METROPOLITAN POLICE TOTAL POLICING

Coroner ME Hassell,
Senior Coroner,
Inner North London St Pancras Coroner's Court,
Camley Street
London
N1C 4PP
[redacted]

By Email to:

[redacted]

[redacted]
Director of Professional Standards
Room 913
Tower Block,
New Scotland Yard
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London
SW1H 0BG

[redacted]

Your ref:
Our ref:

13 November 2013

Dear Ms. Hassell,

I write on behalf of the Metropolitan Police Service in response to your Regulation 28: Prevention of Future Deaths report, dated 23rd September 2013, following the inquest touching the death of Michael Sweeney, heard before you at the Coroners Court sitting at St Pancras Coroner's Court on the 2nd day of September 2013.

As you will recall, you identified that the police officers' use of the phrase 'excited delirium', based on training they had received prior to the incident, indicated that they had correctly recognised Mr Sweeney's behaviour as evidence of a major medical emergency.

However, you also noted that the term 'excited delirium' had little currency outside the police service in the UK at the time of the incident, and in particular, was not at that time recognised by the professionals in the other two agencies, the LAS and the NHS, who were also involved in the incident. You recommended that all three agencies agree on a common terminology to describe the 'constellation of symptoms' exhibited by Mr Sweeney. You noted that this constellation could in other incidents be attributed to a wide range of underlying causes, ranging from illegal substance abuse, to legal drug side effects, to various physical and mental health conditions, and it was therefore necessary to agree upon a term which did not imply any single presumptive diagnosis. You also made the compelling suggestion that since what was being described was a *medical* emergency, logic would dictate that a term meaningful to medical personnel should be the one adopted. Accordingly, your suggestion was that all three agencies should adopt the phrase 'extreme agitation'.

You suggested that following this logic would:

1. require police to modify internal training to incorporate the new term, ensuring however that:
2. the awareness that the 'constellation of symptoms' comprised a medical emergency must be retained in any such training;
3. that police control room staff must receive training on the condition, and on protocols for accurately communicating this information to the ambulance service; and finally,
4. that the London Ambulance Service should amend its own protocols to recognise the condition.

Point 4 above is of course a matter for the London Ambulance Service. I understand they will be replying to you separately on this. 'I would anticipate however that they will in that response make reference to the adoption of a new Memorandum of Understanding between our respective services, on providing '…guidance on joint working including use of CAD Link and Joint Response Units', which we are now in the final stages of completing.

Accordingly, I will now address the overarching proposal that 'extreme agitation' be the adopted common terminology; the three outstanding points above for the Metropolitan Police which follow from the proposal; and, where appropriate, the underpinning provided to our response by the new Memorandum of Understanding. I have been assisted in this by subject area experts in Custody, Policy, and Healthcare matters within the MPS; and will also make reference where appropriate to elements of joint working with our partner agencies.

Use of a Common Terminology

Views were first of all sought, within the MPS, and with our partner agencies, regarding the most appropriate common terminology to adopt. The response was co-ordinated by [redacted], Senior Advisor, First Aid, Policy and Assurance, through her membership of the interagency Clinical Panel on which she sits with colleagues from the London Ambulance Service and representatives of London NHS Trusts. Her stance is supported by [redacted] Medical Director, Metropolitan Police (with overall responsibility for the Forensic Medical Examiner role and himself a practising senior doctor of Emergency Medicine and former council member of the College of Emergency Medicine); and Inspector [redacted] lead on Officer Safety Training related issues, who provides the Metropolitan Police link to the Association of Chief Police Officers' national policy debates on such matters.

The principle of adoption of a common terminology is universally accepted – indeed, the Medical Director supports broadening the stakeholder base further to include additionally the College of Emergency Medicine, the Department of Health, and the Independent Advisory Panel on Custody Deaths, chaired by [redacted] The Medical Director is currently working to progress this.

However, the use of the particular phrase 'extreme agitation' in place of 'extreme delirium' was universally rejected, by both the local partner agencies approached by [redacted] through the Clinical Panel, and by the setters of national police policy through the Association of Chief Police Officers, as reported by Inspector [redacted] The reasons for this were as follows:

Firstly, the suggested replacement phrase, 'extreme agitation', as several subject area experts pointed out, risked introducing into the policing realm precisely the same order of uncertainty the earlier phrase, 'excited delirium' represented in medical contexts. This is because police are frequently called to deal with individuals who are extremely agitated, or described variously as such in the mundane understanding of the term, who nevertheless are *not* exhibiting the particular 'constellation of behaviours' which presages a medical emergency. Using this category of general descriptive terminology to *also* represent a highly specific circumstance, it was felt, therefore runs the obvious risk of the unique medical emergency becoming lost in an undergrowth of ordinarily 'extremely agitated' persons.

Secondly, both national and Metropolitan Police training on the correct terminology to use have in fact already moved on since the date of this incident. Though the 'constellation of behaviours' has at various points in the developing knowledge about it's causes and effects been known (*inter alia*) as 'cocaine psychosis', and 'excited delirium', since 2010 the generally recognised phrase within UK police contexts has been 'Acute Behavioural Disorder' ('ABD'). This phrase was chosen to provide exactly the " 'precision without 'diagnosis' " you indicated would be a necessary element of any common terminology adopted. Inspector [redacted] provides the practitioner's context:

> "The Metropolitan Police Service Safer Restraint Review of 2005 recognised a growing concern that Excited Delirium (as the condition was known then) was too restrictive in scope and didn't necessarily address conditions with wider substance abuse and mental health triggers. Advice was sought from healthcare professionals from the US and UK - most notably Professor [redacted] and pathologist [redacted] who is a member of [redacted] Independent Advisory Panel.
>
> The generic term Acute Behaviour Disorder was selected as the most appropriate term and ABD was subsequently fast-tracked into the National Personal Safety Manual. The Faculty of Forensic and Legal Medicine also adopted the terminology of ABD, and have produced guidance on the management of this condition. The medical implications of the manual's techniques and guidance (including ABD) were reviewed by Professor [redacted] in 2010. Furthermore, additional improvements were most recently made to the ABD advice by Professor [redacted] in 2012, following Rule 43 advice in another case.
>
> The proposed new term in the current case [extreme agitation] was discussed at the National Safe Detention And Restraint (SDAR) Practitioners' meeting in Durham on the 1st October 2013. SDAR is the policing lead for Officer Safety Training nationally and represents the police services of England and Wales, in addition to partner agencies including the Home Office, College of Policing, the Independent Police Complaints Commission, the Health & Safety Executive, the National Offender Management Service and IMSAP, an independent medical advisory panel.
> As expected, the suggestion to rename Acute Behavioural Disorder (ABD) was unanimously rejected by the committee owing to the significant consultation, research and training investment during the past ten years, for police at national and local level, and for the aforementioned partner agencies, which has led to ABD being firmly embedded in national police training - both Officer Safety Training and Emergency Life Support. For these reasons, SDAR is confident that national police training remains at the forefront of ABD issues. Whilst the committee wholeheartedly agrees with the necessity of a joined-up approach throughout the emergency services, it respectfully requests that partners recognise the comprehensive antecedents of ABD, and consider the adoption of this established term rather than introduce a new one."

At present, therefore, the 'constellation of behaviours' now and for some years past described by the MPS as Acute Behavioural Disorder remains an active part of every officer's regular Officer Safety and Emergency Life Support Training.

The logic of this position, and use of the phrase 'Acute Behavioural Disorder' has also been adopted by the London Ambulance Service in the still ongoing joint agency work represented in the MPS/LAS 'Memorandum

of Understanding', the final draft of which we anticipate signing off imminently. In a practice note issued to all LAS staff by their Deputy Medical Director Fenella Wrigley on 30th August 2013, she stated:

> "All [LAS] staff must ensure they review all MPS CAD link calls, for the following terms:
>
> - Acute Behavioural Disturbance or the initials ABD
> - Excited Delirium
> - Cocaine Toxicity
> - And ANY call where the patient is described as BEING PHYSICALLY RESTRAINED."

Following identification of any such call, her note directs, LAS staff must refer the call to an on-call clinician who in turn must upgrade the response category of the call to their most urgent category 'RESP 1', and establish contact with responding medical staff to offer additional clinical support.

In a separate development, a cadre of paramedics with the means to sedate violent patients - a tactic which has shown some success in reducing the risk of fatality in American incidents of ABD - is currently being considered as a preferred choice of medical deployment, where available, to situations where ABD is suspected.

Meanwhile, in a response to coroner in another recent unrelated case, on the 6th of September 2013, senior London Ambulance Service managers [redacted] LAS Medical Director, and [redacted] LAS Director of Service Delivery underlined their commitment to the terminology preferred by police, and to working practices in support of an improved response where it is noted, by quoting from a further practice note they had sent to all staff. In a passage of the note dealing with responses to four high risk categories of patient, they inform their staff that:

> "…Acute Behavioural Disturbance / Excited Delirium...are conditions where a patient's behaviour is significantly altered and often displaying one or more of the following: Acutely bizarre or aggressive behaviour; impaired thinking; disorientation; paranoia or hallucinations. These patients may have a history of illicit drug use (such as cocaine) and/or psychiatric illness. Acute behavioural disturbance / excited delirium carries a significant mortality risk and during restraint these patients require careful monitoring to ensure their safety."

The note concludes by asking staff to reacquaint themselves with the joint MPS/LAS-produced training DVD Death in Police Custody & LAS Medical Advice, which contains content on Acute Behavioural Disorder.

These moves to enhance staff awareness of the condition and the terminology of ABD to describe it, undertaken by our partners in the LAS, have been mirrored in steps undertaken within our own call-handling centre, the Central Communications Command (CCC). On the 20th September 2013, Chief Inspector Horwood issued the following practice direction to all Central Communications Command Staff:

> With immediate effect any call, where the LAS have been, or are being requested where the patient is:
>
> A) Believed to be suffering from Acute Behavioural Disorder (commonly referred to as ABD) or described as having Excited Delirium

B) Suffering from Cocaine Toxicity
C) Currently being PHYSICALLY RESTRAINED

Then this must be placed in the free text of the [message] and sent to the LAS. The LAS will then classify this as a RESP 1 (8 minute intended response).

Operators are reminded that where there is a significant change to a current demand, then a new CAD message with a new [message to LAS] must be completed." This message was reinforced with a copy of the parallel LAS practice note to their own establishment, and further, specific training for CCC civilian staff (who do not receive the ABD message through officer safety and emergency life support training that police officers working at CCC routinely receive).**Conclusion**

Your recommendation regarding a common terminology has been accepted by all partners. It is respectfully submitted however that the adoption by the London Ambulance Service of the term 'Acute Behavioural Disorder' as the term of choice effectively negates the additional training changes recommended in points 1 and 2 of your report, as active training on ABD and responses to it remain an ongoing element in all regular refresher training sessions for police officers, and this, we are given to understand, is now being paralleled within the LAS via their own training and practice direction regimes.

The potential information gap for MPS civil staff working at Central Communications Command who do not receive this training routinely has been addressed by the issuing of direct practice notes, and supported by a programme of in-house training on awareness of the issues and correct procedures to adopt. Meanwhile, the development of a detailed and documented joint agency call-handling protocol with our partners at London Ambulance Service, contained within the new Memorandum of Understanding, gives both 'First Responder' agencies a common wellspring of guidance to draw upon, a robust channel of communication where ABD is suspected, and clarity regarding the expectations each agency can have of the other's response in these circumstances. It is now important that staff in emergency departments are also made aware of this condition and its management. The Medical Director, in his capacity as a senior emergency medicine practitioner, will therefore seek to encourage the adoption of the terminology in this domain, and to increase the supporting awareness by our partners in the NHS.

I hope therefore that you will agree with me that the above package of measures demonstrates that the Metropolitan Police Service is responding effectively to the concerns highlighted by the inquest into Mr Sweeney's death.

Yours sincerely

Allan Gibson
Commander
Director of Professional Standards