22 August 2014

BRITISH TRANSPORT POLICE

[redacted]
Yeomanry House
131 Castle Hill
Reading
Berkshire
RG1 7TA

Dear Mrs Bedford,

Inquest into the death of Stephen Peter Church –
Report to prevent future deaths

I have been asked by the Chief Constable in his absence, to respond to your letter dated 17th July in relation to the Regulation 28 Report highlighting concerns following the inquest into the death of Stephen Church. You will appreciate that this tragic incident occurred in 2011 and since that time the force has made great improvements in how it deals with vulnerable people. We have received much praise for our suicide prevention work and our partnership working in this field is pioneering in policing terms.

With regards to the specific circumstances of Mr Church's death I have instructed my officers to review the matters of concern. I note that the second concern (of three) does not relate to British Transport Police.

With regards to Concern 1: The chain of command within BTP was broken unacceptably leading to only one police officer responsible for detaining Mr Church.

[redacted] arrived at the Royal Berkshire Hospital about 11:45 with Mr Church. [redacted] was assigned to a pre-arranged operation later that day and needed to get to London to collect paraphernalia in relation to that operation. He wanted to leave the hospital so that he could undertake that task. About 12:10 [redacted] telephoned the Duty Officer, Temporary Inspector [redacted] and asked whether [redacted] could be released. [redacted] informed [redacted] that Mr Church was not under the

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influence of drink or drugs and was compliant. [redacted] refused the request and instructed that both officers should remain. This message was conveyed to [redacted]

About 12:30 [redacted] telephoned and subsequently sent a text message to his line manager at Reading, [redacted] was in fact off duty at the time but authorised [redacted] also by text message, to leave the hospital. [redacted] was not made aware of this development. As far as he was aware both [redacted] remained at the hospital with Mr Church.

At the inquest [redacted] stated that he was not aware at that time that [redacted] had instructed both officers to remain at the hospital. He added that had he been aware he would not have sanctioned [redacted] departure. [redacted] conceded in evidence that the text message did in fact include that information but at the time of agreeing to [redacted] departure, he had not read the entire text message, which included [redacted]

I recognise that this breakdown in the chain of command ultimately had implications for the care of Mr Church but I do not believe that this is a systematic failing in BTP processes. Rather, this was an isolated incidence of misconduct. My Professional Standards Department referred this incident to the Independent Police Complaints Commission in 2011 and we currently await the outcome of that investigation. I will ensure that any recommendations in relation to the actions of [redacted] and [redacted] are implemented and that any lessons learned are appropriately promulgated throughout the force.

With regards to Concern 3: There was a lack of joint working amongst the BTP, Royal Berkshire Hospital and psychiatric liaison service staff members to ensure that Stephen Church was safe and the high risk of him self –harming addressed promptly. There was a lack of appreciation amongst the psychiatric liaison service, Royal Berkshire Hospital staff and BTP as to the importance of contacting an approved mental health professional promptly to arrange a mental health assessment.

I note that that Jury was concerned at the lack of joint working in respect of Mr Church's detention and treatment. In particular:

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- No-one took responsibility for contacting the Approved Mental Health Professional (AMHP).
- Hospital staff were not aware that BTP officers were with Mr Church and believed them to be from Thames Valley Police.
- Only one of the BTP officers was aware that Mr Church had been assessed as high risk of self harm.
- Staff were not aware that one officer was left alone with Mr Church.

I acknowledge that regular and detailed communication with the other agencies involved in Mr Church's case could have led to his greater care whilst at the hospital. Further, that additional care staff may have been provided had they been aware that he was with only one officer. This issue of 'proactively maintaining dialogue' is covered in the 'Briefing Note – New Policy for London Section 136, (page 60) under the heading 'Triage Risk Assessment/Triage Psychiatric Assessment'. This element of that briefing note is now included in all relevant BTP training.

I note that the Jury narrative highlighted the following points;

An approved Mental Health Professional should have been called, the fact that one was not called contributed to Stephen Church's death for the following reasons;

- The protocol states that the AMHP should be called promptly
- Stephen Church was considered 'High Risk' by police and medical staff
- The Mental Health Act Codes of Practice clearly states that this is the next step to a Section 136 detainee
- The delay left his mental health un-assessed
- The role of the AMHP was to coordinate the agencies and to provide clear direction and this did not take place

The Inquest heard evidence that the single most important person to be informed about the detention of a person under section 136 is the AMHP. The AMHP has the ability and responsibility to coordinate all other agencies involved in the care of the detainee. As soon as the AMHP is informed all other actions and processes in respect of the care of the detainee can be expedited, thus reducing the amount of time police need to remain at the place of safety.

The inquest heard evidence relating to the Mental Health Act, 1983, Code of Practice especially in respect of paragraph 10.25 which states; (page 21)

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'Where an individual is removed to a place of safety by the police, the following recommendations apply:

- *Where the place of safety is a hospital,* ***the police should make immediate contact with both the hospital and the LSSA (or the people arranging AMHP services on its behalf)*** *{my emphasis} and this contact should take place prior to the person's arrival at the place of safety. This will allow arrangements to be made for the person to be interviewed and examined as soon as possible.'*

The 'Interagency Joint Working Protocol for the Management of Mental Health, Thames Valley Area' (The Protocol) also deals with the procedure for calling an AMHP. It states, (page 12)
'The arresting officer will contact (via Control Room) the AMHP or the Emergency Duty Team out of hours...'

It was acknowledged at the Inquest that British Transport Police was not a signatory to the joint interagency protocol, but officers giving evidence accepted that they would try to work to the aims where possible. I endorse this aspiration but must highlight the impracticalities of British Transport Police being able to achieve this in every case.

The recommendation that police should contact the AMHP in these circumstances will always be problematic for British Transport Police. We do not routinely have lists of available/on call AMHPs. This is information routinely known to health providers at the places of safety and is likely to be subject of regular change and update, sometimes at short notice. It would be impractical and problematic for a national police force such as the BTP to hold this information and keep it up to date. To attempt to do so could result in more confusion, risk and delay should officers require to contact an AMHP prior to the subjects' removal to a place of safety.

My view is supported by reference to a recent meeting of the Mental Health Partnership Board for London, which includes CEOs of the London Mental Health Trusts. At that meeting the question of whose role it was to call the AMHP following a S136 detention delivered a unanimous response; that it was the role of the health professionals as the police would not have access to up to date information. The Board has recently launched a new policy for S136 and S135 arrangements in

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London (which was used to inform the Mental Health Crisis Care Concordat to which BTP is one of the 22 national signatories). That policy does not recommend that Police call the AMHP. The duty on Police is to call the place of safety coordinator who is then responsible for making all necessary arrangements.

I am aware that the Mental Health Act Code of Practice is currently being reviewed and a draft has been circulated for consultation. British Transport Police will be asking for the recommendation for Police to call the AMHP prior to arrival at a place of safety to be removed, as it is impractical and more likely to lead to confusion and delay in provision of an early assessment for a patient in similar circumstances to Mr Church.

I can assure you that British Transport Police is committed to providing the best possible care to those vulnerable members of society who come to our notice. In terms of the demand we face, I can tell you that in 2013/14, 631 people were directly prevented from taking their own lives on the railway and removed from danger. Of these the majority were detained under S136 of the Mental Health Act 1983 and presented to a place of safety for assessment. In more general terms some 150 people per month are currently detained under S136 across BTP jurisdiction and I am unaware of any repetition of the issues you have raised.

Whilst it would be a vast undertaking to be aware of each and every local protocol from the 56 Statutory Mental Health Trusts and the 40 Mental Health Trust providers in England and Wales, we are nevertheless in the process of detailing all 'places of safety' on our Force Control Room Gazetteer to speed up the process of care for Section 136 detainees.

I have committed training resources to front-line officers in the following areas:

- Exercise Jubilee – a Hydra (immersive training) exercise in relation to vulnerable persons and those in Mental Health Crisis
- Suicide Prevention and Mental Health awareness – a one day classroom-based programme for all officers around policies and processes as outlined in the new manual of guidance

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- A two hour input to all Force control room staff on Suicide Prevention and Mental Health issues; the officer in charge of this training has been fully briefed on the findings from Mr Church's inquest and will incorporate the lessons learned into this presentation
- All new officers receive a two hour input from the same officer and again the lessons learned from Mr Church's inquest will be incorporated

In summary, the break down in the chain of command is being addressed as a conduct issue and I am confident that there is no systemic failing in this area. With regards to the other concern highlighted, the BTP Manual of Guidance now includes the following:

'*The original officers and those that may take over supervision of any detainee should ensure that the person is not left alone or unsupervised until the responsibility for the person is formally handed over to a medical professional for the process of assessment and interview*'.

In addition to this, the guidance now also makes clear that;

'Attending officers and the senior nurse at the place of safety must consult...and ensure that the relevant mental health doctor and AMHPs have been advised of the persons status'.

I feel confident therefore that the concerns highlighted at the Inquest have been properly addressed by British Transport Police.

Yours Sincerely

[redacted]

[redacted]

Temporary Deputy Chief Constable

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