The family of a black man who died in police custody have finally achieved a measure of justice. *Neil Hodge* reports

The police killed Mikey Powell

A family of a black man who lost his life in police custody are campaigning to make sure that no one else has to suffer the six years of hell that they have endured trying to hold a local police authority to account.

The family of Mikey Powell have worked with the coroner to produce a list of actions they believe should be circulated to police and health authorities throughout the West Midlands and the whole country so that any restraint during arrest is appropriate, and officers give proper regard to family members and friends who may hold vital information about a person's medical condition. They also want to ensure that people with potential mental health problems are taken to a hospital rather than a police station for the correct supervision.

Powell died after being detained by West Midlands Police on September 7 2003. He was 38, had three children and worked as a team leader in a local metal factory. At the time of his death, he was living with his mother in the Lozells area of Birmingham. He had been unwell and, while suffering a mental ill-health episode brought on by a bout of depression, he smashed a window at their home. His mother called the police for help, assuming they would take him to hospital.

Tragically, the phone call turned out to be the worst decision she has ever made. Within two hours, her son was pronounced dead at Birmingham's City Hospital. In a damning narrative verdict released just before Christmas, an inquest jury concluded that Powell had died from positional asphyxia following police restraint. An eight-two majority at Sutton Coldfield

Town Hall ruled that the sequence of events in the last few minutes of his life "made him more vulnerable to suffering death".

In short, police officers deliberately drove a police car at Powell (after he broke one of the car's windows), beat him with a baton, and sprayed him with four times the recommended amount of CS gas. He was restrained on the ground for more than a quarter of an hour by eight officers who, knowing he was injured, drove him to a police station rather than a hospital, despite the Mental Health Act Code of Practice and the Independent Police Complaints Commission indicating that such practice is unsuitable. No ambulance was called, despite Powell being covered in blood, and he was put onto the floor of a police van "like a dog", according to a friend's testimony.

At the time, West Midlands Police said they had been asked to investigate reports of a break-in. However, just three days later, the Police Complaints Authority was forced to issue a statement confirming: "There was no question of him trying to break into the house." Officers also claimed they believed Powell had a gun, which he did not (he had broken the police car window with a trouser belt).

The central issue at the inquest was whether Powell had been transported face down on the floor of the police van and whether this had led to him dying of positional asphyxia. The police assertion was that he had been placed on his side and had died from the combined effects of his exertion against restraint and the fact that he possessed the sickle cell trait. However, the jury found that he had been driven to Thornhill Road police station on the floor of the van, lying between the seats. Further, on arrival, Powell was kept in the van parked in the station yard for three minutes until he was carried face down 26 metres into the "drunk cell". It was only then that officers noticed he was not breathing. Paramedics tried to resuscitate him, but it was too late.

The family's fight for justice has been a slow and frustrating one. On January 7 2005, the Crown Prosecution Service revealed that none of the police officers connected to the case would face manslaughter charges. Instead, eight officers were to be prosecuted for misconduct and two for dangerous driving and assault. However, at trial on June 28 2006, four officers were cleared on the judge's direction. On August 2 2006, the remaining six officers were cleared – four by the jury and two by the judge after the CPS decided not to have a retrial following the jury's inability to reach a verdict. It was only in November last year – six years after Mikey Powell's death – that his family finally had the opportunity to hear the events leading up to his death being questioned in court.

After the verdict, Sieta Lambrias, Powell's sister, said: "At long last, the truth has come out – we have worked for six years to reach this point – the jury have found that the position the police put Mikey in killed him. Hopefully, this will give some encouragement to other families who have lost someone in custody.

"A chilling feature of this inquest is that Mikey died in police hands. Officer after officer told the court that they would do the same thing again. Most expressed no regret for Mikey's death. We are alarmed about this and think the community should be, too. We will continue to fight to secure police accountability and stop future custody deaths."

Deborah Coles, co-director of Inquest, a charity that provides counselling and legal advice to families whose relatives have died in contentious circumstances, says: "The Chief Constable of the West Midlands police force needs to explain why, six years after this most disturbing death, his officers can give evidence that they would do nothing differently if presented with a similar situation today. Have the police learned nothing from previous high profile deaths and the recommendations arising from inquests and inquiries?"

The Powell family has worked with the Assistant Deputy Coroner for Birmingham, Stephen Campbell, who heard the inquest, to devise a list of recommendations under Rule 43 of the Coroners Rules 1984. This states that a coroner can recommend to a relevant person or authority that remedial action should be taken to ensure such incidents are unlikely to happen again. The rules were amended in 2008, so that a person who receives a report – in this case, the Chief Constable of West Midlands Police – must send the coroner a written response, which the coroner may send "to any other person or organisation with an interest".

Previously, there was no unequivocal statutory authority for coroners to share the full report with other organisations. Some coroners have shared reports and others have not. Therefore, some families have not seen how lessons can be learned to prevent a tragedy similar to the death of their relative in other public authorities – which could be some consolation. Also, information has never been collected centrally. This means issues subject to reports in one coroner district, which may have relevance to other coroner districts, were not identified and disseminated nationally. Consequently, important opportunities to save lives may have been missed.

Tippa Napthali, a relative and head of the Mikey Powell Campaign Group, says: "West Midlands Police has to respond to these recommendations and it – as well as other police forces – has to learn from the horrendous mistakes that contributed to Mikey's death.

"The police need to be taught that people with mental health issues are going to be better served by being taken to a hospital rather than a police cell, and that they should obtain as much information as possible about a person's background and medical history before taking action that might make the situation worse." ●

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Tippa Napthali is organising an event to take place at the University of Leicester on Saturday May 15 to mark what would have been Mikey Powell's 45th birthday and to showcase other families' cases. For more information visit:

www.remembrancevent2010.eventbrite.com

Powell's friends and family have not forgotten. Photos courtesy Mikey Powell Campaign

Police officers drove a police car at Powell, beat him, and sprayed him with four times the recommended amount of CS gas