METROPOLITAN POLICE

DIRECTORATE OF PROFESSIONALISM

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Your ref: 6562
Our ref: IX/69/17
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Dear Ms Persaud,

I am the Deputy Assistant Commissioner for Professionalism in the Metropolitan Police Service (MPS). I write in response to your Regulation 28 Report to the Commissioner dated 27th June 2019, following the conclusion of the Inquest into the death of Mr Edir Frederico Araujo Da Costa.

In drafting this response we have consulted with the relevant subject matter experts from the MPS, principally: Inspector [redacted] Officer Safety Unit, Acting Chief Inspector [redacted] Met Control and Command (MetCC), [redacted] Senior Advisor First Aid, Policy & Assurance, Superintendent [redacted] Chair of Officer Safety Board and [redacted] Medical Director.

Responses to Matters of Concern:

(1) The evidence at the Inquest revealed that not all police officers are up to date with mandatory Emergency Life Support training. In addition, the current system in place makes it difficult for supervisors to check whether members of their team have received mandatory training. I request that the working group, driven by Met training, review the attendance of officers at mandatory ELS training and review the systems in place for supervisors to monitor attendance. I request that in doing so they consider the concerns raised by Inspector BC in his evidence at the Inquest.

I lead a strategic group to address this challenge and I have been supported by Commander [redacted]r from 'Front Line Policing'. Together we have significantly reduced the number of officers who are in need of training. In addition, new issue personal protective equipment is not being given to officers until they are suitably trained and in-date. Corporate communications have been published and the matter discussed personally with the Commissioner in her regular MPS-wide on-line questions and answer sessions. On 12th July 2019 a news item was published on the MPS intranet site confirming this instruction to all officers.

Recognising that the current electronic training system 'PSOP' has some limitations on the data being provided to supervisors, a request for a change with our external partner is being progressed to allow a monthly compliance package to be produced and circulated to senior managers. In the interim, the MPS is re-introducing a paper "Form 250C" training card to be carried by all officers which will be stamped with the date of their last attendance at an approved Officer Safety Training/Emergency Life Support training session. This will make the information more accessible for officers and supervisors to check compliance. As a shorter term measure I have also issued local data packs to enable police commanders to readily understand which of their officers are in need of up-to-date training. Ultimately it is a matter for supervisors to know and account for their own officers and this expectation has been made clear.

In the longer term, the MPS is actively exploring opportunities for OST and ELS training to be built into team rosters making it a rostered tour of duty (as opposed to the self-service system currently in place). This work is expected to deliver improvements from April 2020.

(2) The evidence at the Inquest did not provide assurance that a safety officer had taken control of the restraint or that one officer was taking the lead in communicating with Mr Da Costa and/or monitoring his condition. In addition, the officers who gave evidence considered that the role of the safety officer mainly applied to restraint in a controlled custody setting. The MPS are requested to review the training provided to staff in relation to the role of the safety officer in a street setting and to consider whether a reminder of the importance of the safety officer role, in the street setting, should be issued to staff (by way of bulletin or otherwise).

The current training for the role of the safety officer covers environments to include custody and street settings. The practice of instructing officers to take the lead when they are controlling the head of a subject works well. The safety officer has a better communication and monitoring ability with the subject of the restraint and all other officers have the training to "speak up, speak out". This method ensures everyone present is responsible for the subject's safety. We will however include this reminder in the OST refresher training package from 1st October 2019. This new package will incorporate a presentation delivered by MPS trainers reminding officers of the importance of identifying themselves as the safety officer throughout the incident. In addition, they must provide evidence as to what action they took throughout the incident referencing when they were the safety officer.

(3) The Inquest heard that it is well documented that members of the public may swallow plastic bags to evade arrest or conceal evidence. Placing plastic bags in the mouth raises a very high risk of choking. Police officers should be aware of these risks. The MPS are requested to review the training provided to police officers to ensure they are fully informed about the specific risks around the use of plastic bags and the associated risk of choking.

Future restraint lessons will reference the revised Module 12 of the National Personal Safety Manual (NPSM) which was presented by Inspector Collett during the Inquest as the final draft. The revised Module 12 states the following:

> "If there is suspicion of concealment of drugs or articles within the mouth, officers should encourage subjects to empty their mouths voluntarily without the need for force. If they refuse, officers may consider using reasonable force to encourage them to expel the foreign object(s) from their mouth. However, the retrieval of evidence is always secondary to the person's welfare.
>
> Incidents of choking have occurred due to objects falling into the airway owing to the position of the subject's body. This can be avoided if the subject's head and airway are

tilted forwards. For this reason, the application of force to help expel suspected articles from the mouth should only take place when the subject's head is tilted forwards and not in the supine (face up position). At all times officers must consider and monitor the subject's airway and breathing and follow the basic life support training, as required."

Following the deaths of Mr Da Costa and Mr Rashan Charles in 2017, the MPS suspended the use of mouth searches by force on 3 October 2017. This was initiated by Deputy Assistant Commissioner Matt Twist who commissioned a review into the technique. This then led to revision of Module 12 of the National Personal Safety Manual. It now refers to the 'management of suspected articles in the mouth'. The completed Module 12 was made available to all chief constables by 14th June 2019. The MPS led this work and had full oversight on the content of the final review.

As a result of the Inquest and this Regulation 28 Prevention of Future Deaths' report, from 1st October 2019 the MPS will highlight this in their training. In addition, further training has been scheduled from April 2020 to include the officer safety restraint lesson on 'prone resistance'. This will reflect the findings of the Inquest and guidance around Module 12 considerations. This will remind officers not to restrain a person suspected of having an object(s) in their mouth if resources at that time cannot deal with the restraint safely; a reminder to treat as a medical emergency will be reinforced.

(4) The evidence given at the Inquest hearing revealed a concern that the use of CS spray, when a person has something in their mouth, could increase the risk of a complete airway obstruction. The MPS is requested to review the guidance and procedures in place for officers, in relation to the use of CS spray where a person is believed to be holding items in their mouth.

The MPS has considered the expert testimony of [redacted] provided at the Inquest during which he said that "...it is theoretically possible that CS spray in those circumstances could perhaps make airway obstruction worse" (page 201 of transcript dated 29th May 2019). To emphasise that he was making a theoretical point only, he further added "I am not an expert on CS spray, it is something I have looked up .... There is to my knowledge no firm evidence for what I am saying, it is a rational opinion (pages 200-201 of the court transcript dated 29th May 2019).

The MPS is seeking medical evidence on this subject [redacted] has sought authority to commission a survey of police officers identifying how they react after exposure to CS spray. This will provide initial evidence to progress further research into this matter. It is anticipated once authority is granted this work will begin immediately.

The OST refresher training programme will include lessons to reference consideration of tactics when faced with a person intent on trying to swallow drugs, assessing all tactical options and justification, accounting and recording of which options were considered as well as used. This is in line with wider existing National Decision Model training. Module 4 of the NPSM (entitled Medical Implications) is currently under review to reflect the irritant position and will state there is no current conclusive study confirming irritant spray as a causative factor, however care should be taken. Consultation with stakeholders will take place prior to publication.

Inspector Bruce Collett's provided the following evidence at the Inquest, "The use of irritants is a lower level of force than the application of physical force or restraint and the avoidance of use of irritants may lead officers on to other tactics, which might include physical restraint. This could present a higher threat level to the officers and place subjects at higher risk of choking during this physical interaction (page 10 of the court transcript dated 5th June 2019).

(5) The evidence at the Inquest revealed that agonal breaths were likely to have been missed. The officer provided the description of the breaths as looking like "yawning." The independent expert stated that these were, beyond reasonable doubt, agonal breaths. The MPS is requested to review the training to officers around the recognition of agonal breaths. Within the training, the MPS may wish to incorporate the helpful descriptions provided by the officer in this case.

On 4th July 2019 Sue Warner tasked the MPS Clinical Panel and the National Clinical Panel to identify appropriate video clips which demonstrate agonal breathing which can be shown during ELS (Emergency Life Support) training. The same request was made to the National Police Chiefs Council's First Aid Forum on 18th July 2019. From 1st October 2019 these video clips will be introduced into the new Emergency Life Support programme to support the existing training.

(6) Evidence was heard at the Inquest that errors were made in communicating information to the LAS. This was in part due to the noise levels within the communications command centre for the London Borough of Newham. The MPS is requested to carry out an immediate review into the noise levels within the communications command centre and to take steps to reduce noise levels as far as possible. The longer term plans that the MPS have put in place to review their communications command centre is very much welcomed but it is considered that interim, proportionate measures should be explored.

A physical review at Bow MetCC took place on 11th July 2019 and was followed up on 30th July 2019 by Mike Chinchen from the Strategic Health and Safety Department. Sound testing revealed that there were no current issues. All entry doors into Despatch and First Contact floors were checked for opening and closure noise. There was negligible noise generated upon opening or closing any of the doors. However an inspection has now been carried out by a contracted maintenance provider to check hinges. They have been found to be in working order and unable to be adjusted further to reduce noise. A separate order was raised on 3rd August 2019 to replace all doors for silent or near silent opening or closure and are expected to be delivered within three to four weeks.

As a result of the review, it was identified that printers on the despatch floor were contributing to the noise levels and as such have been moved to an area furthest away from the Operators. On 2nd August 2019 sound reducing screening was erected around printers to further mitigate noise distraction to all staff on the operational floor.

Communication was circulated on 12th August 2019 to all team duty officers to remind Despatch Controllers and First Contact Supervisors to manage non-operational discussions on the operational floors. Although it is almost impossible to create a completely sterile noise working environment, this intervention by team Duty Officers should help mitigate further noise distraction.

On 19th August 2019 further communication was circulated to all team Duty Officers offering double ear headsets to staff within the First Contact and Despatch environment, which assists in reducing outside noise. The issuing of these headsets will be phased with priority in the first instance being given to those supported by an Occupational Health referral and line management.

A recommendation will be made to implement all the above actions at all MetCC sites and the work will be overseen by MetCC Buildings Manager, Marissa Howard.

(7) The controller who was communicating with the LAS received information that Mr. Da Costa had stopped breathing. She did not use the correct procedure to update the LAS in relation to this life threatening deterioration. The MPS are requested to review the operation of the procedure for updating CADs and to take any necessary action to ensure that staff are fully aware of the correct procedure to be adopted.

There is an existing policy in place between the MPS and LAS regarding this matter. It is clear from this policy that on any occasion when the condition of the individual being dealt with by the police either directly or indirectly undertakes a significant change, then a separate CAD should be created and passed to the LAS with the update. LAS will re-triage the nature of the injury and re-assess the priority and their subsequent response. The Memorandum of Understanding between the MPS and LAS dated November 2018, states on page 8;

> "Any updates to the original message can be completed via an EXP/LAS/INFO command. However any significant deterioration of a patient's condition will require a new CAD message with EXP/LAS submission. This message must include the reference to the original CAD and clearly state that the new CAD is for a significant deterioration of a patient's condition."

The new CAD will have its own time of origin but will be linked to the original CAD.

To this effect, on 2nd August 2019 a reminder was circulated to all staff via a weekly MetCC Operational Update bulletin. This policy is emphasised in MetCC initial call handler training and included in the next Personal Development Days (training days) in October 2019. It must be stated however that although on this occasion the policy was not correctly complied with, it is the experience of Team Duty Officers and Met Grip Chief Inspectors that no previous issues have been identified and that the policy has been adhered to.

In Conclusion

Much of the work needed to review our compliance for OST and ELS training was underway or complete prior to the Inquest. Module 12 of the National Personal Safety Manual was fully reviewed by the MPS Officer Safety Unit prior to the Inquest with key adaptations to enhance the welfare of subjects being detained. The Strategic Group led by Commander Dave Musker and the monthly strategic meetings held by myself, will continue to drive forward improvements in compliance. The learning from the Inquest will feature in the new programme of OST/ELS training from 1st October 2019. OST and ELS training is continuously adapting and the strategic and working groups may direct further changes as practices evolve.

I trust this provides the reassurance that we have considered the matters of concern you have raïsed and that we have made improvements and continuously seek to do so.

Please do hesitate to contact me should require further information or clarification.

Yours sincerely

Matthew Horne
Deputy Assistant Commissioner