6 Missed Chances
Additional Briefing for ICVs
October 2019

Background

This briefing is intended to be given as a handout to ICVs following the delivery of the 6 missed chances bitesize training. The training gives an overview of the IPCC, (now named IOPC), report regarding the death of James Herbert in custody in 2010. ICVA has produced this training package in response to a request arising at the ICVA National Conference 2019. The bitesize training gives an overview of the findings of the report, and this briefing contains additional reading and notes on this very extensive report. The briefing also repeats the recommendations from the report and provides an update on changes to the law since James' death.

The focus of the Six Missed Chances Report is on what could have happened that may have changed the outcome for James, and what missed opportunities there were for the police to have changed the outcome of James' arrest and detention.

At the time of his death in the custody of Avon and Somerset Constabulary (ASC) on 10 June 2010, James Herbert was 25 years old. James had been suffering from mental illness and had recently been using legal highs. He had been in contact with the police several times during that day, the first being at around 7.30 am.

The final contact was early in the evening, when police received a call about James placing himself in danger by running into the path of traffic on Bath Road in Wells, Somerset. It was a hot summers day and James was wearing a heavy overcoat. After officers attended the incident, James was restrained and transported to Yeovil police station in a caged vehicle. On arrival, James was carried into the cells, and within minutes an ambulance was called as James had stopped breathing. He was pronounced dead shortly after 9pm.

Chance 1

A missed chance to avert a crisis.

The report makes the point that five different officers directly interacted with James three separate times before 1.00PM on the day that he died and a sixth issued radio messages concerning him. The police took calls from four different members of the public, again before 1.00PM. Officers visited James and his mother at home. At 6.23pm there was another call, this time from James's mother. Many of the police officers had previous knowledge of James.

Taken individually, each interaction with James raised concerns about his mental wellbeing; taken as a whole, they paint a picture of a man who was in significant distress, possibly delusional and deteriorating. There are several references in radio transmissions to officers being concerned about his mental health, but no specific action taken.

What should have happened?

Information should be recorded promptly – the reports made regarding James did not always feature his name and so could be linked as a series of events, nor did they consistently record that James had known mental health concerns and that James had taken legal highs.

Information should be consolidated and shared - Even if individual officers responding to one-off incidents cannot see the pattern, someone at the centre can and should. Furthermore, if information is consolidated, officers are aware of what their colleagues may have said or done.

Mental Health Services should be contacted – several officers were concerned regarding James' wellbeing, but no one contacted mental health services at this time.

Chance 2

A missed chance to de-escalate

James' father noted that James was usually a polite and co-operative individual. The IPCC report notes that whilst James was reported as being non-compliant, he was also non-threatening at the point he was taken to the ground and physically restrained.

The PCSO radioed for immediate assistance as James was in the road. The report notes that the restraint happened 'very quickly' and took place within 4 minutes of the PC's arrival, meaning only very minimal endeavours could have been made to de-escalate.

What should have happened?

Officers should attempt de-escalating communication techniques first - guidance at the time was clear that restraint should only be used when someone is being violent and aggressive, and although James was non-compliant, he was neither of these things until restrained. The timing of the restraint would call into question the amount of verbal de-escalation attempted.

Officers should avoid using restraint on people with mental health problems if at all possible - numerous investigations into deaths in police custody, including James', have identified that when someone is experiencing a mental health crisis, restraint is often experienced as extremely intimidating and can lead to panic. This may cause the person to struggle against it, which is counter-productive when the aim must be to help the individual to calm down.

Chance 3

Once James was restrained: a missed chance to release the pressure

Based on the accounts of officers and members of the public, there is no evidence that at any point did officers appear to consider the possibility of reducing the restraint, to see if that would help calm James down. There is no evidence that officers, at any point, advised James that if he stopped resisting, he might be released and or that the pressure being applied would or could be reduced. They told him to calm down but did not offer the 'incentive' of reduced restraint.

Shortly after James was placed in the van, his mother Mrs Montgomery arrived. She attempted to speak to James and also spoke to the officers. She mentioned to them that he had been taking legal highs, and requested he be given medical assistance. She was assured that he would receive medical assistance once he had calmed down. The additional information she gave was noted down, but not passed on or acted upon.

What should have happened?
Officers should consider reducing restraint if it's counterproductive - In 2010, best practice guidance emphasised that – for anyone – restraint should be used for the shortest possible time, and with the minimum possible restraint. That guidance remains. Where an individual is struggling against restraint, officers should consider whether it is the right option, or whether they could reduce the level of restraint available. It is of course a difficult balance, with decisions being made in the heat of the moment. However, if – as in James' case – the use of restraint correlates directly with an escalation of violence, a logical and appropriate response would be to consider whether restraint was aggravating the situation rather than helping it.

Chance 4

The decision to take James to a police station: a missed chance to get immediate mental health support.
The first PC told the inquest that he detained James under section 136. This meant that James had to be taken to either Yeovil or Bath because they were the nearest police stations that could be used as a "place of safety" under the Mental Health Act.

Either way, in the circumstances, the use of section 136 may well have been appropriate. James inarguably was in immediate need of care and medical attention. However, once section 136 is applied, it should trigger a process to get relevant support and treatment for the patient being detained. This process was not followed correctly for James following his detention: rather than being treated as a patient would be, he was treated as if he was a violent criminal suspect.

What should have happened?
The individual should be told clearly that they are being detained under section 136 and, if possible, be given some explanation of what this means and the reasons for it.

The person should be taken to a non-police place of safety. Even in police custody, the individual must be treated as a patient. A mental health assessment should be requested. Ambulances should be used to take someone to a place of safety

Chance 5

During the journey: a missed chance to check on James' wellbeing
According to the accounts of the officers in the van that transported James from Wells to Yeovil, James continued to struggle during the journey. They could hear him shouting and banging. At one point, he went quiet, so they stopped the van. This was about nine or ten miles into the journey.

The officers were both in the front of the van. According to their accounts, they got out and called to James as he had become quiet during the journey, but he did not respond. When they opened the doors, he began to shout and bang again, so they closed the doors and resumed their journey.

During the journey, the officer who wasn't driving made a radio call requesting the presence of other officers when they arrived at Yeovil police station to help take James out of the van. He advised that James had been banging his head against the walls of the van and as an indication of the level of force the officers felt may be necessary, he included in his message the request that one be Taser-trained.

What should have happened?
Officers should be able to observe a detainee throughout a journey - ACPO guidance on transporting people in custody is clear. "Detainees should not be left alone and unsupervised in vehicles; an officer must be able to observe and monitor the person and react to any situation which may arise."

If someone is violent, officers should stop the journey - The same ACPO guidance also states "Where a detainee becomes violent staff should, where practicable, stop the vehicle, regain control and only then resume the journey; it may be necessary to call for assistance and to change to a more suitable vehicle."

Chance 6

On arrival: a missed medical emergency
On arrival at Yeovil police station at 8.03pm (as recorded on CCTV), the van carrying James was met by a 'reception committee' of seven officers.

James was reportedly slumped over, in a state of undress. He did not respond when spoken to: the only noises he made were described as grunting. According to several accounts, officers were sufficiently concerned to check James was breathing and had a pulse; once this was confirmed, they began the process of manoeuvring him out of the van.

James was taken out of the van and placed on the ground on his back. He was rolled onto his front, and then carried, headfirst, by around six officers, into a cell. This took at least two minutes, as officers were careful not to let James' head hit the walls. Throughout, James was motionless and unresponsive, though some officers' accounts stated he was making a grumbling noise. Some accounts indicate his breathing was heavy; some that it was shallow.

Once in the cell, the officers performed a cell extraction. The officers placed James on the floor and his clothing was removed, along with the handcuffs and two sets of leg restraints. Still, James did not react, though officers stated he was breathing. After the last officer had left the cell, and James still did not respond or move, officers became concerned that he was not 'faking'. Some officers went back into the cell almost immediately to put James in the recovery position. Two of the officers who had helped carry James continued to monitor him through the cell door, and within a couple of minutes went back into the cell, where they found James was not breathing. CPR was attempted and an ambulance called.

What should have happened?
In such circumstances, medical assessment and assistance must be the priority. This is not just about mental health, but also physical. A patient who has been restrained, transported for a long time, and who is known to have struggled forcefully against that restraint, clearly needs to be checked thoroughly. Additional factors such as the use of drugs (in James' case, legal highs) mean the requirement is even clearer. Such a check should be planned in advance, with medical staff on-hand when a detainee is brought in.

As identified earlier, the ambulance protocol for responding to detentions under section 136 sets out a number of "red flags" which indicate the individual detained should be taken immediately to the emergency department. They include "noisy breathing" and "not rousable to verbal command" – both of which were identified as James was being taken from the van. A simple checklist like this could be a valuable asset for officers.

The 6 missed chances report makes 5 recommendations:

1. Police Officers responding to an incident involving someone with mental health problems should prioritise the welfare and safety of all those involves, including the patient.
2. Officers should be effectively trained in verbal de-escalation as the default response to any incident involving someone with mental health problems.
3. Officers should be trained to use containment rather than restraint when dealing with anyone who has, or appears to have, mental health problems.
4. Each local force should ensure that it has in place robust, effective and relevant local protocols that support police officers in the discharge of their duties, backed by effective working relationships with other agencies, on how to respond to incidents involving someone with mental health problems.
5. Forces should develop clear processes for the recording and sharing of information about individuals who are known to, or are suspected to, have mental health problems.

What has changed since the report?

The law has changed. The government held a review and in 2017 the law on using police custody as a place of safety changed with regard to s136.

By virtue of the new section 136A(1) a police station may not be used as a place of safety for a person under the age of 18 years under any circumstances.

A police station may now only be used as a place of safety for a person aged 18 and over in the specific circumstances set out in The Mental Health Act 1983 (Places of Safety) Regulations 2017, namely, where:

> (i) the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person;

(ii) because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and

(iii) so far as reasonably practicable, a healthcare professional will be present at the police station and available to them