

## Introduction

INQUEST<sup>1</sup> is working with the family of Roger Sylvester and their lawyers.<sup>2</sup> We have major concerns about the number of restraint related deaths in police custody and the procedures for holding those responsible to account. These procedures serve neither the public interest nor the family of the deceased. INQUEST has raised its concerns about this case with Government Ministers and human rights organisations. INQUEST believes that the seriousness of this case warrants a fully independent judicial inquiry into the death and the wider issues it raises regarding the disproportionate number of black people who die following the use of restraint by police. Because of the narrow scope of the evidence allowed neither an inquest nor a criminal trial can address these concerns.

INQUEST's campaigning, political lobbying and work with individual family campaigns has placed the issue of deaths in custody and their investigation firmly on the political agenda. The number of restraint related deaths of black people has provoked particular anger amongst the black community, exacerbated by its experience of the abuse of police powers and the inefficacy of current mechanisms for examining police misconduct.

## Case Summary

Roger Sylvester was 30 years old at the time of his death in January 1999. A healthy black man who lived in Tottenham, Roger came from a large and loving family, and had numerous friends. He worked as an administration officer for a drop-in mental health centre and was well loved by colleagues and service users alike. He also helped out in his cousin's mobile phone shop. He had suffered from mental health problems in the past but for the last two years had been well and looking to the future. He had spent Christmas and New Year with family and friends and on Sunday 10 January 1999 went to a family christening. All who saw him on that day and the next day, Monday 11 January 1999, reported him as being well .

Although many of the facts surrounding his death are unclear and contradictory, what is established beyond doubt is that:

- ❑ on the night of 11 January 1999 Roger was detained outside his own home, purportedly under s.136 of the Mental Health Act 1983, and restrained 'for his own safety' by eight police officers;
- ❑ according to the restraining officers they then took him to St Anne's Hospital where, following some 20 more minutes under restraint, he went limp and died;
- ❑ Roger remained in a coma until his life support machine was switched off seven days later;
- ❑ almost five years later, an inquest into the death is only just about to take place, having finally been listed to commence on 8 September 2003 before the Coroner for Inner London North at St Pancras Coroner's Court.

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<sup>1</sup> INQUEST works directly with the families of those who die in custody. We provide legal advice and support and work with families and their lawyers. We monitor deaths in custody - in police custody, prisons, immigration detention centres, as well as the inquiries held into them. INQUEST aims to raise public awareness about controversial deaths, and campaigns for the necessary changes to improve the investigatory process, increase accountability of state officials and avert further deaths.

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The passage of time since the events of January 1999, during which period there has been no public scrutiny of the events leading up to the death, has placed Roger's family under immense stress since their lives have been and will remain on hold while the matter remains unresolved.

### **The delay in the inquest**

The chronological events of the delay can be explained as follows:

- ❑ For a period of some 10 months from January to October 1999, the death was the subject of an investigation on behalf of the Metropolitan Police, initially by their own internal Complaints Investigation Bureau (CIB), but ultimately – following representations on behalf of Roger's family – by Essex Police, under the supervision of the Police Complaints Authority (PCA). The investigation concluded with a certificate of satisfaction issued by the PCA on 21 October 1999, and the evidence collected by that investigation was then sent to the Crown Prosecution Service (CPS) for consideration of a criminal prosecution of the officers involved in the fatal restraint.
- ❑ After some 13 months, on 20 November 2000, the CPS announced their decision that the evidence was not sufficient to justify any prosecution of any officer in relation to the death. This became the subject of a challenge by way of an application for judicial review issued in February 2001 on behalf of Roger's family.
- ❑ On 21 May 2001, the matter came before the Lord Chief Justice, Lord Woolf, who adjourned the challenge pending the outcome of an inquest into the death, anticipating as he did that it should be listed for hearing without delay.
- ❑ Unfortunately, no substantive steps were taken to that end for some 8 months until 25 January 2002 when a pre-inquest review hearing took place before the then Deputy Coroner for Inner London North, Dr Hungerford.
- ❑ 3 months later, in April 2002, all interested parties were notified that the full inquest had been listed for hearing commencing on 14 October 2002 before the then Coroner for Inner London North, Dr Chan.
- ❑ After some 4 months, in August 2002, the hearing date in October 2002 was 'cancelled' following Dr Chan's apparently sudden retirement due to reasons of ill health. In October 2002, all interested parties were notified that the new Coroner for Inner London North appointed in Dr Chan's place was Dr Andrew Reid who would assume his post on 11 November 2002.
- ❑ A further pre-inquest review took place before Dr Reid in March 2003, and the full inquest hearing is now scheduled to commence on 8 September 2003.
- ❑ One issue that continues to cause concern in this regard relates to the venue in so far as the hearing is presently arranged to take place within the small and restrictive confines of St Pancras Coroner's Court. The court is unlikely to accommodate all those from Roger's family and friends who wish to attend and hear the proceedings for themselves. It is understood that Dr Reid has considered various alternatives, but nothing suitable has been found.

### **Disclosure and the issues at the inquest**

After much prevarication by the Metropolitan Police, most of the relevant documentation from the Essex Police investigation has finally been disclosed to Roger's family. Because the method of the

disclosure was ‘bitty’ it has left a strong suspicion that all may not be right. What is clear from the disclosure given, however, is that critical scrutiny at the inquest will focus upon:

- ❑ the lawfulness of the method of restraint applied to Roger in the context of the training of police officers in restraint techniques;
- ❑ the extent to which that restraint caused or contributed to the death in accordance with the opinions expressed by the consultant forensic pathologists who are being called to give their evidence;
- ❑ the relevance of the deceased’s history of mental illness in this context;
- ❑ the extent to which the nursing and medical staff involved at St Anne's Hospital could or should have prevented the restraint in the context of the training they receive;
- ❑ the means by which the risk of repetition of the circumstances giving rise to Roger’s death can be reduced or eliminated in the future.

### **The conduct of the investigation into Roger's death**

As indicated above, the investigation of the events leading to Roger's death was initially placed in the hands of the Metropolitan Police Complaints Investigation Bureau (CIB) with the approval of the Police Complaints Authority (PCA). The conduct of the investigating team from the CIB gave rise to a formal complaint on behalf of Roger's family, and by the end of January 1999 they had been replaced by a team from Essex Police. The complaint about the CIB team pointed to failures of basic policing and a failure to secure evidence from the scene of restraint, from Roger’s person or from the restraining officers and their persons. It also encompassed the general poor quality treatment of the Sylvester family. The complaint eventually gave rise to disciplinary proceedings which culminated in April 2003 when the original senior investigating officer Det Sup Curtis and his assistants DS Theobalds and DS Cockram were found guilty of neglect of duty. There remains a real concern that this neglect resulted in the irretrievable loss of vital evidence.

In the eyes of Roger's family, the subsequent conduct of the investigation by Essex Police has failed to eliminate their suspicion and concerns. Sheila Sylvester comments:

*“The investigation has not centred on the behaviour of the eight officers who laid hands on my son that fateful night. Their actions were not investigated with the thoroughness and rigour that would have been the case had they been civilians. This is unjust. Instead Essex Police chose to investigate Roger, the victim, in an attempt to blame him for his own death.”*

### **Misinformation**

As is often the case in the event of a death in custody, a considerable amount of misinformation has made its way into the public domain about the cause of Roger’s death and about his character. His family and friends have had to fight against the misrepresentation of his image by the police and media who have portrayed him as a mentally ill drug user – a common racist stereotype attributed to young black men. Such a ‘character assassination’ of the deceased is a pattern that INQUEST has seen repeated time and again in controversial deaths in custody in what is often an attempt to deflect attention away from police conduct.

- ❑ On 14 January 1999, while Roger lay in a coma at hospital, Scotland Yard issued a press release describing Roger banging on a neighbour’s door in an ‘aggressive and vociferous manner’. It was quickly established that he had in fact been banging on his own door and that

there was no evidence that he had been behaving aggressively. A complaint to the then Assistant Chief Commissioner, John Stevens, resulted in an insufficient apology

- At the opening of the inquest into Roger's death in January 1999, the then Coroner's pathologist Dr Freddie Patel made completely unfounded, unprofessional, inaccurate remarks to the press implicating that Roger was under the influence of crack cocaine at the time of his death. The remarks were made in an "off the cuff" briefing to journalists outside the Coroner's court. These remarks were subsequently reproduced in newspapers. Following a complaint by the family, Dr Patel was removed and another pathologist appointed in his place. A further complaint to the General Medical Council resulted in a finding on 9 January 2002 that Dr Patel was guilty of serious professional misconduct. Nevertheless, no apology has been received from Dr Patel or the then Coroner, nor has any evidence been produced to support the rogue remarks.
- On 30 January 1999, *The Times* newspaper ran a full-page article claiming that police officers believed Roger's death was due to his heart being 'swollen by crack cocaine'. The article repeated other police misinformation, including the claim that he had been 'flinging himself to the ground' when police called for reinforcements. It also reported that the officers concerned had received death threats following Roger's death. Again, no evidence has been forthcoming to support any of these allegations.
- For their part, relatives and friends have described Roger Sylvester as a fit and healthy young man, stable and family oriented, who had suffered from a depressive illness for several years. He had been very well from September 1997 onwards, and for the last five years of his life he had been employed as an administrative assistant for the London Borough of Islington.

### Comment

By the time of Roger's death in January 1999, officers throughout the Metropolitan Police had received warnings and guidance on the potential dangers of restraint asphyxia, following the restraint related deaths in Metropolitan Police custody of Richard O'Brien in April 1994, Wayne Douglas in December 1995, and Ibrahima Sey in March 1996.

When members of the public die the reaction of the authorities raises very serious questions about the protection of human rights. INQUEST's monitoring of deaths in custody (and their investigation by police officers) indicates that the Government has failed to ensure the protection of the Right to Life, as required by Article 2 of the European Convention on Human Rights. The caselaw under the Convention<sup>3</sup> as reflected and amplified by the domestic courts<sup>4</sup> serves to establish the following propositions:

- ❑ the right to life under Article 2 is the most fundamental of all human rights – it is put at the forefront of the Convention, and the power to derogate from it is very limited;
- ❑ articles 1 and 2 of the Convention require that when an individual dies in circumstances where there is evidence suggesting involvement or responsibility on the part of agents of the state there must be an effective official investigation;
- ❑ in the absence of a criminal prosecution of those responsible for the death, the holding of an inquest in public by an independent judicial official, the Coroner, in which interested parties are able to participate, must be regarded as a full and effective investigation;
- ❑ such an investigation should be capable of leading to a determination of whether the death amounted to an unlawful killing, and the identification and punishment of those responsible for an unlawful killing;
- ❑ in the absence of such an investigation legal protection of human rights would be ineffective in practice because it would be possible in some cases for agents of the state to abuse the rights of citizens with virtual impunity;
- ❑ the investigation should be conducted diligently with a genuine determination to identify and prosecute those responsible;
- ❑ where fundamental values and essential aspects of private life are at stake, effective deterrents may be indispensable, and may only be capable of being provided by the criminal law;
- ❑ the ultimate effectiveness of a remedy may depend on the proper discharge of their functions by those responsible for conducting the investigation and prosecution on behalf of the state;
- ❑ article 13 of the Convention entails, in addition to a thorough and effective investigation, effective access of the complainant to the investigatory and prosecutorial process;
- ❑ where an individual is killed in circumstances where there is evidence suggesting involvement or responsibility on the part of agents of the state, it is incumbent on the state to provide a

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<sup>3</sup> X and Y v. The Netherlands (1986) 8 EHRR 235, paragraph 27; McCann v UK (1996) 21 EHRR 97, paragraphs 159-164; Aydin v. Turkey (1998) 25 EHRR 251, paragraphs 103 and 104; Kaya v. Turkey (1999) 28 EHRR 1 paragraph 86; Assenov v. Bulgaria (1999) 28 EHRR 652, paragraphs 102, 104 and 117; Selmouni v. France (2000) 29 EHRR 403, paragraphs 79 and 87; Velikova v Bulgaria (27.4.00, ECHR), paragraph 80; Salman v Turkey (27.6.00, ECHR), paragraph 104; Jordan v UK (4.5.01, ECHR), paragraphs 102-109, 115 and 142-144; Edwards v UK (14.3.02, ECHR), paragraphs 69-73.

<sup>4</sup> R v. DPP ex p Manning (2000) 3 WLR 463, paragraphs 26 and 33 per Lord Bingham of Cornhill CJ; R (Wright & Bennett) v SSHD (2001) EWHC Admin 520, paragraphs 33-43 per Jackson J; R (Amin & Middleton) v SSHD (2002) EWCA Civ 390, paragraphs 59-63.

plausible explanation of how the death was caused, failing which a clear issue arises under Article 2 of the Convention.

### Campaigning/Political Work

INQUEST has been working closely with the Roger Sylvester Justice Campaign<sup>5</sup> set up by Roger's family after his death. We have brought his death to the attention of Government Ministers, MP's, Trade Unions and Human Rights organisations. INQUEST and family members met with the late Bernie Grant MP and drafted an Early Day Motion about police restraint methods and deaths in police custody calling for an independent inquiry that was tabled by Bernie Grant and Harry Cohen MP and signed by 33 MPs. Support for an independent inquiry has also been received from The Mayor of London, Ken Livingstone, the Tottenham MP, David Lammy, Lord Harris, Chair of the Metropolitan Police Authority, Jeremy Corbyn MP, Haringey Council, *The Voice* newspaper and the following organisations:

- ❑ NACRO
- ❑ UNISON
- ❑ The Runnymede Trust
- ❑ Churches Commission For Racial Justice
- ❑ The Monitoring Group
- ❑ National Assembly Against Racism
- ❑ Liberty
- ❑ Newham Monitoring Project
- ❑ CARF
- ❑ Institute for Race Relations
- ❑ 1990 Trust
- ❑ Diverse Minds.

**Deborah Coles**  
**Co-Director, INQUEST**  
**July 2003**  
**Update October 2003**

### NOTE

The Roger Sylvester Inquest concluded on Friday October 3<sup>rd</sup> and the jury returned an unlawful killing verdict.

The jury said that his death was caused "when more force was applied than was reasonably necessary causing a significant contribution to the adverse consequences of restraint:

1. Held in restraint in position too long;
2. Lack of medical attention;
3. No attempt was made to alter his position of restraint.

The family of Roger Sylvester and INQUEST believe that this is a just verdict on account of the evidence heard.

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<sup>5</sup> The Roger Sylvester Justice Campaign is a family-run campaign and can be contacted at PO BOX 25908, London N18 1WU [www.rsjc.org.uk](http://www.rsjc.org.uk)

The four-week inquest was held at St Pancras Coroner's Court before the coroner Dr Andrew Reid. The jury were given four verdicts to consider, Unlawful Killing, Accidental Death, Open and Non Dependent Abuse of Drugs.

During the inquest the officers told the jury that they knew that excessive restraint was dangerous and life threatening. The same officers maintained that they would do nothing different if placed in the same situation today.

Within the Prison Service, officers have been instructed against using the prone restraint for more than 5 minutes. The jury also heard that in some psychiatric institutions staff are told not to use the prone restraint for more than 30 seconds.

The inquest, the Roger Sylvester's family has had to endure a concerted attack upon his character on behalf of the Metropolitan Police Commissioner and the officers involved in the fatal restraint. The attack, conducted by repeated and persistent references to his supposed 'violence' and 'exceptional strength', is of course very familiar to INQUEST and other families who have lost loved ones under restraint in custody, with the object of shifting attention away from the contribution of restraint to the death.

The jury heard no evidence that Roger Sylvester's actions on the tragic night amounted to anything other than a struggle against the fatal restraint. The only evidence of any 'violence' on his part amounted to a suggestion that he tried to bite or spit at one of the officers restraining him. Yet the jury heard that none of the eight police officers sustained injury.

Many issues have arisen during the inquest including the controversial concept of excited delirium. The coroner rejected the submission from the police that there was evidence that Roger Sylvester had simply died from natural causes. He ruled that he did not recognise excited delirium as a condition that by itself could cause death. He drew attention to the fact that all reported cases show that death requires some other unnatural factor such as cocaine or restraint.