Re Olaseni Lewis, deceased

1. Introduction

1.1. Olaseni Lewis, known as Seni to his family, was an ambitious young man, 23 years-old, and a successful graduate with an IT Degree from Kingston University and plans for further postgraduate study. In August 2010 he was physically well and had no history of mental illness. But within 48 hours of beginning to exhibit uncharacteristically odd and agitated behaviour – and within 18 hours of being brought to hospital – he was all but dead, having collapsed in the course of prolonged restraint by police officers. He never regained consciousness, and he was eventually pronounced dead four days later.

1.2. In fact, it appears that Seni was restrained – first by hospital staff and then by police officers – for a total duration in excess of some 45 minutes within the last hour prior to his collapse. This was against the background where police officers and hospital staff alike are trained to be aware of the fatal dangers of prolonged restraint in cases such as this, not least because of a significant number of deaths in similar circumstances over the last two decades.

2. Factual background

2.1. In the early hours of Tuesday 31 August 2010, Seni's family sought professional help and took him to the Mayday Hospital A&E in Croydon, from where he was sent for observation to a place of safety, known as a 'section 136 Suite', in Maudsley Hospital in South London. In due course, a decision was taken that he required a few days in hospital for assessment, treatment and rest. However, given his home address, the bed managers at Maudsley insisted that he would have to go to Bethlem Royal Hospital. He was taken and admitted there as a voluntary patient that evening. Having helped him to settle down, his family and friend had to leave at around 8pm when visiting hours ended. They did so with assurances that they would be contacted if there were any problems whatsoever.

2.2. Four hours later, at around midnight, Seni's family were to learn that he had collapsed and taken by ambulance to Mayday Hospital where he was placed on a life support machine. Four days later, on 4 September 2010, brain stem death was confirmed and his life support machine was switched off.

2.3. His family have since gathered an outline of what in fact happened after they were told to leave Seni on the ward at Bethlem. They understand that he became more and more agitated in their absence, and even more so when he was told that he could not leave, contrary to his understanding that he was there voluntarily. Eventually, it appears that he was sectioned in order to detain him against his will, and he was then restrained and held face down on the floor by several members of hospital staff whilst the medication was administered.

2.4. At the same time, it appears the police were called because Seni was said to have damaged a door on the ward. When the police arrived and pointed out that Seni was a patient in their care, the hospital staff sought their assistance to take him from the ward to the seclusion room on a lower floor in the Intensive Care Unit at Bethlem.

2.5. Seni was then handcuffed and taken down the stairs to the seclusion room by the police – and at all times, while he sought to resist being taken down, he was not violent towards the officers or anyone else.

3. The fatal restraint

3.1. Once inside the seclusion room, as the family understand it, Seni was held forcefully on the floor by the police officers. He was so held for a total of at least 40 minutes in the course of successive episodes of prolonged restraint involving some 11 police officers altogether. In the course of the final episode, further medication was forcibly injected into him by one of the medical staff.

3.2. Shortly thereafter, once he had ceased to struggle against the restraint, he was left on his own in the room, still lying face down on the floor. That was the point at which he was seen to be motionless, and in reality he was all but dead by then. Following attempts to resuscitate him, an ambulance was called and he was taken to the A&E at Mayday where his family found him on a life support machine.

4. The IPCC & the initial investigation

4.1. It then fell to the IPCC to investigate the events leading to Seni's death. From the outset, however, it appears that the IPCC chose to undermine the point of their investigation: they ruled out the possibility that the circumstances might disclose disciplinary or criminal wrongdoing on the part of the officers involved in the fatal restraint. As a result, the matter was not recorded as a 'recordable conduct matter', and in consequence the relevant officers were not put on notice that their conduct was under investigation, nor were they questioned in interview, under caution or otherwise. So, the written accounts presented by those officers in respect of their involvement in the fatal restraint remained untested by the IPCC.

4.2. Nevertheless, in August 2011 – one year after Seni's death – the IPCC purported to conclude their investigation and refer the matter to the CPS for a decision as to whether any charges should be brought against any of the officers. Two months later, in October 2011, the CPS returned the file to the IPCC with their agreement that it should never have been referred in the first place. Under pressure from the family to explain this state of affairs, the IPCC eventually admitted in May 2012 that it had to do with 'confusion' and 'oversight' on their part, and they then purported to refer the matter back to the CPS again for a 'review' of the case, still without the benefit of any questioning of those involved in the fatal restraint. The IPCC subsequently acknowledged their errors in the conduct of their investigation, particularly with reference to their readiness to accept the unquestioned and untested accounts of those involved in the fatal restraint.

5. The IPCC & the MPS

In March 2013, the IPCC sought to embark upon a fresh re-investigation, only to be obstructed by intransigence and worse from the MPS. For their part, the family found themselves faced with the sorry spectacle of the IPCC and the MPS at odds with each other, unable or unwilling to do what the public should be able to expect: to work together to ensure that everything necessary is done to allow an effective investigation. The MPS, for their part, appeared intent on hiding behind technicalities in an attempt to prevent any such investigation, while the IPCC looked on, seemingly paralysed into inaction.

6. Judicial Review

In the circumstances, the family were left with no choice but to seek judicial intervention by way of an application for judicial review whereby the High Court was asked to order the IPCC and the MPS to meet – and be seen to meet – their obligations in relation to this family: as a matter of law and, ultimately, as a matter of justice and common human decency. On 23 August 2013, the High Court ruled that the initial investigation had indeed been unlawful, and that the IPCC was required to undertake a re-investigation on a proper footing in accordance with its obligations under Article 2 of the European Convention of Human Rights.

7. The IPCC & the fresh re-investigation

7.1. In September 2013 – over two years after Seni's death – the IPCC launched a fresh re-investigation, announcing that they were "determined to conduct a robust and thorough re-investigation, as it is what is demanded to finally understand what happened to Seni Lewis". In the ensuing months, the family saw little sign of the "robust and thorough re-investigation" they had been promised: indeed, they were given cause to raise repeated concerns about the level or resources being made available for this matter at the IPCC, with a single relatively inexperienced investigator left to her own devices to cope with the complex demands of this case.

7.2. Not surprisingly, the purported re-investigation was not concluded – and its outcome in the form of a report was not made available to the family or the CPS – until April 2015, some twenty months after its commencement and over four and a half years after Seni's death. The IPCC concluded that seven of the eleven officers involved in Seni's restraint had a case to answer for gross misconduct, and that the remaining four officers had a case to answer for misconduct.

7.3. At the time of this briefing the MPS has responded to the IPCC finding by stating that there is no evidence to suggest that any of the officers who came into contact with Seni have a case to answer for misconduct or gross misconduct and is therefore refusing to hold misconduct proceedings. On 3 August 2016 the Commissioner at the IPCC exercised her power to direct that misconduct proceedings take place. As yet the family are yet to hear from the MPS on a timetable for when such proceedings will be brought.

7.4. For their part, the family consider that, from the very outset since Seni's death in September 2010, they have seen multiple and repeated failures at all levels of the IPCC. That no officer has faced misconduct proceedings some six years after the relevant events is further evidence of the sorry history of this matter.

8. The CPS decision

8.1. Following the second IPCC investigation, the matter was again referred to the CPS for a decision as to whether the available evidence justified criminal proceedings against any individual arising out of the circumstances of this matter.

8.2. On 29 May 2015 the CPS lawyer communicated the CPS decision to the family confirming that no charges would be brought against any of the officers or the healthcare staff involved in the restraint. She stated that she had not considered offences of corporate homicide as there had never been an investigation into this aspect of the case. She confirmed that she had not needed to consult counsel again following the conclusion of the second IPCC investigation because *"the new material provided did not take the case very much further*". For their part, the family were not in the least surprised that this decision was in the negative: they considered that it was a decision necessarily shaped by the flawed and inadequate investigation of the circumstances in which Seni met his death.

9. The corporate homicide investigation

9.1. On 16 April 2015, the family were notified by the Coroner that a PIRH which had been listed for 22 April 2015 at the conclusion of the IPCC investigation was to be adjourned. A belated decision had been made that a further criminal investigation was required into potential offences of gross negligence manslaughter and corporate homicide against the staff of Bethlem Royal Hospital and/or its management at the South London and Maudsley NHS Trust.

9.2. The family were told that the reason lay in discussions which appear to have been taking place since 2012 between the Health and Safety Executive, the Metropolitan Police and the IPCC, without the knowledge of the family, only to be disclosed to the Coroner in March 2015. The Coroner confirmed that the inquest could not progress until the conclusion of all criminal investigations. The family are yet to be provided with an adequate explanation for why it took nearly five years to launch this investigation, causing yet further delay to the inquest timetable.

9.3. In August 2015 Devon and Cornwall Constabulary assumed responsibility for the corporate homicide investigation and in December 2015 a file was submitted to the CPS for early investigative advice. Further investigative work was undertaken and a file submitted to the CPS for a charging decision in June 2016.

9.4. On 11 October 2016 – over six years after Seni's death - the CPS confirmed that no charges were to be brought against SLAM or its staff.

10. Inquest

10.1. The inexplicable delays to the inquest timetable has meant that the family and the public alike continue to be denied the benefit of effective scrutiny into the circumstances in which Seni came by his death. The delays have caused anguish to the family who have patiently endured the repeated postponements to their quest for answers since 31 August 2010, some six years ago.

10.2. In the circumstances, the family look now to the full inquest into those circumstances – and the Senior Coroner for the South London Area, Ms Selena Lynch, who has responsibility for that inquest – to ensure that this matter receives the rigorous scrutiny that has been so notably absent since Seni's death. An inquest must now be listed urgently, notwithstanding the availability of the interested parties' legal teams. Any further delay would be intolerable for this family, and arguably a breach of their right to an effective investigation into their loved one's death.

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