

The following are the recommendations under Rule 43 \* put to the Coroner by the family's legal representatives following the jury verdict on 18<sup>th</sup> December 2009. These recommendations are compiled not only in relation to Mikey's case but to other similar cases both in the West Midlands region and nationally.

**\* About Rule 43**

Under Rule 43 of the Coroners Rules (as amended with effect from 17 July 2008):

Where:

1. a coroner is holding an inquest into a person's death;
2. the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
3. in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

The coroner may report the circumstances to a person who the coroner believes may have power to take such action".

Although the [Independent Police Complaints Commission](#) (IPCC) has made a range of recommendations in this case, to which [West Midlands Police](#) have responded, the family submits that the following issues which have emerged in the inquest proceedings would properly form the basis of a Rule 43 report by the Coroner.

**(i) Communication**

3. The evidence has shown that the family members were not asked for any information about Mikey's health or background until after the police van had left, and Inspector Guest spoke to them in the family home.
4. The family feels that they were not listened to adequately or at all during events at their home in Wilton Street, and that had they been involved, they would have been able to work with the police, and that this would have led to a more positive outcome. They consider that one reason for this was their race.
5. It was submitted that had the family been positively involved in the restraint of Mikey prior to the departure of the van, they would have been able to provide information about his past mental health history; his behaviour in the preceding few days; and his possible drug use.

6. Any or all of this information could well have:

1. reduced the level of restraint to which Mr Powell was subjected
2. led to an ambulance being called
3. led to a different decision being taken as to the manner in which he was transported in the police van.

7. Had any or all of these things occurred, the risk of Mikey's death and further similar deaths might have been eliminated or reduced.

8. The family invited the Coroner to recommend to the appropriate police authority that the policy and training of police officers in regards the importance of proper communication with a detainee is amended to include:

1. Recognition of the importance of also communicating with family members who are present or otherwise contactable (for example, if they have called 999); and,
2. Recognition of the importance of obtaining as much information as possible about a detainee's background and medical history from anyone able to give that information.

9. It is recognised that better policy and training may be necessary to enable officers to develop techniques for using this information when arresting individuals. Police policy and training must particularly acknowledge the particular needs of vulnerable detainees and those with mental health problems.

10. It is suggested that the policy and training for 999 operators should be amended to include a recognition of the fact that the caller may hold vital medical information that can assist the police in their response; and a procedure whereby if the 999 operator is unable to obtain that information, s/he should ensure that control makes arrangements for others to follow up with the caller to do so.

**(ii) Transportation on the floor of police vans**

11. There is genuine concern arising from the fact that West Midlands Police have still not implemented the ban on transporting people on the floor of police vans as recommended by the IPCC.

12. The Coroner was invited to recommend that this should happen and that the relevant Force Order be amended accordingly as a matter of urgency. If this means that additional suitable vans need to be acquired then this should occur.

13. The Coroner was asked that there be further research and then guidance given as to the safest method of transporting detainees sitting down.

### **(iii) Transfer to hospital**

14. The guidance given to officers as to when it is appropriate to transfer a detainee to hospital requires improvement. Had Mikey been transported to hospital, it is the agreed view of the pathologists that his chances of survival would have been better.

15. It is therefore recommended that paragraph 2.3 of Order 32/2008 be amended along the following lines:

"(a) An ambulance must be called for any detainee who appears unconscious, who has suffered a head injury or road accident and is displaying signs of possible serious damage as set out in the [National Institute for Clinical Excellence](#) (NICE) guidelines, is displaying the symptoms of excited delirium, is suffering from deep gashes that may require hospital assessment or stitching, is or has been bleeding profusely (and the circumstances are such as to inhibit an appropriate examination), or is behaving unusually and has taken drugs, or who has unusual behaviour and the officers are informed by bystanders that s/he has taken drugs, or is otherwise in that person's opinion sufficiently ill to be taken to hospital".

### **(iv) Places of safety and violent detainees in need of medical help**

16. It is submitted that West Midlands Police Acting Chief Constable Scobbie's evidence raised real concerns about the ongoing use of [police stations as places of safety for those with mental health difficulties](#), despite the Mental Health Act Code of Practice and the Independent Police Complaints Commission indicating that the same is unsuitable. There are also genuine concerns about the police's reluctance to transfer 'violent' prisoners to hospital.

17. Accordingly the Coroner is asked to consider a Rule 43 recommendation that would lead to:

- (i) Proper recognition of the inappropriate nature of police stations as places of safety;
- (ii) Police officers being advised that hospitals will not automatically turn away patients on account of their violence, but may expect officers to remain with the patients; and
- (iii) Inter-agency working that would lead to an increase in the availability of medical settings as places of safety.

### **(v) Race/diversity issues**

18. Many of the officers involved in the response to Mikey's mother's 999 call gave evidence that they had formed certain views about policing in Lozells, due to the nature of "black on black" gun crime there. Despite their denials, this mindset was likely to have affected the response of the officers to Mikey.

The Powell family believe that they were treated differently because they were black, and a racist incident is defined by the Association of Chief Police Officers as "any incident which is perceived to be racist by the victim or any other person".

19. It is likely that West Midlands Police has in employment officers responsible for monitoring diversity issues, producing equality schemes etc. We recommend that the Coroner should refer the issue of the apparent or potential stereotyping of Mikey, his family and the community to those individuals, with a view to improvements in police policy and training in this regard. Policy and training should stress the need to treat people as individuals, rather than by reference to their race or any other such factor.

#### **(v) Recording within police vans**

The jury's task in this inquest would have been made much easier had there been video and audio recording from within the police van of Mr Powell's transportation from Wilton Street to Thornhill Road. Such recording may well lead to the prevention of further deaths as officers would know – as with custody suite recording – that their movements were being captured, and it would lead to greater general transparency. The Coroner was invited to make a Rule 43 recommendation in this regard.

We would also refer to the '[Four Finger Campaign](#)' which advocates that all officers fitted with cameras which are running when ever they are in contact with a member of the public.

#### **(vi) Police officers' awareness of mental health issues**

21. The Coroner was referred to the fact that at the recent [inquest in Leeds into the death of Martin Middleton](#), the Coroner David Hinchcliff made a Rule 43 recommendation to the effect that efforts should be made to improve police officers' awareness of mental health issues. Similar concerns have arisen in this case, so the Coroner was invited to make a similar Rule 43 recommendation.

#### **Conclusion**

22. For the reasons set out above, the Coroner was asked to make Rule 43 recommendations in the areas identified.

*Adapted from the original submission by the family barristers:*

*RAJIV MENON  
HENRIETTA HILL*