and
 - reporting and debriefing.

Investigating restraint-related deaths

1. Government departments, relevant agencies, the justice system, the PCA and the three services involved should face up to their responsibilities in investigating restraint-related deaths.
2. Investigations should be robust, independent and transparent.
3. Delays, secrecy, defensiveness and insensitivity should have no place in investigations.
4. Families of victims should be involved as far as possible in investigations and given the appropriate emotional and legal support.
5. Evidence and other material as well as findings from internal inquiries should be disclosed to families or their representatives at the earliest possible stage in an investigation.
6. Whether there is evidence of wrongdoing or not, families should receive a swift and genuine apology from senior officers or managers.
7. A mechanism should be introduced to pick up lessons from an investigation as early as possible, even while it is still ongoing, to be fed into a national body with inter-agency representation.
8. A mechanism should be introduced to monitor coroners' recommendations and to ensure these are disseminated to and acted upon across the agencies.
9. 'Near misses' as well as fatalities should be the subject of thematic inspection by Her Majesty's Inspectorate of Constabulary (HMIC) and a mechanism should be introduced to ensure that lessons are learned across the agencies.

References and further reading

Deaths in Police Custody: reducing the risks, Police Complaints Authority, London, 1999, ISBN 0-9533157-2-X

Policing Acute Behavioural Disturbance, Police Complaints Authority, London, 2002 ISBN 0-9533157-7-0

The 2001/2002 Annual Report of the independent Police Complaints Authority, London 2002, ISBN 0-10-291721-3

The 2000/2001 Annual Report of the independent Police Complaints Authority, London, 2001 ISBN 0-10-291037-5

The 1999/2000 Annual Report of the independent Police Complaints Authority, London, 2000, ISBN 0-10-557011-7

The Institute of Race Relations records black deaths in custody at www.irr.org.uk/resources/custody

Statistics on deaths in custody can be found at www.inquest.org.uk

Analysis: Deaths during forced deportations by Liz Fekete, Institute of Race Relations, January 2003 can be found at www.irr.org.uk