Avon and Somerset Police response to ICVA – IPCC 'Six Missed Chances' Report

It has been over 9 years since the tragic death of James Herbert whilst in police custody. In that time, as a result of the 'Six Missed Chances' report and other developments we believe that improvements have been made which would considerably reduce the likelihood of such a situation occurring again.

The IOPC report made five recommendations and we would like to take this opportunity to comment on the progress against each of these as well as draw attention to other specific local initiatives intended to improve the response to people in crisis.

Recommendation 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.

Awareness of mental health issues has been promoted heavily. The force published a new vulnerability strategy (mental health plan) and procedural guidance in April 2018.

The strategic vision is

To ensure that people who present to police while experiencing a mental health crisis will be supported and managed in the most appropriate way by the most appropriate service

And the principles outlined in the procedural guidance are:

- It is Avon and Somerset Constabulary's policy to deal compassionately, fairly and appropriately with people with a mental disorder, learning disability or other neuro-diverse condition according to their needs.

- Our aim is to ensure that people who present to police whilst experiencing a mental health crisis are supported and managed in the most appropriate way by the most appropriate service.

- The force fully endorses the nine core principles of the National Police Chiefs' Council National Strategy on Policing and Mental Health (Draft)

To support this, the force has also invested in officer training which will be outlined separately in this response.

Recommendation 2: Officers should be effectively trained in verbal de-escalation as the default response to any incident involving someone with mental health problems.

In addition to regular Officer Safety Training (OST) which covers *Acute Behaviour Disturbance* the force has commenced separate specific de-escalation training for front-line officers.

This is a full-day's training which builds on OST and allows officers the chance to reflect on their approach and how behaviour can breed behaviour as well as providing guidance on how to break that cycle and change direction.

Recommendation 3: Officers should be trained to use containment rather than restraint when dealing with anyone who has, or appears to have, mental health problems.

This is probably one of the areas where there has been most focus. Nationally, there have been a number of tragic incidents where people have been restrained whilst experiencing *Acute Behaviour Disturbance* and where there has been a fatal outcome.

As has been documented elsewhere, this has been identified and has featured heavily in OST and other training for a number of years. It is covered in College of Policing Approved Professional Practice.

The principle of "contain not restrain" wherever possible is now embedded in OST and has been supported in other training, unique to Avon and Somerset, which will be outlined shortly.

Recommendation 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.

As has been mentioned, the force now has a full Vulnerability Strategy which includes a plan for the management of mental health presentations and procedural guidance which covers the most frequently occurring situations where policing and mental health intersect.

In addition to this, the force has produced a Mental Health Operational Handbook which has been shared with key partner agencies. This is available to all officers and staff via our internal website and is an easy to read guide which includes many process maps, flow charts and escalation procedures. It was highlighted as good practice in a recent inspection by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service.

The force invests in two officers who work full time on mental health. A sergeant is employed as the force Mental Health Liaison Officer. His work is primarily operation and tactical but focuses strongly on the building of understanding and joint protocols between the police and other agencies.

In January 2018, he was joined by an inspector who is employed as the force Mental Health Coordinator. His work is tactical and strategic.

Between them they have developed the Operational Handbook, procedural guidance, the mental health strategy and numerous bespoke training packages which continue to be delivered across the force. Both liaise with partner agencies on a daily basis and are involved in work with the NHS to re-design services and pathways.
Both are involved in the preparation of response plans to specific patients who frequently come to police attention. These are prepared with clinicians and are intended to provide background information to attending officers as well as a list of considerations and options to help inform approach and decision making.

Additionally, they are involved in national work on the evaluation of triage services and on the management of *Acute Behaviour Disturbance.*

Recommendation 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.

The relationship between Avon and Somerset Police and partner agencies such as local mental health and acute trusts is strong. The MHLO and MHCo have built and developed a wide network of contacts at all levels within such organisations. Both have been invited to and are involved in NHS-led work to redesign and improve system wide pathways.

The force currently has access to a triage service where mental health nurses can be contacted for advice and guidance in real-time. This service has been evaluated in the last twelve months and discussions are continuing with a view to refining and improving the service which can be delivered.

However, there remains an area of risk around this recommendation. There is currently no pathway by which officers can make direct referrals to the NHS if they encounter someone about whom they have concerns which do not require an immediate response.

For example, if an officers attends an incident where they meet someone they believe could benefit from follow up from mental health services (not in a 'crisis' situation) there is no mechanism to initiate this. Mental health services provide secondary care and will not accept direct referral. Access would have to be gained via referral to primary care – someone's GP – and there is currently no way of initiating this. The result of this is that the officer will complete a safeguarding form at the conclusion of their involvement but there is nowhere to forward this on to.

This has been identified as a strategic risk and priority. Avon and Somerset Police escalated this to the newly re-formed Crisis Care Concordat Group and it has been accepted as a priority for that group to address collectively. Work and discussion is underway to close this gap as soon as possible – with interim measures also under consideration at the present time.

In the medium to long term, the MHCo is involved in NHS led work to completely redesign the crisis pathway but efforts are underway to create a 'meantime' function.

Officers can currently access triage and out-of-hours services and are actively encouraged to do so. This will be effective in immediate or crisis situations but will be less so in situations where there are concerns but they are less pressing. This prevents easy referral for earlier intervention. Early intervention may lead to the prevention of future escalation into crisis. This, therefore, is an area of intense focus and discussion.

Acute Behaviour Disturbance

The situation regarding *Acute Behaviour Disturbance* is complicated. The condition was first identified in 1849 at an institution in America. It became known as Bell's Mania after the doctor who first documented it. Since then it has gone under many different names, the most recent being Excited Delirium and now Acute Behaviour Disturbance (ABD.)

Despite the fact that the phenomenon has been documented since this time, there has been disagreement in the medical world about it ever since. You will not find it listed in either the Diagnostic Standards Manual (DSM – United States) or the ICD (Rest of the world.) It, therefore, does not exist as a standalone condition in any medical reference book albeit the individual symptoms can be found.

It is, therefore, currently best described as a 'constellation of symptoms.'

Despite the fact that it cannot be found in medical reference books it has been listed as a cause of death in numerous inquests. There is also an abundance of research literature on the subject as well although there are people who do not believe that it exists.

It is referred to in the College of Policing APP and the Royal College of Emergency Medicine (RCEM) have written guidelines on how to manage suspected cases.

These two documents are relatively closely aligned in that the police advice is to treat any suspected case as a medical emergency and to request clinical support immediately – and the RCEM guidelines advise that the best way to deal with such cases is rapid tranquilisation and immediate transport to hospital.

There is, however, a step in between which is where problems arise.

Whilst the College of Paramedics have now issued a position statement on the management of ABD, the College is not recognised as the professional body for the ambulance service. ABD does not feature on many (or even any) ambulance databases and calls for assistance will always be treated as a Category 2 call because the patient is conscious and breathing.

In effect, this means that an ambulance on route to such a request can be diverted to a Category 1 call.

Things are also complicated by the fact that paramedics cannot administer the sedatives recommended in the RCEM guidelines. Only specially trained paramedics or doctors can do so and they are less readily available.

The differences in opinion and this conflict were laid bare at a national conference to discuss the issues which was held in Sheffield last year and attended by the Avon and Somerset Police Mental Health Coordinator and Liaison Officer. Avon and Somerset was one of only three forces invited. Also present were representatives from NHS England, RCEM, the ambulance service and many other medical professionals.

It was clear at that meeting that no consensus could be agreed and that work would have to be undertaken at a national level to ensure that all policies and guidelines matched up. This work has started but is likely to take at least another year to report.

It was, therefore, left to individual forces and medical agencies to try and come to their own interim arrangements. The College of Policing have since written and distributed new advice on ABD. This has been incorporated into Avon and Somerset training but it also went on to say that all forces should liaise with their respective ambulance services to ensure they treated ABD calls as a Category 1.

This was a surprise given that the College were represented at the national meeting and were aware that it was not possible to come to such individual arrangements and that any change would need to be universal.

The Mental Health Coordinator and Liaison Officer have, however, had initial talks with relevant people within the local ambulance trust and work is continuing to try and come to some form of interim position.

Following the findings of a couple of Coroner's Inquests, the local ambulance trust has now provided staff awareness and briefing about ABD to its call-handlers and clinicians. This has led to an improvement in the discussions between agencies during such incidents.

Police officers have been advised to report the symptoms, advise that someone is being restrained (if that is the case) and to ask for an ETA. If this appears to be delayed or lengthy then they have been advised to consider alternative methods of transport (including police vehicles) in order to get the person to medical assistance as quickly as possible.

The practical effect of all of this is that, since James' tragic death, awareness amongst police officers with regards to ABD and restraint has increased exponentially. Indeed, they are now more likely to 'over-diagnose' it than not recognise it. The difficulty now comes in ensuring that the medical assistance officers are instructed to summon arrives promptly and can be managed effectively.

Training within Avon and Somerset Police

In addition to the training on ABD and 'contain not restrain' that officers receive as part of their annual officer safety training, the force has also undertaken the following:

- All officers who receive the above-mentioned officer safety training are receiving a one-day input on 'De-escalation' training. This will further enhance their considerations and options when dealing with incidents which have traditionally led to restraint.
- All existing uniformed sergeants and inspectors (as of 2018) undertook a bespoke one day training input on decision making around mental health related incidents. This was built around the National Decision Model and made direct reference to ABD and 'contain not restrain.'

- Communications and Custody teams have received bespoke inputs, tailored to their own needs, but along similar lines to the sergeants / inspectors training and which again referred to the management of suspected ABD.
- Communications supervisors have received a bespoke input on decision making around mental health related incidents.
- The force is now training Mental Health Tactical Advisors. By January 2020 there will be almost 70 PC's, PCSO's and Communications staff who will have attended a four-day course which is designed to improve recognition of mental health related incidents and decision making around them. This is a course unique to Avon and Somerset which includes workshops with a hostage negotiator (for conversation management skills) and with clinicians and people with lived experience. Students also spend an entire day on placement with mental health services as part of the course. They examine case studies where there is learning, legislation, procedure and policy as well as risk-assessment and the National Decision Model. The aim is not for these officers to provide clinical advice – but to be better able to advise colleagues on how to appropriately apply policing to mental health related incidents. The ultimate objective is to train a number of the tactical advisors to become trainers themselves so that the force can roll-out wider training to all staff.

The De-escalation training has been delivered by Officer Safety Trainers and all of the mental health courses have been designed and delivered by the Mental Health Coordinator and Mental Health Liaison Officer.

Conclusion

It is essential that Avon and Somerset Police learn the lessons arising from James' tragic death in police custody in June 2010. Processes and training have improved significantly since then and officers are more aware than ever that something may be a medical emergency rather than a situation which requires arrest and detention.

There are still significant hurdles to overcome, at a national level, to ensure that the medical response to such situations is consistent and timely but Avon and Somerset Police are part of those national discussions and are doing all we can locally to educate and inform our staff and work with our partner agencies to ensure the most appropriate response in the meantime.

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