Record of Inquest

Following an investigation commenced on the 13th day of September 2010
And Inquest opened on the 13th day of September 2010;
At an inquest hearing at South London Coroner's Court on the 9th day of May 2017 heard before [redacted] Senior Coroner in the coroner's area for South London Area, and the undermentioned jurors, the following findings and determinations were made:

1. Name of Deceased (if known)

Olaseni Olatokunboh Conrad LEWIS

2. Medical cause of death

Ia **Hypoxic Brain Injury**

b **Cardiorespiratory Arrest**

c **Restraint in Association with Acute Behavioural Disturbance**

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

See paragraph 4

4. Conclusion of the Jury as to the death

Narrative - see attached

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **22 March 1987** **Croydon**	
(b) Name and Surname of deceased **Olaseni [redacted] Conrad LEWIS**	
(c) Sex **Male**	(d) Maiden surname of woman who has married
(e) Date and place of death **Third September 2010** **.Mayday Hospital, 530 London Road, Croydon, Surrey**	
(f) Occupation and usual address **ITC Analyst/Engineer**	

Signature of Senior Coroner ..... [redacted]

Signature of Jurors (if present)

....

....

....

....

In the South London Coroners Court
Inquest touching the death of Olaseni Lewis

Narrative conclusion:

The admission process of Mr Lewis onto Gresham 2 ward Bethlem Royal Hospital (at 1700 hours on the 31st August 2010) was unsatisfactory due to the lack of a full doctor's assessment, inadequate risk assessment and the failure to acknowledge the calming influence of family members.

Mr Lewis was given prescription medication in accordance with the drug chart, but it was ineffective in treating his escalating agitation.

The Trust failed to meet their own agreed targets for PSTS trained staff, which contributed to the failure to manage Mr Lewis' care adequately.

The lack of communication throughout between the police and the medical staff was a failure, and contributed to an inadequate response to Mr Lewis' medical needs.

On their arrival to Gresham 2 (at 2200 hours) the police chose to apply handcuffs in order to prevent a breach of the peace. It was shortly after this that medical staff requested assistance from the police to transfer Mr Lewis to the seclusion room, due to a lack of trained and physically able medical staff.

These five cumulative factors led directly to the police restraints within the seclusion room.

Whilst in the seclusion room, the first period of police restraint (at approximately 2204) was 'prolonged' lasting around 10 minutes and was unnecessary and unreasonable, due to the length of time Mr Lewis was held in a prone position.

The subsequent failure to close the seclusion room door led to a second prolonged period of police restraint (at approximately 2214) lasting over 20 minutes. The excessive force, pain compliance techniques and multiple mechanical restraints were disproportionate and unreasonable. On the balance of probability, this contributed to the cause of death.

The police officers failure to consider acute behavioural disorder (ABD) as a medical emergency was not in accordance with their training. In addition to this, the police training was inadequate in its definition of 'prolonged restraint' for people exhibiting signs of ABD.

During the second period of police restraint Mr Lewis became unresponsive, whereby the doctor recorded a pulse of 45-50 beats per minute, but failed to respond to the medical emergency. On the balance of probability this also contributed to the cause of death.

The police failed to follow their training, which requires them to place an unresponsive person into the recovery position and if necessary administer basic life support. On the balance of probability, this also contributed to the cause of death.

Signature of Coroner
Signature of jurors