Judicial Communications Office

12 March 2021

FINDINGS INTO THE DEATH OF GERARD McMAHON

Summary of Findings

The Coroner, Mr Joseph McCrisken, today delivered his findings into the death of Gerard McMahon. He found that the deceased had taken cocaine leading to an Acute Behavioural Disturbance ("ABD"). He said the force used during the restraint was justified but the restraint itself was poor in terms of technique. All three officers had not undergone Personal Safety Programme ("PSP") training within the 12 months before the incident. While the training material was reasonable in terms of information about ABD and Excited Delirium ("ED"), it was not delivered in an effective way. The Coroner found that both the officers involved and the PSNI had a responsibility to receive training and this was a joint failure.

Gerard McMahon ("the deceased") died on 8 September 2016 in the Intensive Care Unit of the Royal Victoria Hospital ("RVH"), Belfast. A number of hours prior to his death the deceased was involved in an interaction involving physical restraint by Police Service of Northern Ireland ("PSNI") officers. The deceased's death was investigated by the Police Ombudsman for Northern Ireland ("PONI") and a file was forwarded to the Director of Public Prosecutions. In February 2020, the Public Prosecutions Service confirmed that there would be no criminal prosecution of any PSNI officers related to the death.

The inquest was held over eight days, commencing on 15 February 2021. The Coroner indicated that his findings would comply with Article 2 of the ECHR so that he could also consider "by what means and in what circumstances" the deceased came by his death. He clarified that a Coroner cannot express any opinion on questions of civil or criminal liability. The scope of the inquest was agreed in advance and is set out in paragraphs [16] and [19] of the findings.

The inquest heard that the deceased worked as a DJ in local nightclubs. His mother said he had been struggling with addiction issues for a number of years and had been attending Narcotics Anonymous. She said he would often consume alcohol when taking cocaine and this gave rise to acutely disturbed behaviour. She suspected his drug use began in the middle of 2015 possibly following an assault. His GP referred him to the Community Addiction Team around June 2016 and he was offered an appointment for September 2016 but died before he could attend. The Coroner said he was satisfied that the deceased had been abusing cocaine for a number of years before his death and that he was probably abusing it recreationally for a time prior to the assault in 2015.

The events of 7 and 8 September 2016

The events of 7 and 8 September 2016 are set out in paragraphs [25] to [72] of the findings and have been reported widely by the media during the inquest.

Post-mortem examination

The Coroner said there had been intense discussion regarding the cause of death during the inquest and for that reason he rehearsed the post mortem findings in some detail in paragraphs [73] to [97]. The pathologist, Dr Lyness, examined witness statements and CCTV footage and thought the

deceased's behaviour demonstrated some form of ABD, characterised by erratic, often combative, behaviour, inappropriate shouting and undressing. In his opinion, there was little doubt that the ABD was due to the deceased having taken cocaine. The pathologist commented that it is well recognised that the effects of cocaine are unpredictable and may precipitate death, at any time, commonly from either a sudden disturbance in the heart rhythm or an epileptic type seizure. The pathologist also recorded a large number of injuries on the deceased's body, including the scalp, face, neck, chest, abdomen, back and all four limbs.

The pathologist concluded that there was little doubt that the deceased demonstrated some form of an ABD due to the toxic effects of cocaine. He was subsequently physically restrained by police officers and suffered a cardiac arrest. However, the pathologist considered it extremely difficult, from the autopsy findings alone, to state with absolute certainty as to what relative extent the physical restraint, ABD, cocaine toxicity, rib fractures, exposure to CS spray, obesity and coronary artery atheroma played in the complex interactions that precipitated the acute deterioration in his condition prior to his admission to hospital. He recorded the cause of death as:

> *"1(a) Hypoxic ischaemic necrosis of brain, pneumonia and multiple organ failure*
> *Following*
> *Cardiac Arrest during physical restraint*
> *In association with*
> *An acute behavioural disturbance, Cocaine toxicity, Rib fractures, Exposure to CS Spray, Obesity and Coronary Artery Atheroma."*

Other expert evidence

The inquest received evidence from a number of experts. Their evidence is set out in paragraphs [98] to [133] of the findings.

Police policy and procedure

Chief Inspector John Keers, who has responsibility for the management of the PSNI Tactical Training Department gave evidence on the relevant PSNI policy and procedure. His evidence is considered in paragraphs [134] to [159] of the findings.

Conclusions

The Coroner's conclusions are set out in paragraphs [160] to [201] of the findings.

The Coroner said he was satisfied that the deceased took cocaine while he was present within Thompson's Garage and that he behaved in such a way which concerned other patrons to the extent that they contacted security staff. This involved the deceased having his trousers undone. He said that the staff who removed the deceased did so using reasonable force. When outside, the deceased can be seen on CCTV attempting to strike one of the security staff and other staff intervened and took him to the ground. The Coroner said he could not be satisfied that the fracture to the deceased's larynx came about by one of the security staff placing a hand around his throat but that he was absolutely satisfied that the police officers did not cause this injury.

The Coroner noted that once the deceased reached the back of the City Hall he had suffered a number of heavy falls. He appeared to have removed his trousers, t-shirt and possibly one shoe by this stage. The Coroner was satisfied that this behaviour occurred as a result of the ongoing ABD

but could not be sure what injuries, if any, were caused when the deceased became involved with a member of the public in the Markets area.

The Coroner was satisfied that the categorization of the initial call to the PSNI as "priority" was correct. He said there was no access to CCTV footage at this stage and although the deceased's behaviour was odd there was no emergency and no immediately life threatening situation. The Coroner said the decision of the call handlers not to seek assistance from the CCTV control room was not satisfactory and this should have been used to glean further information. When interviewed the call handlers failed to appreciate the assistance they could have provided to their PSNI colleagues on the street. The Coroner said that training in recognition of ABD along with access to CCTV may have assisted the officers to deal with the deceased and noted that the new PSNI ABD/ED e-learning package includes an example scenario showing how an air support crew were able to advise colleagues on the ground about an individual showing signs of ABD.

The Coroner said that the initial interaction between the deceased and Officers A and C was reasonable in all the circumstances. He said it was not unreasonable for Officer A to display his CS spray pending compliance by the deceased or for Officer C to apply handcuffs to the front once the deceased fell to the ground. He commented, however, that once the handcuffs were applied to the front a conversation should have taken place between Officers C and A concerning any potential risk and the appropriateness of the handcuffs remaining in the frontal position, as opposed to the rear. The Coroner said there were opportunities to remove the handcuffs and place them to the rear without the deceased having to be placed face down for this to happen.

The Coroner had been referred to the restraint training provided by the PSNI and informed that guidance on ABD/ED/PA would have been provided. He said it seemed that, on paper at least, the PSNI had appropriate training material available containing sufficient information to alert officers to the risks of ABD/ED/PA. The issue, he said, was with the delivery of this information. In 2013-2015, the relevant documents (Service Procedure 59/07 and Appendix E) were not made available to trainees as reading material. The Coroner said it would have been better if this material had been given in advance or after the training as essential reading and this would have reinforced its importance. He appreciated that ABD was rare but said that the lack of recognition by Officer C, who had receive the relevant training just over 12 months previously, was a poor reflection. The Coroner was satisfied that if the relevant documents had been communicated properly to Officers A, B and C in the 12 months prior to this event they may have been in a position to at least suspect that the demeanour and behaviour of the deceased was as a result of something more than just alcohol or drugs. He said they may have even been in a position to mention ABD/ED to colleagues and discuss the potential for hospital treatment and been warned about the mechanics of restraint.

The Coroner was satisfied that when the deceased was brought to the Grand Opera House, Officers A and B dealt with him as if he was intoxicated through alcohol and/or drugs. He said they did not realise he was suffering from ABD, should not be restrained and was to be treated as a medical emergency. He was satisfied that maintaining the deceased in a seated position was appropriate. The Coroner said when the deceased started struggling he was placed on the ground because of "lack of planning, risk assessment, communication and knowledge of appropriate restraint techniques". He said that while the restraint on the ground was extremely poor, he was satisfied that the officers were justified in using a degree of force to restrain the deceased as it was possible he could have posed a very real risk to himself or road users. The Coroner said the force used was not excessive but the efforts were made more difficult by "a staggering and inexplicable lack of communication between the officers during the restraint". He found it "astounding" that at no point

during the restraint did Officers A, B and C speak to each other about what they were doing: "No officer took control. The result was an uncoordinated restraint."

The Coroner commented:

> "I am satisfied that PSP training included elements concerning the importance of communication. I am, however, not satisfied that the officers were properly trained in the importance of having a 'control' or 'restraint' officer. This officer should ideally be the one closest to the detained person's head and more able to monitor their condition. … This complete breakdown in any command structure led to the officers becoming engaged in a restraint with no single officer in command and, in my view, no 'end game' as to how the restraint might end."

The Coroner then considered the decision by Officer A to discharge CS spray into the deceased's face. He said the use of CS spray in these circumstances was "not just unwarranted but also irresponsible". He said the training manual indicates that CS spray should not be discharged at a distance of less than a metre and may not be effective on individuals who have taken drugs. The Coroner also said that discharging the CS spray so close to colleagues was completely inappropriate.

The Coroner commented that when it was suspected that the deceased was deteriorating it was appropriate to call an ambulance, to move him into the recovery position and to ask for a defibrillator to be brought to the scene. He said, however, that there was a delay in beginning cardiopulmonary resuscitation. This was as a result of Officers B and C being incapacitated by CS Spray, Officer A being exhausted from the struggle with the deceased, and Constable Gordon, whose subsequent efforts at CPR must be praised, misunderstanding his first aid training and thinking that a defibrillator should be applied prior to chest compressions commencing. The Coroner said that as a result time was spent preparing for defibrillation when chest compressions could have been commenced. He accepted the medical evidence that this delay made no material difference as the deceased was likely in asystolic cardiac arrest at this stage and this, combined with an underlying metabolic disturbance caused by cocaine, meant that the situation was not recoverable. The Coroner noted that Constables Gordon, Kingsberry and Mould performed effective CPR achieving a return of a pulse and said that, despite the issue raised regarding the commencement of chest compressions, these officers deserved considerable praise and recognition for their efforts at attempting to resuscitate the deceased.

Cause of Death

The Coroner was satisfied that the following formulation accurately answered the question as to how Mr McMahon came by his death:

> *1a. Hypoxic Ischaemic Necrosis of brain, Pneumonia and Multi-Organ Failure*
>
> *Due to*
>
> *1b. Cardiac arrest during restraint of an obese individual suffering from cocaine induced Acute Behavioural Disturbance.*
>
> *2. Rib fractures, Coronary Artery Atheroma.*

The Coroner was satisfied that all rib fractures identified at post-mortem played some role in the development of a pneumonia and death. Accordingly he included rib fractures at part 2 (underlying conditions not directly causative). Similarly he considered that coronary atheroma would have meant that the deceased's heart may not have been as able to survive a cardiac arrest as well as a person's heart without 60% narrowing. He considered that this condition did not directly cause the death but was an underlying factor. The Coroner did not consider that CS Spray played any role in the death and accordingly it is not included in the formulation.

At inquest there was discussion as to what respective roles the ABD and the restraint played in the death. The pathologists were asked if the deceased would have died absent the restraint. None of them would give a definite answer. The Coroner said he was satisfied on all the evidence that at the time he interacted with police the deceased was already very unwell. He said that he was likely suffering from a developing rhabdomyolysis, hyperkalaemia and kidney injury brought about by the ABD and cocaine ingestion:

> "It is possible that he would have survived without the restraint but the restraint did occur and in my opinion this, in combination with the ABD, caused a cardiac arrest leading ultimately to Mr McMahon's death. The answer to the question - Would Mr McMahon have died without the restraint? – is, maybe."

In postscript, the Coroner noted that since 2018 the PSNI has implemented an online learning package specific to ABD. There is also a "Speak Up Speak Out" policy which informs officers that ABD is difficult to recognize and, if an officer involved with a subject has reason to suspect that an individual is exhibiting symptoms of the condition, they should "speak up speak out" and treat the subject as a medical emergency. Completion of the e-learning package is mandatory and must be completed annually and refreshed before the officer attends for PSP refresher training.

NOTES TO EDITORS

1. This summary should be read together with the judgment and should not be read in isolation. Nothing said in this summary adds to or amends the judgment. The full judgment will be available on the Judiciary NI website (https://judiciaryni.uk).

ENDS

If you have any further enquiries about this or other court related matters please contact:

Alison Houston
Judicial Communications Officer
Lord Chief Justice's Office
Royal Courts of Justice
Chichester Street
BELFAST
BT1 3JF

Telephone: 028 9072 5921
E-mail: Alison.Houston@courtsni.gov.uk