METROPOLITAN POLICE | TOTAL POLICING

DIRECTORATE OF PROFESSIONALISM

Ms. Selena Lynch,
Senior Coroner,
South London Coroner's Court,
2nd Floor, Davis House,
Robert Street,
Croydon, CRO 1QQ.

[redacted]

Tel.: 020 8313 1883

[redacted]
Deputy Assistant Commissioner

7th Floor
New Scotland Yard
London
SW1A 2JL

Email: [redacted]
Tel: 020 7230 0008

Our ref: [redacted]

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Dear Ms. Lynch,

I write on behalf of the Metropolitan Police Service (MPS) in response to your Regulation 28 Report to prevent future deaths dated 28th June 2017. This followed the conclusion of the inquest on 9th May 2017 into the circumstances of the death of Olaseni Lewis on 3rd September 2010, at Mayday Hospital, Croydon.

In your report you raised six matters of concern:

1. The court was told that officers are not expected to read Standard Operating Procedures and the Officer safety manual, and there is little 'required reading' or ready reference for police officers regarding restraint techniques and dangers.

2. Officers had been taught about Acute Behavioural Disturbance (ABD) but most did not recognise that Mr Lewis was suffering from ABD. The training on ABD appeared unnecessarily complicated and was not fully understood by officers. They incorrectly assumed that it was a formal diagnosis of some sort and that healthcare professionals would be able to recognise and treat the condition. An expert psychiatrist indicated that the description might be helpful to the police community, particularly when the condition is caused by drugs, but it causes difficulty when police and mental health services work together and where the underlying cause is related to mental illness. The question that arose was whether it is necessary to attach a label to it at all. It might be more easily understood if officers are taught that people who resist restraint and appear to be suffering from mental illness may not respond as expected, and are therefore more vulnerable to die suddenly during restraint.

3. Police were taught that prolonged restraint was dangerous, but had no idea what 'prolonged' meant, and were left to use their own judgement. They also seemed to think that prolonged restraint referred to time spent in a prone position and that as long as the detainee was held on his/ her side the danger was ameliorated or removed. The pathological and psychiatric expert evidence clearly indicated that restraint in any position can lead to sudden death in patients who are highly agitated. The jury found that the police training was inadequate in its definition of 'prolonged restraint' for people exhibiting signs of ABD.

4. Police officers were given no advice or training what they could or should do if control was not achieved within a given period of time.

5. There was no training or understanding about the respective roles and responsibilities of healthcare and police staff. There was (and still is) no Memorandum of understanding.

6. The jury concluded that medical staff requested police assistance due to a lack of trained and physically able medical staff. The Trust had a policy for closing wards or placing them in special measures when training levels fell below a given level, but this was followed and there was a lack of clarity around who was assessing compliance.

Matters of Concern 1- 5 relate to police actions and we have responded to these below. The sixth matter of concern is directed at the South London and Maudsley NHS Foundation Trust.

In drafting a response we have consulted with subject area experts, principally Inspector [redacted] Mental Health Team; Inspector [redacted] Specialist Command and Operations lead for Officer Safety Training (OST); and [redacted] Strategic Manager, Strategic Safety and Health.

Dates, relevant parties and communications have where possible been confirmed by reference to emails, meeting minutes, published policies, intranet communications or other documents. The following is based on a review of such documents by [redacted] of the MPS Directorate of Professional Standards (DPS), and the review in turn of this response in draft by the above parties.

Response to Matters of Concern:

1. Officers have always been encouraged to read Standing Operational Procedures (SOPs) to help ensure their understanding and compliance with policy and best practice. Officers also have a responsibility to use all the information, training and resources provided to them to keep their knowledge up to date under the College of Policing's Code of Ethics (6:1 Duties and responsibilities, (College of Policing, 2014)). This sets out and defines the principles and standards of behaviour for the policing profession of England and Wales.

   At the time of Mr. Lewis' death in 2010 and at all times subsequently, all MPS SOPs and guidelines on mental health and officer safety have been available to officers on the MPS Intranet. A number of years ago it became accepted that the number and format of SOPs was overly burdensome on officers' time and it was not realistic to expect them to be familiar with them. To make the guidance easier to access the MPS has reformatted its SOPs into much shorter, and more user-friendly "Toolkits". The "Toolkits" have been designed to make information easier to locate and comprehend. They contain e- links to related information to provide additional depth and context where required. This change reflects previous learning. The Policing Mental Health SOP has been replaced with a Mental Health Toolkit, which went live in July this year.

   In addition, the Officer Safety Training Programme (OST), which is pass/fail and mandatory for all officers below the rank of superintendent, reinforces each of the significant areas of information during the instructor-led modules. For example, the complex issues surrounding the condition that has come to be known as Acute Behavioural Disorder (ABD) forms a golden thread through regularly taught, refreshed and assessed modules within restraint training. In this way, officers become aware of the policy and guidance on the issue and importantly their application in the operational setting.

The Officer Safety Manual, which has now been replaced by the national Personal Safety Manual (owned by the College of Policing), has always been primarily a trainer resource, albeit available to all MPS officers on the MPS intranet. The PSM is also available on the College of Policing training website, called POLKA.

The content and format of SOPs/toolkits/guidance on officer safety and mental health policing is continually reviewed to reflect learning and best practice.

2. It is widely recognised that the status of ABD remains a point of conjecture for many healthcare professionals. The police service in England recognised this rare but increasing phenomenon in the mid-90s and adopted the American terminology of Excited Delirium in mandatory training. The Senior Coroner heard evidence that that terminology was largely connected to the use of drugs, whereas behaviour manifesting in the same way and raising the same risk of sudden death during or following restraint became known to arise also from the misuse of drink, and/or related to certain health conditions, both physical and mental. Leading pathologists and other healthcare professionals advised the police service to adopt the wider umbrella term of ABD. That term is accepted by the Royal College of Emergency Medicine and its use by police in London mirrors terminology used by the London Ambulance Service (LAS) in their training. This shared terminology has assisted in communication and understanding between the police officers and LAS when dealing with individuals displaying such symptoms. This supports the individual receiving urgent medical care.

   Following previous Coronial recommendations the training on ABD was expanded to include recognising the signs of ABD. Officers have always been instructed to treat ABD, or signs of ABD, as a medical emergency.

   The Independent Medical Science Advisory Panel (IMSAP) is an ad hoc panel of leading independent healthcare professionals who advise the National Policing Lead for Personal Safety Training on medical matters relating to physical restraint and self-defence techniques and equipment. The MPS believes that this on-going partnership helps to ensure that its officers receive the best informed training on what remains a complex condition that can present in very challenging and often violent situations. The benefits of changing this approach, which is firmly embedded in national and MPS training, appear to be unclear and could undo much good work already achieved by the police service with medical partners.

   The potential confusion this term may cause when working with other mental health service providers highlighted in your report is however acknowledged. This barrier can be reduced through improved working relations with the police and health care professionals. Work in this area includes the production of the 'Safer Restraint' DVD by the MPS in partnership with South London and Maudsley NHS Trust (SLaM) and the ongoing work of the MPS Mental Health Team in support of the national Memorandum of Understanding (MOU) announced by the College of Policing in January 2017 (College of Policing, 2017). The MOU was provided to you as an appendix to [redacted] statement dated 26/01/2017. In addition there is an initiative being led by the National Policing Lead for Custody called "60 seconds to save a life", which is looking at introducing a verbal checklist, which will assist officers' decision-making and any handover to medical colleagues.

3. The introduction of time limits for prolonged restraint has been subject to much discussion in the police service. Advice from the Independent Medical Science Advisory Panel (IMSAP) was that there is no clinical basis for this due to the *'many and various physiological factors that would preclude a firm medical basis for such an approach'* (Independent Medical Science Advisory Panel, 2014). The advice further cautioned that the introduction of a time limit could give rise to a misconception that restraint within this time period was safe. Doubts were also raised over the practicalities of accurate time keeping such events.

   Furthermore IMSAP considered the safeguards incorporated into current police training represented effective and appropriate control measures. These include monitoring the persons' vital signs and treating all suspected incidents of ABD as medical emergencies. Police training is designed to help officers make good decisions that protect the safety of the individual, the general public and officers. A copy of this report is attached as Appendix 1 for your reference.

4. As outlined above at 3, the advice received from IMSAP is that the attachment of any specified time value to the term "prolonged" would be without a clinical basis. Suggestions during the inquest in relation to the option of leaving Mr. Lewis in mechanical restraints only (i.e. handcuffs and leg restraint) were not supported by the expert evidence, as it would not have removed the basis for resistance/struggling and therefore would not have reduced the risk to life. Police training in respect of all suspected incidents of ABD is clear, consistent and unambiguous. Officers should treat all suspected incidents of ABD as a medical emergency. The emphasis is then on obtaining appropriate and timely medical intervention, whether from LAS or other health partners.

5. The service level agreement (SLA) that had been in place since 6 September 2000 between SLaM/BRH and the MPS had fallen out of use by 2010 (C170, Holmes ref D20, pages 7563 – 7576). Although SLAs were agreed between SLaM and various MPS policing boroughs in 2004 - 6, one was not in place with Bromley. Following Mr. Lewis' death, a new Joint Protocol was agreed between SLaM and relevant MPS policing boroughs (including Bromley), which came into effect in September 2012 (C280, Holmes ref D50, pages 8093 – 8134).

   A national MOU was announced by the College of Policing in January 2017 (College of Policing, 2017). This sets a clear national position about when the police can be asked to attend mental health settings, for what reasons and what can be expected when they do attend. Under the terms of the MOU, police should not ordinarily be called to assist healthcare staff restrain a patient who is presenting management problems within health settings. Where the police are asked to support health care staff this should be in line with local protocols. The MPS Mental Health Team are actively engaged in the development of these on behalf of the MPS (see pages 9 – 10 of the statement of [redacted] dated 26/01/2017).

   The national MOU aligns with the College of Policing's Approved Professional Practice guidelines concerning mental health, (College of Policing, 2016), and Department of Health's Code of Practice: Mental Health Act 1983 (Department of Health and Welsh Office, 1999). It includes provisions for ensuring medical oversight during restraint. A copy of the Police Attendance Protocol included within this MOU is attached as an appendix 2 to this document for reference.

This development should significantly improve understanding and working relations between the police and health care professionals and is consistent with NICE guidelines (NICE, 2015).

In conclusion

The MPS response to incidents involving people with mental illness, including emergency mental health situations, has evolved significantly since the death of Mr Lewis. This has been achieved through continual training and joint working with partner agencies and organisations resulting in improved communication and understanding between agencies. In conjunction with the national MOU these changes represent significant, positive developments that will improve patient welfare and staff safety.

Yours sincerely,

[redacted]

Deputy Assistant Commissioner