METROPOLITAN POLICE

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Commander Christine Jones QPM
Commander
Territorial Policing

New Scotland Yard
Room 1034
10 Broadway
London
SW1H 0BG
[redacted]

Mrs Louise Hunt
Senior Coroner
Birmingham and Solihull Districts
50 Newton Street
Birmingham
B4 6NE

Monday 20th July 2015

Dear Mrs Hunt

Re: Kingsley BURELL (deceased)

Thank you for your letter dated 20 May 2015, and my apologies for the delay in responding to your Regulation 28 Report to Prevent Future Deaths.

My role is that of the lead for policing and mental health for all forces across England and Wales, consequent of my appointment to lead this work on behalf of the National Police Chief's Council (formerly the Association of Chief Police Officers, or ACPO). This is in addition to my roles and responsibilities as a Commander in the Metropolitan Police, where I also have the Force lead for policing and mental health and for Domestic Abuse.

I have read and absorbed the details of this very sad case and am grateful for the opportunity to respond in my capacity as national lead for policing and mental health to the three points you make as Matters of Concern on page 2.

Point 1

Medical evidence at the inquest confirmed that Mr Burrell was suffering from acute behavioral disturbance. As a result he continued to struggle against restraint. Patients with this condition are at risk of death through prolonged restraint and struggle against restraint. Most training in relation to restraint deaths focuses on positional asphyxia. Position in this case was not a major consideration. It was clear from the inquest that there was alack of understanding of how to treat someone with an acute behavioural disturbance. Minimizing the period of key restraint is key. West Midlands Police have undertaken considerable work and training of staff concerning this condition.

My concern is that this has not been rolled out nationally and therefore many other forces will not understand the implication of this condition and how best to treat it. I suggest contact is made with

Chief Inspector [redacted] at WMP for full information on the changes made in the West Midlands Area.

Whilst it is helpful that West Midlands have cited their activity in respect of positional asphyxia and other risk factors associated with restraint, it is not accurate to suggest that the force has implemented safe practice independent of all forces nationally. Indeed, Acute Behavioural Disorder (ABD) and Excited Delirium were specifically highlighted in a 2010 Guidance Document issued by the former National Policing Improvement Agency (now renamed The College of Policing). The NPIA then ran a series of national events throughout 2010/2011 where every single force in the country was briefed and provided with training materials to address this specific set of risks.

In 2013 the national poling lead for Officer Safety Training requested the College of Policing to review national compliance in ABD training. Although the findings were varied, overall compliance was to standard in relation to the prominence these risks were given within training packages. Uniformity in terminology and the ability quickly to embed learning outcomes are issues the College continue to progress.

In this tragic case, police officers were called in to a mental health environment to effect restraint upon a patient. Aside from the moral and ethical issues pertaining to police officers entering into a care environment to effect this type of force, I am examining the whole issue of the role of police in these types of circumstances and indeed whether this is simply an issue of a lack of capability, capacity and training for health practitioners rather than that it is and should be presumed a police matter. I hope you will be reassured to know that to this end I have been working with the College of Policing and have instigated an expert reference group, chaired by Lord Alex Carlile, to ascertain not only the legal platform upon which activities should sit, but further who should effect them and what is defined as safe practice across all public service disciplines. This work will also inform evidence based advice on types of restraint, who should direct and own them, and how and by whom clinical health is actively monitored and prioritised. I should be delighted to share this with you as work progresses.

It is my view, and that of policing nationally, that there is NO safe period for restraint, and our officers are taught accordingly that restraint of any type is a risk which must be mitigated through close supervision of the individual under restraint, including vital sign observation, positional relief and an understanding of the impact upon breathing ability when handcuffs are used in certain positions. When mental ill health is apparent in restraint cases, all officers are instructed to treat this as a clinical emergency and to immediately call for emergency ambulance support. The ability, however, of local ambulance services to meet demand is another issue, and actual provision varies significantly.

Point 2

The West Midlands area now have a crisis team that works with people who are in a mental health crisis. This involves a mental health worker and ambulance crew working together with the Police to try to help patients with acute mental health disorders. My concern is that this is not a national system. Chief Inspector [redacted] at West Midlands Police can provide full details of the scheme.

The activity referred to above is known nationally as 'Street Triage', which at this stage does not conform to a prescribed template and therefore the nomenclature does not necessarily describe the local arrangements in place. Broadly, it is often joint service patrols between police and mental health professionals and is intended to address crisis or pre crisis cases which would otherwise result in the exercise of restrictive powers under the Mental Health Act 1983 (usually Section 135 or 136). There

is much work yet to be done to ascertain the value and capability of street triage services where they exist, and there is much evidence thus far that they are by no means sustainable in their myriad of current forms. Indeed, perhaps their very presence describes the paucity of capability in accessing appropriate mental health service without the involvement of police. Their formation, however, is a direct result of the work I conducted with Geraldine Strathdee of NHS England when we first explored the pertinence of patient history as a component part in decision making when considering the exercise of powers under the Mental Health Act. This came as a precursor to the Crisis Care Concordat.

All areas of the country are now committed to the Crisis Care Concordat, the formation of which I was heavily involved in, and progress against local action plans is perhaps the best indicator of progress in providing accessible, 24/7 crisis and pre crisis care.

It is of note, however, that in the case of Mr BURRELL 'street Triage' services would absolutely not have been deployed as he was already within the confines of a Mental Health environment.

Point 3

> *This case has resulted in a multi-agency review of how patients are managed between the services when crisis occurs. A new conveying of patients policy has been devised. Critically police now only attend a mental health ward if there was a patient who is threatening staff or there is disorder on the ward. My concern that this is not reflected nationally. Chief Inspector* [redacted] *at West Midlands Police can provide full details of the policy.*

Chief Inspector Russell has cited my own national instruction to Chief Officers in respect of the monitoring and reviewing of all service requests to mental health environments, and for escalation and supervisory involvement on every occasion where police are requested to, or effect, restraint in a health environment whatever the circumstances.

This is to assist my work with the expert reference group and to ensure a clear picture of demand and need is presented. The multi agency membership includes NHS England, the Royal College of Psychiatrists, the Royal College of Nursing, NHS Protect, the Department of Health, the Home Office, the Care Quality Commission, the IPCC, NICE, the College of Policing and others, and will report initial findings regarding the role of police in mental health settings by the end of this calendar year.

I do hope that the above answers your concerns, but please do come back to me if there is anything further with which I can assist, of if you require clarity in respect of the commentary I have provided.

Yours sincerely

[redacted]

Commander, Metropolitan Police Service
National Police Chiefs Council Mental Health and Policing Business Lead