INQUEST
Working for truth, justice and accountability

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DAMNING VERDICT IN RESTRAINT-RELATED DEATH OF ANDREW JORDAN

28 year old Guyanese man Andrew Jordan died following attempts to detain him under the Mental Health Act on 7th October 2003. Andrew, who had a history of schizophrenia, had been visited by a Mental Health Team from Oxleas Primary Care Trust and the police at his home in Erith. After initially refusing entry to the house Andrew opened the door to talk to the police.

A number of police officers entered and proceeded to restrain him. Andrew was later carried belly down out of the house, onto a stretcher, still cuffed, before being placed on a trolley, still cuffed face down and strapped in with two straps, one across his legs, the other across his chest to an ambulance waiting outside the house. Shortly after the ambulance left with Andrew inside, accompanied by police officers, he started to fit. The ambulance crew assumed he was hyperventilating rather than fighting for breath and admitted at the inquest that if oxygen had been applied straight away, it would have given him the best chance of survival.

Andrew remained in a prone position, (belly down) face to the side; it was only when Andrew's hand turned cold and his lips purple that he was turned onto his back. By this time Andrew was effectively dead (no vital signs).

When Andrew was initially placed in the ambulance, the paramedic decided to take Andrew to the Woodlands mental health unit instead of taking him straight to an A & E department where he would have received emergency life saving treatment. During his evidence he admitted this critical decision was an error on his part. Equally, as the only paramedic on the ambulance crew, he also conceded he should have remained in the back of the ambulance attending to Andrew as opposed to leaving this to his less qualified colleague.

The jury concluded:

1) **'A contributory factor in Mr Jordan's death was the lack of communication between all services as to his condition'**
2) **'Deficiencies in the training on positional asphyxia amongst some of the medical staff was detrimental to the treatment that Mr Jordan received'**
3) **'Mr Jordan died in part because asphyxia caused by prolonged restraint was not subsequently treated'**.

A full, detailed and highly critical narrative verdict was returned.

Key points which emerged during evidence include:

- The London Ambulance Service (LAS) paramedic who attended the scene admitted that as the more qualified of the two crew members, he should have been in the back of the ambulance as opposed to with the driver;
- The paramedic should have asked for a doctor when Andrew started to collapse given that they would have been better qualified to assess Andrew rather than himself, especially as two doctors were at the scene;
- LAS crews had not received training in positional asphyxia at the time of Andrew's death, only since October 2005;
- Since Andrew's death, protocol devised by Oxleas Mental Health Trust is much more detailed and requires more background information to be given to police officers about patients;
- All officers had been fully trained in positional asphyxia yet Andrew was kept in a semi-prone position, kneeling, chest over sofa, for at least 10 minutes. Positional asphyxia sets in after 4-7 minutes;
- Four officers restrained Andrew despite him already being in Kwik-cuffs, which are designed for one officer to control a detained person easily on their own;

Deborah Coles, co-director of INQUEST, said:

> *"The inquest has heard very disturbing evidence about the treatment and care of a mentally ill man in police custody. This case once again raises serious concerns about the ongoing dangers of current police restraint methods, especially where prolonged and dangerous use of the prone position occurs. Andrew's death also highlights the inappropriate training in the dangers of positional asphyxia given to London Ambulance Service staff. It is a damning indictment of the failure of state agencies to learn the lessons of previous deaths.'*

Andrew's Family said:

> *"We are very pleased with the verdict that the jury has returned. However, nothing will bring Andrew back. He leaves behind a grieving family including his young daughter. We, as a family, feel vindicated for our belief that the authorities, including the metropolitan police, Oxleas Mental Health Trust, and London Ambulance Service failed Andrew. The result was his death. We are glad that the jury recognised this when returning their verdict. We would like to thank INQUEST and our legal team. We just hope that lessons are learnt from Andrew's death and no other family has to go through what we have been going through for the last two and a half years.'*

The Jordan family were represented at the inquest by INQUEST Lawyers Group members Susie Yau of Fisher Meredith Solicitors and barrister Leslie Thomas from Garden Court Chambers.

Notes to editors:INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.

Further Information	www.inquest.org.uk
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