MAY 2013

Independent Report Commission on Mental Health and Policing

Contents

Foreword

I would wish the first words of this report to be my heartfelt gratitude to the families of those who have died, either directly or indirectly, as a result of the failings of the MPS and or their partner services to respond to their relatives' crisis. In carrying out the Commission's work I have had the sad privilege to meet with parents, brothers, sisters, friends and supporters of people in varying stages of grieving for their lost ones. I and my fellow commissioners would wish to thank the families for being generous with their time, patient with our process and dignified in their tolerance of our questions. While reports like this cannot take away the anguish they have suffered, it is my hope and the duty of those who receive this report to ensure that the recommendations are implemented in the name of the families as citizens who have lost loved ones in terrible circumstances. They deserve the reassurance that other families will not suffer the same loss.

When I accepted the Commissioner's request for this report, we agreed that it would need to go directly to him, as it is only through his leadership that change will happen. I am grateful to the Metropolitan Police Commissioner for requesting this work and in particular for seeking an independent perspective on the issues. This demonstrates the seriousness with which he regards the issue. I would hope that this is a welcome sign of a leadership that is prepared to be self critical; and to adopt a learning culture in development of a vital public service.

I would also like to express my sincerest thanks to the members of the Commission for their hard work, the MPS for their assistance and cooperation and to the families of individuals who have been the subject of our case review.

Before agreeing to chair the independent commission I shared the view of a number of police officers I have spoken to and spent time with during the course of the Commission's work that mental health should have little to do with policing. However during the course of this review I have come to the conclusion that mental health is one of the core parts of police work because 1 in 4 people in any one year are likely to face a mental health issue. These people turn to the police for support and protection, and their particular vulnerability is likely to put them into contact with the police.

It is worth reiterating that this report is not focused on deaths in custody nor is it about race and policing in London. However during the course of our work in this area we have come across both deaths in custody and we have not shied away from making observations about race where there is a need to do so.

I wish to state too, that the focus of this report is about whole systems organisational change; and not about finding fault with individuals. The emphasis is on the MPS better equipping frontline officers to carry out their roles in relation to people with mental health issues[1]. This means making sure there is a corporate strategic commitment which, in our view, is lacking.

It should be noted here that during the course of this Commission, the MPS has set up strategic and corporate mechanisms in relation to mental health through the work of the Diamond Group, the re-convened Mental Health Programme Board, and through the development of its Mental Health Team. It has undertaken a review of previous recommendations from MPS and external reports on mental health related issues and set up subgroups to implement these recommendations. While this work is welcome there have been times when it has also caused some confusion as to the role of the Commission. While I understand and welcome the MPS's desire to understand its position regarding its response to incidents involving mental health, it would be an opportunity missed if the recommendations of this Commission

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1   Mental health issues is the agreed term for this report. This description is used to provide consistency in reference to individuals with mental health issues, which some organisations and individuals may refer to as problems, conditions or mental illness. Mental disorder is only used when specifically quoting the Mental Health Act.

are not taken seriously, because there is a sense that the MPS's internal processes have already addressed all issues. It is likely that the approach and recommendations in this report will require some re-engineering as well as the creation of better leadership, better policy and better practice in the area of the MPS and mental health. Therefore I hope it is viewed in this light.

While it is true that other agencies, namely the NHS and social care, are critical players in the provision of services to people with mental health challenges, the work of the Commission has been focused on the role of the MPS. This includes its ability to act as an effective partner to other agencies and the vital importance of having clear protocols in place, particularly at the interface between the police, the NHS and social care. The NHS is a key partner with the MPS in the delivery of safe services to people with mental health issues, and there are specific recommendations in this report for the NHS. We have also taken the same approach to our observations about social care. In short, while the MPS has accountabilities in this area, the MPS cannot and should not replace the NHS and social care services who need to play their part in the delivery of safe services.

In short, therefore, to improve the MPS's response to mental health, there must be a clear vision, leadership that recognises public safety, and a police force that respects all of its citizens, in particular the most vulnerable.
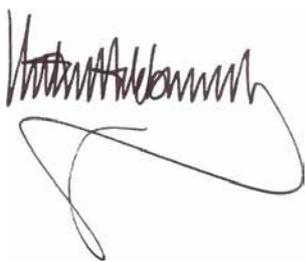
Lord Victor Adebowale CBE
Chair, Independent Commission
on Mental Health and Policing

Executive Summary

The Independent Commission on Mental Health and Policing was set up in September 2012 at the request of the Metropolitan Police Commissioner. Terms of reference and membership are attached at Appendix 1 on page 68.

The Commission's brief was to review the work of the Metropolitan Police Service (MPS) with regard to people who have died or been seriously injured following police contact or in police custody and to make recommendations to inform MPS conduct, response and actions where mental health is, or is perceived to be, a key issue.

While reports like this cannot take away the anguish families have suffered, it is the hope of the Commission, and the duty of those who receive this report, to ensure that the recommendations are implemented in the name of the families as citizens who have lost loved ones in terrible circumstances. By doing so, a level of reassurance can be given to the families that others may not suffer the same loss.

Although the Commission was focused on the MPS, the issues identified are national and the recommendations are likely to be applicable to all forces across the country.

The Commission independently examined 55 MPS cases covering a five-year period (September 2007 — September 2012). As some cases are still to receive judicial findings in those reviewed, we have been careful to avoid making any comments that would prejudice future findings. All cases, therefore, have been made anonymous[2].

We focused on the roles and responsibilities of the MPS in dealing with issues of mental health in custody, at street encounter and in response to calls made to police, including call handling processes when dealing with members of the public where there is an indication of mental health.

Everything which follows in this report must be seen through the lens that mental health is part of the core business of policing. The role of the police is not a clinical one but mental health issues are common in the population and will often be found in suspects, victims and witnesses. A person may commit an offence or cause a public disturbance because of their mental health issues. In addition, the police may be first on the scene of a person in mental health crisis or a potential suicide. It therefore cannot be a periphery issue, but must instead inform every day practice. As existing guidance[3] states: 'Given that police officers and staff are often the gateway to appropriate care — whether of a criminal justice or healthcare nature — it is essential that people with mental ill health or learning disabilities are recognised and assisted by officers from the very first point of contact. The police, however, cannot and indeed are not expected to deal with vulnerable groups on their own.'

Findings and evidence from case reviews, surveys, meetings and visits

The shortcomings in the police performance are the primary focus of attention in this inquiry. In many instances this is an issue of the systems and procedures as well as the behaviour of individual police officers. There are also issues identified in regards to how the MPS and other agencies, including the NHS and social services, work together and how roles and responsibilities are handled when responding to a situation involving an individual's mental health. For example, during the course of our meeting with the London Ambulance Service (LAS) we were told that their protocol states that if the call is in regards to someone with a mental health issue and the Police are on site, the priority is reduced for the LAS to attend.

It is important to note at the outset that in the case reviews we also found instances of prompt, efficient and expert responses to people with mental health issues.

Based on the Commission's review of the evidence a number of findings are highlighted, namely;

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2   Cases within the report are referenced by numbers, rather than initials, to protect the identity of the individuals and families involved.

3   Joint ACPO/NPIA/DH guidance (2010) 'Responding to people with mental ill-health or learning disabilities.

Findings and evidence from case reviews, surveys, meetings and visits

1. Failure of the Central Communications Command to deal effectively with calls in relation to mental health
2. The lack of mental health awareness amongst staff and officers
3. Frontline police lack of training and policy guidance in suicide prevention,
4. Failure of procedures to provide adequate care to vulnerable people in custody
5. Problems of interagency working
6. The disproportionate use of force and restraint
7. Discriminatory attitudes and behaviour
8. Failures in operational learning
9. A disconnect between policy and practice
10. The internal MPS culture
11. Poor record keeping
12. Failure to communicate with families

Summary of Recommendations

The Commission's findings lead to 28 recommendations for change, falling under three areas for action:

• Leadership
• On the frontline
• Working together: Interagency working

LEADERSHIP

Mental health is core business and needs to be reflected in all policy, guidance and operating procedures;

Recommendation1: Implementation of the One Met Model for policing in London should reflect, at all levels, in day to day police business, the impact of mental health for vulnerable adults who are at risk.

Recommendation 2: The MPS should include a mental health-specific indicator as part of performance measurement of the 20% Mayor's Office for Police and Crime (MOPAC) target for improving public confidence.

Recommendation 3: MOPAC should hold the MPS to account for identification and delivery of a mental health specific performance indicator within the 20% MOPAC target.

ON THE FRONTLINE

Skills, awareness and confidence of frontline staff need to improve in regards to mental health and the MPS must become a learning organisation;

Recommendation 4: The Mental Health Liaison Officer (MHLO) role should be full time to at least co-terminous levels with mental health trusts and supported by expert teams based on assessment of local needs.

• The MHLO role should have explicit and accountable links with external agencies, including the NHS, Local Authorities and the voluntary sector.

• The MHLO role should be integrated and supported throughout the MPS, including with frontline police officers and neighbourhood teams.

• The MHLO role should be operationally accountable at senior management level; and should include provision for continuing professional development.

Recommendation 5: The MPS Commissioner should take personal responsibility for devising and implementing a strategy to ensure that the culture and working practices of the MPS demonstrably promote equality in relation to those with mental health conditions. This should include devising a strategy with key milestones and providing annual reports on progressing this strategy. This report should also detail complaints concerning the treatment of people with mental health conditions and action taken to address them.

Recommendation 6: The MPS needs to implement an organisational learning strategy in order to give lasting effect to the recommendations of external bodies, and the key findings of internal reviews. This strategy should include a named lead and clearly defined timeframe for implementation and review, ensuring that responsibility for the implementation process resides at Commander level and not within each business group.

Recommendation 7: The MPS should ensure that personal issues of mental health and wellbeing are incorporated into staff induction, and ongoing mental health awareness training.

• The MPS should ensure that processes for debriefing and supervision enable police officers and staff to discuss issues of concern and stress which may relate to their own mental wellbeing.

- The MPS should ensure that occupational health policies and procedures enable all frontline staff to access appropriate mental health support, without recourse to stigma or discrimination, if a need is identified.

Recommendation 8: The MPS should establish a high level expert group of stakeholders that can provide the MPS with ongoing and specific advice and review; which are aimed at improvements in outcomes with regard to race, faith and mental health. This group should report to the Commissioner.

Recommendation 9: That the MPS should create a comprehensive suite of mandatory training for staff and officers developed in partnership with experts, including from the voluntary sector, and individuals with mental health needs. This programme should be developed in conjunction with the London Mental Health Partnership Board; College of Policing and be independently evaluated.

Recommendation 10: The MPS should seek external experts in mental health to assist in the routine review of guidance, SOPs and information materials. This review should be a public report, available on the MPS website and submitted at six-monthly intervals to the London Mental Health Partnership Board.

Recommendation 11: The MPS should adopt a corporate approach to suicide prevention with both a strategic and operational focus. Suicide prevention training and guidance must be put in place immediately with the advice and assistance of external stakeholders.

The police need to develop a safer model of restraint

Recommendation 12: The MPS has to work with ACPO and the College of Policing on policy and training on restraint to ensure that the principles outlined in this report are enforced or utilised.

Better information and IT systems are needed

Recommendation 13: The MPS information systems need to be improved to provide:

- A central intranet depository to collect policies and protocols information, advice, news on mental health issues to be a resource to police officers and staff; and

- A centralised database and paper based collection of all internal and external case reviews involving mental health.

Recommendation 14: A new process needs to be introduced in the review of standard operating procedures and policies with relevance to mental health so that stakeholders from the statutory and voluntary sectors are involved as partners in the process.

Recommendation 15: Establish a system on Merlin for vulnerable adults which includes both a mechanism to record and a mechanism to refer incidents involving adults in mental distress.

Recommendation 16: The MPS should invest in technology for CCC which is fit for purpose.

- Guidance and protocols on vulnerable persons and mental health at CCC should be reviewed in collaboration with external sources, including service users and carers, as well as voluntary sector agencies, to improve their effectiveness at identifying relevant issues.

- Within the bounds of confidentiality information about carer/ family member and a health support person should be captured.

Improved health care in custody must be assured

Recommendation 17: Mental health nurses with experience related to offenders must be available to all custody suites as required. The MPS should conduct a 360 degree review every six months to ensure that they are accessing the proper advice from psychiatric nurses in the delivery of health care in custody suites.

Recommendation 18: Practices and policies in custody suites must acknowledge the needs of people at risk on grounds of their mental health issues as part of pre release risk assessment and take appropriate steps, to refer them to other services and to ensure their safe handover to relatives, carers or professionals.

Recommendation 19: The MPS should adopt the Newcastle health screening tool or one that meets the same level of effectiveness for risk assessment in all custody suites.

Recommendation 20: The MPS Commissioner should publish a public report on the care of people with mental health and drug or alcohol conditions in custody suites, the referral pathways and the outcomes of pre release risk assessments.

Recommendation 21: The MPS should transfer commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS.

WORKING TOGETHER: INTERAGENCY WORKING

There needs to be more effective interagency working

Recommendation 22: The Mental Health Partnership Board should have formal recognition and mandate specifically agreed with NHS England, the MPS, the Association of Directors of Adult Social Services (ADASS) and Mayor's Office for Police And Crime (MOPAC) as part of the Mayor's accountability for health. This would constitute a central oversight mechanism for improving mental health and policing in London.

Recommendation 23: NHS England should work with Clinical Commissioning Groups, health and wellbeing boards and the CQC to ensure that:

• No person is transferred in a police van to hospital;

• Funds are made available through an appropriate dedicated response for mental health, for instance provision of a dedicated paramedic in a car; and

• That demand management systems of the LAS be reviewed, and changes implemented in order to ensure parity of esteem between mental and physical health.

Recommendation 24: NHS England should work with Clinical Commission Groups to ensure sustainable liaison psychiatry services are set up, which are based on and reflect the needs of local populations.

Recommendation 25: The MPS should:

• Establish joint protocols to identify a basis for effectively sharing information London-wide with partner agencies for adults at risk with mental health problems;

• Work with the Mental Health Partnership Board to establish a multiagency mechanism for risk assessing, case managing and information sharing in relation to people with mental health problems who are perceived to be at high level of vulnerability.

• Ensure senior and authoritative representation on the Local Authority-led multiagency Adult Safeguarding Partnership Boards.

Recommendation 26: The MPS and its NHS partners should immediately implement the Bradley Report recommendation so that all police custody suites should have access to liaison and diversion services.

Recommendation 27: The MPS should urgently work with local authorities and mental health trusts to ensure existing protocols and procedures for information sharing; risk assessment and management are adhered to and monitored. This should include taking account of local authority led strategic safeguarding structures to promote public safety and wellbeing.

Recommendations 28: The MPS should agree protocols for joint working on service provision with reference to AMHPs, emergency duty teams and wider social care services.

Conclusion

If all our recommendations are implemented, it is the view of the Commission and the collective conclusion from our recommendations that the events that informed this inquiry, are far less likely to happen in the future.

We therefore hope the Commissioner takes on board these recommendations as a priority and implementation is seen within the timeframes we have outlined in this report.

Introduction

The Independent Commission on Mental Health and Policing was set up in September 2012 at the request of the Metropolitan Police Commissioner. Terms of reference and membership are attached at Appendix 1 on page 68.

The Commission's brief was to review the work of the Metropolitan Police Service (MPS) with regard to people who have died or been seriously injured following police contact or in police custody and to make recommendations to inform MPS conduct, response and actions where mental health is, or is perceived to be, a key issue. Although the Commission was focused on the MPS, the issues identified resonate nationally and the recommendations are likely to be applicable to all forces across the country.

The Commission independently examined 55 MPS cases covering a five-year period (September 2007 — September 2012). The Commission has had access to MPS case files and records, operating procedures and internal discussions and meetings. As some cases are still to receive judicial findings in those reviewed, we have been careful to avoid making any comments that would prejudice future findings. We have anonymised all cases reviewed.

This report also draws on interviews with families of those involved; people who use services; members of the general public; police officers and staff; and organisations in the statutory and voluntary sectors.

We focused on the roles and responsibilities of the Metropolitan Police Service in dealing with issues of mental health:

- In custody;
- At street encounter;
- In response to calls made to police, including call handling processes when dealing with members of the public where there is an indication of mental health.

The MPS operates within a national policing context. MPS standard operating procedures (SOPs) are set within guidance determined through the Association of Chief Police Officers (ACPO) and the previous National Policing Improvement Agency (NPIA), whose operational functions now rest with the Home Office, College of Policing and the Serious Organised Crime Agency (SOCA). There are also important working relationships with the NHS, the ambulance service and social services.

This means that although the issues explored in this report are focused on the MPS, their relevance is wider.

The Commission is aware of current work on mental health and policing that is being undertaken by other bodies. Of direct relevance is the work of the Independent Advisory Panel on Deaths in Custody chaired by Lord Harris, and the London Criminal Justice Liaison and Diversion Advisory Board involved in implementing the Bradley Report[4], the Mental Health Partnership Board [5], the Care Quality Commission (CQC) and the Independent Police Complaints Commission (IPCC). In particular the work of the Mental Health Partnership Board on the operation of Section 136 has informed our work[6]. We have met members of these bodies and taken their work into account where possible in framing our recommendations.

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4   The Bradley Report, Lord Bradley's review of People with Mental Health problems or learning Disabilities in the Criminal Justice System resulted from a comprehensive and independent review of the experience of people with mental health problems and people with learning disabilities in the criminal justice system. Its recommendation could lead to major changes in the way offenders with mental health problems are supported and treated in England. They include the proposed creation of a national network of criminal Justice mental health teams to divert people towards support services from police stations, from courts and following release from prison.

5   The Mental Health Partnership Board assumed responsibility for the work of the Overview & Scrutiny Committee for London from April 2013

6   Section 136 of the Mental Health Act gives the police the power to take a person with a mental disorder, found in a public place, who is in need of 'immediate care or control' to a place of safety.

Section 1
Mental health is a core area of MPS work

Everything which follows in this report is based on mental health being seen as a part of the core business of policing. Without this understanding the Commission believes that, at worst, people can, do and will continue to lose their lives; or, at best, will receive a substandard service.

The Commission found that mental health is not consistently treated as part of core business and has, until very recently, remained an invisible dimension of some areas of day-to-day work where its impact is relevant.

One MPS staff member described the role as understanding 'what it means to be a modern police service which has to deal with complexity on an everyday basis.'

She added: 'We are not at war with the people of London on most days.' 'Therefore we need to ask how we as a service are being prepared to deal with these issues.'

The following areas highlight why mental health is so critical to be everyday workings of the MPS.

1. Mental health is everyone's business

In Britain it is believed around 300 people out of 1,000 will experience mental health issues every year. More than one million Londoners live with mental ill health, ranging from anxiety and depression to bipolar disorder and schizophrenia.

Mental ill health is more common in London than in other parts of the country with 18% of people living in the capital having a common mental health problem, compared to 16% nationally[7]. It is estimated to cost the capital nearly £2.5billion in health and social care costs as well as £5.5billion in lost working days[8].

A person's mental ill health may not be relevant in their dealings with the police, just as their physical ill health may not be. However, there are particular contexts in which mental health status, including illness, will, or should, influence the police behaviour or outcome.[9]

People with mental health issues may come to the attention of the police as witnesses; victims of crime or suspects. A survey of MPS officers[10] indicated 'daily or regular' encounters with victims (39%), witnesses (23%) and suspects (48%) with mental health conditions, and 67% encountered unusual behaviour, attributed to drugs and/or alcohol.

Individuals with mental health issues have a significantly increased risk of being a victim of crime, particularly serious crimes[11]. Victims who self-report mental health conditions are less satisfied with the service they receive from the MPS[12].

The Psychiatric Morbidity of Offenders Study (1998)[13] found that 70% of prisoners had a mental disorder. More recent studies are less comprehensive but do not contradict this finding[14]. This discounts lower level public order offences, which do not attract prison sentences. HMIC Inspection of MPS custody suites in 2011-12 reported[15] that an average of 25% of individuals taken into police custody are on the record as having a mental health problem or are currently suicidal/self harming. This figure excludes many who do not self declare or who are missed by the risk assessment process (estimated in a recent study to be at least a third[16]). This figure also excludes nearly half of those who do go on to commit suicide on release from custody.

There is little understanding of how often the police respond to incidents linked to mental health, largely because the data is not available. A review of mental health related calls[17] in London undertaken for this inquiry identified mental health is an increasing demand on the MPS. Of a total number of 3, 958, 903 calls to police between September 2011 and August 2012, 1.5 per cent (60,306) were flagged on the Crime Related Incident System (CRIS) as being linked to mental health. In 2012 there were 61,258 mental health related calls;

7   Navigating the Mental Health Maze (2007), London Assembly Health and Public Services Committee.

8   Mental Health in London (2011) — a discussion document prepared for the London MH CEO Group for presentation to NHS London.

9   MPS Corporate Development, Evidence & Performance (2013) *Mental Health and the Police: Understanding Demand and Incident Management in the Metropolitan Police Service.*

10   Stanko, B (2012). A Snapshot of Borough Mental Health Liaison Officers. Internal Corporate Development presentation. 'Daily or regular' refers to a few times a week

11   Cummins, I. (2012). *Policing and Mental Illness in England and Wales post Bradley.* Policing, Volume 6, Number 4, pp. 365–376

12   Keenan, M. (2012). User Satisfaction Survey: Q1 *12-13 Focus on Mental Health. Corporate Development User Satisfaction Survey* (USS) Quarterly report. Mind Another Assault, Mind, London , (2011)

13   *Psychiatric Morbidity Among Prisoners in England and Wales,* Dept of Health , 1998

14   Bradley, K. (2009). *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System.* London: DH. Herrington, V., & Roberts, K. (2012). Addressing Psychological Vulnerability in the Police Suspect Interview. Policing Journal Volume 6, Number 2, pp. 177–186

15   The average is taken from suites in 8 HMIC inspections of borough custody suites during 2011-12.

16   McKinnon I, Grubin D, *Health Screening of people in police custody — evaluation of current police screening procedures in London* Eur.J Public Health 2012;

17   Stanko, B (2012) Mental Health and the Metropolitan Police Service

this is 21,741 more than robbery and 47,203 more than for sexual offences. The MPS review also stated that it has been estimated that 15% — 25% of incidents are linked to mental health. Using this estimate the daily contact rises to a minimum of 1,626 — calls per day- the equivalent of around 600.000 calls per year[18].

In cases we reviewed, call takers sometimes coded an incident simply as a crime when in fact the real issue for the police attendance was a medical emergency related to a mental health crisis. This lack of recording would indicate that the recorded numbers are undoubtedly a fraction of the actual number, as most calls where mental health is a relevant issue will not be identified and recorded as such.

Estimates from MPS police officers specialising in mental health are that mental health issues account for at least 20% of police time[19], and would be much higher (up to 40% if wider work with vulnerable people is included)[20].

There can be little doubt that a significant amount of the time spent by an average police officer will be with people with mental health issues, either in street contact, supporting people as victims of crime, or in rarer situations as perpetrators.

2. The duty to protect life

The police have a legal duty to protect life and can be liable under Article 2 of the Human Rights Act for failure to do so. If the police identify that an individual has mental health issues, and respond appropriately they may save a life, prevent suicide or a homicide. Where this does not happen, these events are tragedies for individuals and communities, are costly for the MPS and reflect poorly on its reputation.

3. The role of police intervention to prevent crime and refer to health services

Police intervention may have a significant role in preventing the impact of deteriorating mental health. If undetected and unaddressed mental health issues, like physical issues, can escalate and then account for a population which is over represented in police time. This includes the repeat callers who are vulnerable, confused and distressed; as well as a small number who participate in a pattern of acts of low level crime and who end up in a high secure unit or in prison, as their health deteriorates. The police are sometimes the first public service to deal with an individual with mental health issues[21]. Early diversion to mental health services or social care support is beneficial for everyone involved; and saves police resources.

As stated in the Bradley Report, 'It has become increasingly apparent that when people with mental health problems in the community are in crisis, neither the police nor the mental health services alone can serve them effectively and it is essential that the two systems work closely together.[22]'

4. The police role under mental health legislation

The police have specific powers and duties under the Mental Health Act 1983 (MHA). Given that an increasing number of people who are subject to or are assessed under the MHA are living in the community, the police are likely to encounter more situations involving mental health issues than in the past. INQUEST told us of a rising trend of mental health cases, and stated that around 90% of their current cases of deaths after police contact involve mental health[23].

18 MPS Corporate Development (2013) *Mental Health and the Police: Understanding Demand and Incident Management in the Metropolitan Police Service*.

19 This also was quoted by Michael Brown, the Mental Health Cop to the Commission in March 2013. See also http://mentalhealthcop.wordpress.com/2013/02/13/twenty-percent/

20 MPS Corporate Development (2013) Mental health and the police: understanding demand and incident management in the Metropolitan Police Service.

21 MPS, *Mental Health and the Police: Understanding Demand and Incident Management in the Metropolitan Police Service* (2013).

22 Bradley, K. (2009). T*he Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. London p54.

23 Inquest meeting with Commission, 25 February 2013.

5. The stigma of mental illness.

People with mental illness are still among the most stigmatised members of society. This has an impact in their dealings within their communities; with their neighbours and local organisations; and with institutions, including health and social care, courts and prisons. Understanding stigma, and how it affects the behaviour and judgements of the community, including health professionals and the police themselves, may help to change how the police deal with a wide range of issues that are presented to them. The current Time to Change campaign has revealed that the attitudes of health professionals are slow to improve[24] The police also need the cooperation of people with mental health problems in pursuing their wider duties. The police's role in detecting crime is critical to public safety. In order to do this they require public support including from those with mental health issues and their families which can only be fostered through better experiences of police action.

6. Duty of care to the MPS workforce

The MPS is a large employer with over 48,000 staff. Mental ill health costs an average employer £1,000 for every person they employ, about a third of which can be saved through better management[25]. Police work can be stressful, mentally demanding and distressing. However, the nature of their role also requires them to be in control and psychologically robust. This puts the MPS in a unique situation where the mental health and wellbeing of their staff requires particular attention.

24 Henderson.C. and Thronicroft G. E*valuation of the Time to Change programme in England* 2008.11 The British Journal of Psychiatry (2013) 202.

25 *Mental Health at Work; Developing the Business Case*, Sainsbury Centre for Mental Health 2007.

Section 2
The Evidence Base

Our evidence base is made up of:
- The review of cases;
- Public evidence — including surveys of service users, the public and police officers;
- Interviews with families;
- Interviews with professionals and interest groups;
- Review of MPS internal documents and operating procedures; and
- Review of existing external evidence.

A wide range of organisations and individuals working in the mental health sector contributed their views to this inquiry. We held meetings with service users and carers, approved mental health professionals, nurses working in liaison and diversion services and we interviewed a number of individual psychiatrists. We also visited a number of mental health trusts as part of our evidence gathering.

The Commission had access to wide ranging forums at all levels within the MPS: We attended individual meetings, programme and departmental meetings and training sessions; and the Chairman of the Commission took part in territorial police officer shifts. We learned a great deal about how the MPS operates and how many people who work within the MPS view their roles in a wider context. A full list of meetings held is set out in Appendix 5 on page 75.

The case review and findings from the review of public evidence

The Commission's remit was to examine the cases over the last five years in which a person with a mental health issues had died or suffered serious injury after contact with the Metropolitan Police or in police custody. How we interpreted the criteria is reproduced in Appendix 1. We found 50 deaths in the chosen period — from September 2007- 2012.

We included all cases of suicide; and all cases of acute behavioural disturbance (ABD)[26] because at the time of death the person clearly had an acute mental disturbance, whether it was due to mental health issues or drug abuse.

We included all cases where a suicide occurred within 48 hours of police contact, excluding cases where the police contact was incidental to the outcome.

One of the immediate challenges was that the MPS does not keep a central record of all cases involving a referral to the Independent Police Complaints Commission (IPCC) nor do they collect together the reviews of cases involving mental health issues. Files were not centrally stored in a single location but rather across departments and sites with some files being incomplete. The research also had to take into account that the contents of the file depended upon the nature and extent of the MPS involvement after the person had died. Within these limitations it has still been possible to identify common themes and issues.

In addition, we also selected five cases that were referred to us as involving 'serious injury' after police contact or in police custody.

A detailed account of the cases and how we interpreted our criteria for inclusion is reproduced in Appendix 2 on page 69.

The cases of death fell into 5 categories:
1. Suicide while police in attendance or after police contact (20 cases)
2. Suicide or death after police custody (14 cases)
3. Suicide of police officers while in MPS employment (4 cases)
4. Death during police custody or under police control (1 case) and where the person was subject to restraint that contributed to death (5 cases)
5. Homicide of a third person after the perpetrator, known to have mental health problems has been in police custody or been in repeated police contact. (6 cases)

The Commission invited family members of those involved in the cases to give their views of the police involvement in the case. Nine families responded. We are very grateful to those whom we were able to contact and who chose to speak to us. Their views have informed this report.

It is impossible to single out one family case as being worse than any other. It is clear that a death can result from a small set of errors or misjudgements as from the most egregious mishandling of a case. All the families we spoke to were in varying states of grieving and distress over the loss of loved ones in circumstances that nobody

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26   Acute behavioural disturbance may occur secondary to substance misuse (both intoxication and withdrawal), physical illness (such as post head injury, hypoglycaemia) and psychiatric conditions (including psychotic and personality disorders). Of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life threatening. The clinical features of excited delirium include a state of high mental and psychological arousal, agitation, hyperpyrexia associated with sweating, violence, aggression and hostility with insensitivity to pain and to incapacitant sprays. Faculty of Forensic and Legal Medicine , 2011.

would wish to experience. Witness statements in the case files also bore testimony to pain and shock of their loss. The Commission wishes to repeat its gratitude for the time, dignity and patience offered to the Commissioners during the course of our work.

However one case, Case 1, illustrates the worst combination of poor leadership, lack of a clear strategy, policy, practice and coordination. Many of the cases the Commission reviewed, which resulted in a death, had some of the elements that came together in such tragic alignment in this case.

In Case 1 a series of increasingly alarmed calls were made to Central Communications Command (CCC) by the hostel manager with respect to a man from the black community, who was in a mental health crisis, acting bizarrely and out of control. Despite this CCC failed to arrange deployment of the police until it appeared that a bystander would be injured. The jury found that the CCC response was an unacceptable failure to act appropriately and that the lack of timely response to calls was also unacceptable and inappropriate. Communication between the police at the scene and CCC, the police station and the Integrated Borough Office was insufficient and the nature of the crisis was not understood.

The man was chased and restrained in the prone position for approximately 8 minutes. He was struggling but not violently and therefore the jury found the length of restraint in the prone position was unnecessary. Unsuitable force was used. He was restrained in the police van and taken to the police station. His condition deteriorated during the journey. The police failed to recognise that he was mentally ill and therefore did not take him under s136 to hospital as required by the Mental Health SOP. On arrival at the police station he was almost unconscious (it was reported that the police officer stated he was 'feigning unconsciousness'). He was left without adequate care by the police in the caged police van and then in the cage at the police station. He died in the police cage. The jury narrative stated that there was a lack of care by the police in their failure to recognise his physical and mental health needs and to attend to him promptly.

The shortcomings in the police performance as demonstrated in this case and others in this report are the focus of attention in this inquiry. In many instances this is an issue of the systems and procedures rather than the behaviour of individual police officers.

It is important to note, however, at the outset that in the case reviews we also found numbers of instances of prompt, efficient and expert responses to people with mental health issues. Police often showed diligence, understanding and compassion for a person in acute crisis and responded with calm and reassurance. They understood their powers and roles. Police also attended promptly to crises and were patient when delays occurred within the hospital environment. In some instances they were commended by the IPCC, the coroner or family members for their performance. In our meetings with professional groups there was also praise for the police professionalism and approachability. In addition the surveys showed that individuals considered that they were treated with dignity and respect most of the time. Bereaved families also identified good practice by the police, although this was less often voiced.

Service User: 'A friend called the police fearing I was suicidal. The police came to my house and contacted my Mum and a friend to come round and sit with me. They remained with me at my house until someone arrived.'

Mother: 'They were all so cool, calm, very professional — the way we were treated by the various police officers. The Sergeant was very good, and he liaised with me for the coroner's Inquest. I [had] a good service from the police all the way through.'

The following findings relate principally to the Commission's overall case review and also refer to the evidence gathered through the surveys, meetings and visits. They revealed a set of themes which inform our recommendations for change.

Findings and evidence from case reviews, surveys, meetings and visits

1. Failure of the Central Communications Command to deal effectively with calls in relation to mental health
2. The lack of mental health awareness amongst staff and officers
3. Frontline police lack of training in suicide prevention
4. Failure of procedures to provide adequate care to vulnerable people in custody
5. Problems of interagency working
6. The disproportionate use of force and restraint
7. Discriminatory attitudes and behaviour
8. Failures in operational learning
9. A disconnect between policy and practice
10. The internal MPS culture
11. Poor record keeping
12. Failure to communicate with families

The total number of cases reviewed, including 50 cases of death and 5 examples of serious injury, is 55. The Commission's findings relate to all of the 55 cases. Our aim was to be wide ranging, to go beyond the recommendations made by the coroner or IPCC or internal reviews to consider the wider question as to whether there were common themes and lessons to be learned for how the police might improve their service to people with mental health conditions.

Our cases covered a range of different contexts, including welfare visits, mental health assessments under the Mental Health Act, arrests and criminal charges, representing the types of circumstances in which the police might become involved. However the cases do raise a controversial issue of what the public can and should expect of the police force when dealing with people who are unwell or vulnerable.

In around a quarter of the cases there were no lessons to be learned as the police response was entirely appropriate, in the remainder we found shortcomings that were identified by internal or external reviews or from our own conclusions.

Although there were examples of good professional conduct where police officers were prompt, compassionate and patient, we believe that the many errors or shortcomings discovered by the Commission are not isolated and uncharacteristic failings but a reflection of the whole system. Evidence of this can be seen through shortcomings in current policies, training programmes, leadership and operational processes which do not add up to a systemic commitment to deal well with mental health issues nor constantly improve practice for the public good.

The major findings reveal distinct but interrelated failings in the prevailing MPS culture and practice. These failings provide the basis for the areas for action explored in Section Three of this report.

1. The failure of Central Communications Command (CCC) to deal effectively with calls in relation to mental health

This is the failing found most frequently in the case review. It covers both call takers and supervisors. It includes inadequate or inaccurate collecting and recording of information, (including past events), failures to grade a call appropriately (according to the actual level of risk), to link calls with previous calls (and so to identify repeat callers), to pass on critical information, and to keep updating the frontline officers so that they understand the nature or degree of the emergency. These errors had huge consequences for the way the incidents proceeded[27].

Frontline police were given incomplete wrong information that led to treating something as a crime rather than a medical crisis. Police intervention was delayed or cancelled in an emergency and vulnerable people were stigmatised or a relevant mental health condition overlooked[28]. The consequences were fatal for the individual or someone else.

27　Examples include Case 2, 3, 5, 9, 11, 13, 16, 18, 20, 27, 31, 33, 37, 39.
28　This was so for instance in Cases 3, 8, 9, 28.

In Case 2 a woman made many calls to the police over a 2 day period prior to the homicide she committed. While police did respond initially and took her to hospital they did not follow up her later calls adequately. In mounting distress she made four calls from the hospital within an hour. She begged the police to come to take her into custody because she was very scared. She said that she was having a breakdown and had become very dangerous. 'Last time I felt like this I killed someone' and she said the hospital was not helping her. She gave her name but no check was made of the police record which would have confirmed the truth of her statement of previous homicide. The calls were each downgraded by a supervisor to require no response because she was in hospital and therefore in a safe place. After several hours she walked out of hospital and did indeed go on immediately to kill a bystander.

It appears to the Commission that overall the police seriously underestimated the seriousness of the woman's requests for help and therefore the urgency of the situation. After one 999 call the police did contact the hospital but there was no more communication between them. The police did not work in partnership with health services to share their intelligence as the situation evolved.

In Case 3 a man from the BME community killed a woman with whom he shared a regular friendship. He was acting under the delusion that God required this of him and explained his reasoning to the police in this way. He had made over 30 calls to 999 in previous weeks — some calls of a delusional nature but also seeking help for bullying and homophobia (help he did not receive and was distressed about). It was clear he was in need of assistance but it appears that these issues were not taken seriously and the internal DPS review criticised CCC on that account. The Computer Aided Despatch (CAD) on his case was closed instead of his being classified as vulnerable or any other action taken to check up on him, or suggest a referral to health services.

In Case 13 involving a woman who took her own life at home there had been a series of incidents involving her mental ill health in the preceding days. She had a history of mental illness and alcohol abuse. As a result of a friend's call about his concern for her being suicidal a welfare check was made on her. The call was graded by the call taker as requiring a response within 48 hours which was considered incorrect by the DPS review. The previous incidents were not added to the information. Police officers did attend the scene within an hour despite the grading. After they left the premises there was another call from a neighbour that she had asked then to be called on account of the 'Grim Reaper' and the call taker was reminded that there had been other suicide attempts. The call was graded as requiring an immediate response but later downgraded as to not require a response unless requested by the LAS. When the LAS gained entry she was dead.

In these and other cases there was a failure to identify the pattern from a series of increasingly agitated calls to CCC that indicated an emergency. The cases reviewed draw attention to problems with current CCC technology, inadequate criteria for collecting relevant information and lack of training. This is overlaid by evidence indicating notions particularly in relation to suicide, that mental health issues are not really the business of the police.

2. The lack of mental health awareness and knowledge among staff and officers.

The call takers at CCC are the gatekeepers of the police service and their attitudes and knowledge is critical to the outcome for the caller or the person at risk. The expertise of CCC staff (including call takers and supervisors) seemed from the cases to vary considerably from the most professional to one betraying misunderstanding and bias around mental health.

> Case 4 involved a voluntary inpatient in a Mental Health Unit (MHU). He phoned police complaining of having been assaulted by staff. The officer said police would attend (the CAD was graded S so he should have been within the hour)[29]. In fact, the hospital was then contacted, said that he had been restrained while drunk, so the CAD was closed with no further action. At 5:15 he was found hanged in his room. Police staff were reprimanded in the DPS review for not being empathetic on the phone — he asked the person he called 'are you angry with me too?' for not calling him back when the police officers changed their minds about attending, and the police officers for not attending before closing the CAD.
>
> The DPS report also made a criticism of the police staff failure to identify Case 4 as an adult at risk and to apply the Safeguarding Adults at Risk SOP in her manner of dealing with him on the phone.

In several cases it was evident that police on the street lacked understanding of mental health issues, including vulnerability and adults at risk. At times they also failed to grasp the significance of information from family or bystanders, and from their own observations in order to assess the situation and decide on an appropriate response.

There is a theme in several cases reviewed[30] and reported to us anecdotally that the police did not adequately seek or use information from others (for example family, bystanders, carers, other professionals); know how to work cooperatively with them where relevant; and going in to 'take control' when it appears with hindsight a more measured approach would have been very feasible and would have prevented harm. The reported court case of

ZH for instance, involved a teenager with autism who jumped into a swimming pool fully clothed when the police rushed to restrain him.

In custody suites custody officers lacked assertiveness in making their own minds up about vulnerability and risk. Custody staff tended to rely too heavily on the Forensic Medical Examiners (FMEs) whose advice was based on a brief examination solely to assess whether the person was fit to be charged or interviewed[31]. In several cases the medical examination lasted no more than a few minutes. In some cases the custody sergeant's own judgment over the course of a day might well have led them to a different conclusion as to the person's vulnerable mental state and the Custody Standard Operating Procedure (SOP) advises them to form their own judgment. Custody staff recorded 'no risk' on risk assessment forms when the detainee had admitted to suicidal feelings or had attempted suicide in the very recent past[32].

There needs to be appreciation that the experience of being arrested followed by a long period of custody could intensify the mental distress of someone who had been suicidal or displayed clear signs of mental ill health. The IPCC stated in its review of a decade of deaths in custody;

> People with mental health needs are likely to find the custody environment distressing and this can exacerbate their mental state and in some cases lead them to try to self harm or attempt to commit suicide[33].

Custody officers also failed in several cases to complete pre release risk assessments before releasing the person from custody or did not complete them, leading to Rule 43 reports [34]by the coroner in two cases reviewed.

In some cases, including one where the police attended on a welfare visit[35] and several in custody[36], the person was interpreted as being well despite strong evidence that they were suicidal because, at the moment of meeting them, they were quiet and withdrawn rather

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29   Grade S meaning 'Standard Response' and that officers respond within an hour.

30   An issue in Case 10 and case 5.

31   For instance Case12 and 19.

32   For instance Case 21 and Case 50.

33   IPCC, Deaths in Custody Report An Examination of Cases 1998/9-2008/9 p.2.

34   The Coroner has legal power to write a report following an inquest. This is known as a 'report under rule 43' because the power comes from Rule 43 of the Coroners Rules 1988. S/he will do this when s/he feels that there is a risk of other deaths occurring in similar circumstances. The report is sent to the people or organisations who are in a position to take action to reduce this risk. They then must reply within 56 days to say what action they plan to take.

35   Case 30.

36   Cases in custody including Case 12, 25 and 31.

than aggressive. In other cases officers did not distinguish between the agitation of a terrified man in a state of delirium or behaving bizarrely (grunting incoherently, weeping and calling for help[37], stripped naked in another, or standing half-dressed in the middle of the road doing karate moves in another[38]) and acts of violence to a person. Even when there had been no actual force, except their own, to restrain the individual, officers saw the person as violent.

In Case 1 the coroner reported that 'the focus of attention both at the scene of restraint and in the police station on the risk of violence have masked the very real mental and physical health needs of the man in custody.'[39]

The police deal with situations involving violence, both on the street and in custody, as a regular part of their work and understandably violence is something they expect. However this can then be used to describe any form of resistance to them. This then turns into an unconscious bias that automatically links mental health and violence and indeed then reflects a prejudice that is still common among members of the public. The language used to describe the situation (from CCC onwards) is that of danger and violence when in fact there was, at the time, no indication that violence, (rather than resistance or agitation when the police approached) was involved. In several cases there was significant force used (including blows to the head, gunshot wounds and tasers) but the evidence is not clear as to whether alternative techniques would have produced less traumatic results[40].

In one case, for example, when the caller had said the person was 'kicking off and running out' the call taker recorded it as 'just gone berserk attacking everyone'.[41]The stereotyping of agitation and disorientation as violence appeared in the cases as particularly pronounced with men from African and African Caribbean or mixed raced heritage background[42].

The lack of understanding of mental health was also displayed in stigmatising attitudes to mental health issues. In several cases the Directorate of Professional Standards (DPS) review found that the person's concerns had not been taken seriously by CCC call takers or by a frontline police officer because of their known

mental health issues[43]. In one case of serious injury involving a woman with a previous hospital admission for mental illness there appears from evidence in the files to be a failure to grasp that a person who has just attempted suicide (and is hospitalised as a result of the seriousness of her wounds) is in distress and not just seeking attention[44].

There was broad consensus on the need for greater police awareness, knowledge and understanding from many people who gave evidence to the Commission, including service users, families and members of the public.

Service users responding to the online Commission survey[45] identified the need for greater knowledge and awareness of mental health issues as a major area for improvement. Fifty-six (56 percent) of those who described their experiences (many of which involved use of Section 136 of the Mental Health Act) said they thought MPS understanding of mental health issues was poor.

In particular, people raised issues of dignity and respect and the need for greater empathy and humanity to be shown, especially amongst frontline officers.

Service user: 'There should be specialist knowledge of mental health issues and adequate training to the police. They should never make us feel we are wasting their time. They should treat us with respect and dignity, not like criminals. They should listen to what we have to say rather than intimidate and laugh at our distress.'

Service user: 'Very poor. A complete lack of empathy and understanding. Their poor attitude towards me simply compounded my low self-esteem and did not help at all. I would never ask for their help (for mental health issues) again.'

37   As in Cases 10 and 12.

38   Case1.

39   DR Andrew Harris, Coroners' Rle 43 letter, 22 October 2012.

40   Case 35, case 10, case 11, case 40.

41   Case 6.

42   As found by the coroner in Case 1, also case 6 and (possibly) cases 35 and 11 (evidence is contested).

43   This was found in Case 10 and Case 3 as well as two service users who responded to the service user survey, carried out by Mind.

44   Case 47.

45   Results of the service user survey are detailed in Appendix 3 on page 72.

3. Frontline police lack of training in suicide prevention.

We found that there were varying, seemingly inconsistent ways of responding to people who were suicidal from the point of CCC contact to the deployment (or not) of officers to attend. This included a failure to detect or respond to indications that the person was at high risk. We had several cases of a welfare visit[46] to a person who had been reported as suicidal, or who had themselves rung to say they were suicidal. The police had withdrawn from the scene only for that person to proceed to end their life once the police had left.

The Commission found evidence that the police lacked adequate written guidance as to their options. There were cases where police were called to the scene of a likely suicide attempt and the person fell to their death. Although it is not possible to speculate whether police action could have prevented that outcome, the approach taken and the forces deployed differed widely in each case. In one case the officers in plain clothes took care to stand back rather than intervene and the bereaved family complained at the lack of action by the police at the scene[47]. In another, questions were raised in the review as to the absence of negotiators[48]. However in another case the police were praised for their speedy response[49].

We also noted from these cases the inadequacy of police guidance and procedures to deal with mental health issues. This includes a lack of clarity about the nature and extent of the role of the police in relation to welfare checks, little guidance on suicide prevention and inadequate coverage of mental health issues in SOPs[50]. The coroner in the inquest of Case16 called for a SOP on welfare visits.

In case 30 a woman jumped from her 7th floor flat after police attendance a half hour earlier. They attended following a frantic 999 call from her boyfriend, whom she had called stating her intention to die. The call taker recorded the details correctly. He said he was on his way to the flat. The woman admitted to police that she had terrifying thoughts but said, 'I am fine'. Police stayed at the door of her flat that was dark (she refused to put on the lights) and chatted for five minutes. They asked her if she would like an ambulance which she declined. They assessed her as calm and withdrawn but 'not aggressive or agitated'. Their witness statements demonstrate their distress at her death. Knowing that her boyfriend was on the way to reach her they did not, nonetheless, attempt to contact him or consider waiting for his arrival.

A clear majority (85%) of people who responded to the service user survey said there was a need for better training of staff. It was also identified by families as important. Some people in the public survey said that training must take place across the MPS, and not be regarded as just the remit or responsibility of a few people.

Sister: 'There's a tendency to talk about people with mental health or learning problems as though they're not human. But it's worth remembering that you're dealing with a human being. It's respect as well. The bottom line is assumptions are made about people with mental health [issues]. There's stigma attached and they're discriminated against; and unless you've had personal experience that's how you treat people. Also, I think people have a fear of people with mental health problems — that they're going to attack them. So I think a lot of training [is needed].'

Professional: '[What is needed is] specialist police units with several officers that deal with mental health with a clear structure with transparent ways of working, as opposed to one MH [mental health] liaison officer.'

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46 Welfare checks are made by police in some instances when requested by a social worker or others. These are made in respect of people who are considered vulnerable. The formal term is 'concern for safety.' Though most officers and staff use the term welfare check. In Case 16 the police were asked to conduct a welfare check following a cancelled Section 135 Assessment.

47 Case 18 The officers in question have defended their actions as considered — that to have approached the woman would had alarmed her.

48 As in Case 15.

49 Case 7 where the only criticism was the failure to link with previous calls on previous suicide attempts.

50 This is discussed further in Section 3 on page 31.

4. Failure of procedures to provide adequate care to vulnerable people in custody

In the cases we reviewed there were significant failings in the risk assessment processes. As it is based largely on self reporting, the initial risk assessment failed to capture the individual's mental health status or suicidality. This led to an inaccurate picture of the person's level of risk of suicide or of their mental health needs. This, in turn, meant that neither an appropriate adult nor a mental health professional was engaged, even if an FME was on hand to assess the person's general health or the capacity to be charged.

> 'There's a tick box rather than dialogue approach to assessment/information gathering. Dialogue can draw out the 'whys' for people's behaviour and can help officers better understand issues.' (CPN Nurse in custody suite)

We found evidence of practices in custody suites that fail to recognise, respond to or adjust their practices for vulnerable people suffering from mental health issues. While we found that procedures for putting people at risk under observation were properly followed, there were shortcomings in risk assessment procedures at reception; in the mental health expertise and standard of health care offered by Forensic Medical Examiners (FMEs)[51]; in the custody staff's understanding of the FME's assessments leading to a Rule 43 in the immigration cases 21 and 22; in decisions about referral to other services[52]; in the use of appropriate adults; and most particularly in the carrying out, or failure to carry out, pre-release assessments. This fact was the subject of criticisms in seven of the cases reviewed.

There were also failures by police officers, evidenced by the case review, to seek or use information from third parties, such as family members or friends, to inform risk assessments and decisions about release.

In case 21 a man (we call 'Mr X'), aged 18, (of Afghani heritage) was approached by officers on general patrol in the middle of the night. He had no means of 'identification' and was taken into custody for suspected immigration offences. He was released after 2 hours as immigration authorities said he was of no interest to them. He was later seen entering the River Thames where he drowned. Prior to contact with police, he had been taken to A&E with lacerations to his hand which the hospital stitched and bandaged. The psychiatrist had concluded he had drug induced Psychosis. The matter was investigated by the IPCC[53]. The report highlighted failings by the MPS during his time in detention. Such failures included the custody officer answering 'No' in response to questions such as 'Appears to be injured or unwell?' and 'Has indications of self harm.' This was the case even though the CCTV shows the man pointing to his bandaged wrist and despite the fact that he was dressed in a hospital gown.

No interpreter was called although English was not Mr X's first language. The custody officer who took over failed to read the custody record or to complete a Pre-Release Risk Assessment. He stated that Mr X was 'a bit mad' later explaining that this was in regards to thinking he was 'strange', rather than as an indication of mental health issues. The CCTV also appears to catch the custody officer making inappropriate remarks about Mr X, including his haircut, and did nothing to challenge other staff who made inappropriate remarks including when someone said 'Happy Halloween' as he was released.

Both police officers co-operated with the IPCC investigation and took full responsibility for their failings.

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51 As in Case 12,19 and 41.
52 Evidenced in cases 42 and 19 and 50.

53 IPCC Investigation.

A young man of Asian origin was arrested and taken to custody. A week earlier he attempted suicide by taking poison and was admitted to hospital. At the police station he was interviewed with an interpreter and an appropriate adult present. His carer was contacted to be the appropriate adult but was not available during the day. The custody staff were aware of his previous suicide attempt. He was listed as a vulnerable person on account of information (on the police database and from other police forces) regarding mental illness, self harm and suicide attempts and put on constant watch. A risk assessment was carried out. An FME attended and following a four minute interview decided that there was no cause for concern, he was fit to be detained and to be interviewed and there was no need for a medical review. He admitted the offence, a caution was administered and he was released from custody at 5.30pm after a day in custody. He said he would visit his brother. He was released without a risk assessment. He took his life the following day by setting himself alight in a quiet residential area. He died of his wounds.

A man had become ill with depression a year before his death. He became suicidal and was signed off work and treated by a home treatment team. A change in his medication precipitated an acute medical crisis and he made his way to London. He was discovered by police officers slumped over the steering wheel of this car, arrested for being drunk in charge of car and taken into custody.

Police statements state that he exhibited very bizarre behaviour — talking gibberish, body twitching, tongue poking out, primitive grunting noises, loud screeching, head and handcuffed hands banging violently on the caged area of van, licking counter in police station, excitable, manic but not aggressive. A risk assessment recorded that he saw a psychiatrist every two days, his previous suicidality and his current drugs regime and mental health diagnosis. He failed to provide a breath test because he was too unwell to breathe properly into the device and a decision was made to charge him with failure to provide a breath test. At the second visit after 8 hours in custody the FME, found him to be 'calm' and fit to be charged. He was then released from police custody without a pre release risk assessment.

After his release the man immediately phoned a friend several times in an agitated state to say he was going to stay at a hotel. He said he wanted company. Attempts by his friend to find him in the area failed. He was found later that evening having collapsed and died from a combination of alcohol and an overdose on two antidepressants.

His wife had contacted police about his disappearance the night before and expressed her anxiety because of his drink and current psychiatric problems. After his death she stated her upset because she was not informed of his release in time to alert friends in London to meet her husband on release from custody, in order to get him admitted to psychiatric hospital.

Sister: 'The police didn't care about [my brother]. They had a duty of care; and they did not fulfil that towards him o.k. They lied. They were careless. They basically didn't care about this human being who was suffering a severe mental crisis.'

Professionals in the public survey clearly recognised the importance of good custody arrangements with other agencies. One person said: 'Police custody is one of the first stages of the criminal justice system and an early stage where mental health problems can be identified and addressed in partnership with the police/CPS.' However, it was also noted that while there is some good practice, there is also wide variation. Responses from people with mental health issues, and their families also identified the need for more appropriate arrangements in custody including; 'mental health professionals should be on call to go to police stations if needed 24/7.'

5. Problems of interagency working

Significant problems of interagency working were evident at both operational and strategic or policy levels in numbers of the cases reviewed. There seemed at times to be boundary disputes, a lack of coordination and a sense of buck passing driven by the need to manage limited resources in some cases. While interagency working is not always easy and risks at boundaries between agencies always exist, it is clear from these cases that better, more standardised interagency planning, procedures and protocols could be used to mitigate risk of tragic outcomes. One example is the London Ambulance Service (LAS) protocol that does not respond to someone with a clear medical mental health crisis as an emergency if the police are present. It appears, from evidence gathered, to

be still too easy and too common for health, social care and police services to get into on-the-ground disputes about responsibility, instead of all parties ensuring a cooperative collaborative approach is maintained to put the person's welfare at the centre.

There are numbers of cases where the lack of communication between agencies or unnecessary gaps proved fatal. Of interest also were a series of near miss cases where this was also regularly found. In one case the medical staff communicated with police but also stood aside while the police restrained a person in hospital. He died following the restraint. There are serious questions as to the nature of the engagement between the police and mental health professionals. In another case there were failures in record keeping, risk assessing and communication between the MPS and social services which all contributed to a woman's death. In yet another case, it appears that the Approved Mental Health Professionals (AMHPs) consider that there was a lack of service provision by the MPS on the weekend; but the MPS believe it is the AMHPs who were unavailable. In one case it was the A&E who considered the MPS at fault for failure to use section 136 of the MHA, whereas the MPS were critical of the delays in getting a mental health assessment in the hospital. In case 26 the coroner criticised the lack of joint understanding between the police, SERCO and the prison authorities who were involved in transporting a suicidal man from police custody to prison. Information was not correctly recorded, passed on or properly assessed.

A 17 year old young man who had previously attempted suicide later committed suicide at home after having left the hospital. This occurred despite repeated efforts by social services and the hospital consultant to have him urgently assessed under the MHA and returned to the hospital under section. The police were called to attend, which they did. However, they waited for over an hour in the middle of a busy Friday night outside the place of assessment. The LAS kept downgrading the priority of their attendance; and the assessment had to be cancelled. A suggestion to convey him to hospital in a police car was refused by the senior officer as being contrary to the SOP. A further attempt by the AMHP the following morning failed as the police refused to attend. This was due to a mistake in recording the time of a previous welfare check. The young man ended his life at home that afternoon.

Had the LAS attended or had there been flexibility in the SOP this would not have occurred. In addition it was found that the police did not have enough information about the urgency of the situation because the information received at CCC was not passed on to them.

The father and mother believe that he was failed by both the police and the health services.

Key issues in other cases included:

- The use of police vans, rather than the LAS, to transport people in a mental health crisis. The failure of the LAS to attend on several occasions left the police no option but to transport a person who was very ill and agitated in a police van. In a case from 2011 that is yet to come to inquest, a man suffering from an acute mental health episode was restrained and taken to hospital by police after an ambulance had been called but had not arrived. He died subsequently.

- The problem of delays was compounded by problems in finding beds, leaving the police with a disturbed person in a police van for longer than was necessary. This occurred in numbers of cases not involving a death, which we found in the MPS files.

In case 43 a man was detained under Section 136 of MHA. Due to the complete lack of ambulances he was conveyed by police van to the mental health unit in the local hospital. Upon arrival he was refused entry to the unit despite the clear terms of the local protocol. It was said that the man was well known to an adjoining Borough's mental health team and that he should be conveyed there instead. When it became apparent that they were not going to gain admittance a decision was made to take him to the next mental health unit. Again because of a lack of ambulances he was conveyed in the police van. Once at the next unit there was a delay. The unit co-ordinator initially refused to accept the man because he was not found on the local streets and because he had an injury. After some gentle persuasion he was finally admitted. The police should not have been forced to do the transfer. Had hospital A wished the patient to be transferred they should have done it themselves.

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- **Poor coordination between the police and social services.** This sometimes involved confusion over leadership and tactics when a Section 135[54] warrant was to be implemented. There was a suggestion from some cases that AMHPs felt less able to coordinate the progress of Mental Health Act assessments and make the decisions necessary to prioritise the welfare of the service users when the police were in attendance. There are also issues with regard to coordinating the presence of AMHPs and police at Mental Health Act assessments, particularly out of hours (overnight and at weekends) when thinly staffed social services Emergency Duty Teams may need to respond.

- The lack of robust systems for the police to identify and refer vulnerable people at high risk but who are not offenders to appropriate multiagency services. In one case the multi agency risk assessment (MARAC) should have been used but was not, in another there was no multiagency system that could apply, pointing to the need for a new system. These cases are highlighted below.

Case 3 involved a person classified as a repeat caller. He had been identified as a vulnerable adult with mental health issues. He was treated as a nuisance caller, having made a series of 10 calls immediately prior to the tragedy. The CAD reported that police attendance was not required. This was justified on the basis that the caller was a repeat caller with mental health issues. The internal review of this case included the following critical comments: 'There was clearly a pattern of behaviour occurring over these five days that should have presented an opportunity for the MPS to support…his needs. With the extensive intelligence available to the MPS over a period of time, the MPS should have been looking at managing the risks and his vulnerability and looking to seek engagement with partners who have those skills to deal with people with mental health issues.'

In Case 9 a man of Asian origin came to the attention of the police because of reckless and criminal behaviour. He had mental health issues and was dependent on alcohol. He had suffered with severe depression following his mother's death.

The man was in touch with his local Community Mental Health Team (CMHT), but did not take medication reliably. He set fire to the house where his father lived. His father and another man died in the fire. Within three months prior to his father's death there were seven incidents where the police were called in relation to his erratic behaviour, violence and threats to his father; one incident involved accidentally starting a fire, another involved a fire on kitchen stove. At another time the son was found unconscious in the street. The police laid criminal charges for assault and theft against him in relation to some incidents, bail was given and conditions set that he stay away from home. The father was known to social services through the elderly care team; while the son was involved with mental health services.

The CIAT review findings in this case found that, while the police had responded adequately on each individual occasion there was a failure to understand the pattern of events and thus a failure to refer to MARAC and an inaccurate recording of risk.'

These issues were also mirrored by families in their evidence. People simply could not understand why agencies did not work together more effectively. Key issues identified by them were: unclear referral processes; tensions between agencies; and gaps in the knowledge of frontline police officers. The family of a man in one case tried many times to engage the police in referring him to other agencies. They believe that the double homicide which subsequently occurred could have been avoided had the police, NHS and social services communicated more effectively.

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54 Under s 135 an AMHP may seek a warrant from a magistrate to enter the premises of a person where they reasonably suspect that the person has been or is being ill treated, neglected or kept otherwise than under proper control or is unable to care from himself. The warrant is addressed to the police officer who may enter the premises and take the person with an AMHP to a place of safety.

Brother 'I raised my concerns with social services. As far as I can see there was no contact between police and social services. They waited until he hit the curb in a downward spiral, and there was no other way but upwards. There he couldn't go.'

Sister: 'The thing that was most upsetting was the breakdown, of a lack of liaison procedures between the police and [the mental health team] and Approved Mental Health Professionals.'

Ex-partner: 'It was appalling. I was there throughout the trial. The police were commended for their involvement; but really it started off with a lack of support from London ambulance, police, the hospital — all of the agencies.'

It was also recognised in the public survey, however, that the police service are having to mop up situations mental health and social services should be dealing with, and that with the cuts to public spending this was only likely to get worse. Several women in the public survey, made the point that crisis teams were very quick to refer to the police rather than going out to see a woman themselves, and some said that some police officers showed more care and were doing a better job than some mental health workers. This observation just points to how crucial it is that (particularly as public services are under increasing financial strain) an interagency, whole system and collaborative approach is promoted so that all parts of the system play their full part in reducing risks and bad outcomes for people with mental health issues.

6. The disproportionate use of force and restraint.

The tactics and behaviour used to restrain people with mental health issues is the most disturbing of our findings and one over which the police have the power to take complete control to improve their practice. The Commission examined several cases involving prolonged restraint by the police. It is at least questionable whether there was a need to take control with such force or in such numbers in any of the cases reviewed. In one case there was no evidence of any violence by the black man who was known to be mentally acutely unwell although his agitation in trying to get away from his situation and from those who wanted to contain him was evident. In another, also involving a man from a black community his fear and anger are alleged to have been exacerbated

when the police intervened with handcuffs and restraint in a hospital setting. His struggling included remarks against the police for treating him like a criminal.

In each case we examined there is little evidence that de-escalation techniques were used or that opportunities were taken at different stages for alternatives to be tried. In the case of one man from a BME community there are questions over the relations between the NHS staff and the police and whether communication between them took place effectively. The main issue is whether the police should have been engaged in a restraint and the length of time it took.

In case 6 there was one long period of restraint by hospital staff, a short restraint by police and a second police restraint of around 30 minutes. In total this involved 11 police officers in the restraint that took place in hospital. The man died soon after this process.

In a third case (case 10) there is some evidence of excessive force. The man was clearly seriously unwell and behaving wildly although not showing violence to any individual . There was a strike to the head which contributed to his collapse within minutes of being restrained and the coroner in the case found that the restraint had contributed to his death. In the case of ZH the Court of Appeal found that the young man had been subjected to inhuman and degrading treatment because of the nature and extent of the restraint. 'Police officers sometimes forget that their uniform is in itself a statement of control.' (Detective Inspector) In another two cases it has been alleged by family members that excessive force was used but there is not a legal finding on the issue at this stage.

In two cases reviewed (one involving death, the other serious injury) allegations of brutality by the police are being investigated[55]. In several of the cases reviewed tasers were used, although according to the police evidence, to no immediate effect. The MPS survey on Mental Health and the Police reported that in 2011-12 the deployment of tasers in 34% of the cases were linked with mental health in some way[56]. Given the controversial nature of the use of tasers on people with mental illness this is a matter of concern.

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55   Cases 35 and 36.

56   Officers logged related circumstances as mental health, emotional distress, suicidal/self harm or conditions such as bi-polar and psychosis. MPS Mental Health and the Police: understanding demand and incident management in the MPS (2013).

Other evidence

In addition we received evidence from service users that they had suffered from the police restraint in circumstances in which, in their views, restraint was unnecessary or at least disproportionate. It had been intimidating and counter-productive. Some said they were now scared of the police. Several people told us that they, or their family members, were detained and restrained by 7 or 8 police officers when they were unwell.

> Service user: 'They pinned me down and restrained me with male police. At the time I was having severe flashbacks of abuse I suffered as a child. I became more aggressive because they were reconstructing the abusive restraints I fear. Also I would of responded better to female officers. Please don't restrain me as when you are called to attend me it is usually when I am disturbed by horrific flashbacks of abuse. You scare me more.'

In evidence from interviews with service users[57], which included people from African Caribbean, Asian and mixed heritage, people complained about their treatment by the MPS. A key issue was use of excessive force or restraint. We were told that the police, who had some knowledge of their illness and were responding on that account, treated them as criminals. They were handcuffed (often unnecessarily in their view) and large numbers of police attended when there was not a credible threat of violence. This was also reported to us by INQUEST, whose casework and monitoring shows that a disproportionate number of those who die in police custody following the use of force are from black and minority ethnic communities (BAME). In 2011, 38% of all deaths in police custody were people from a BAME background[58]. Finally the IPCC reported in 2012 that having reviewed deaths in custody over a 10 year period that Black people, and those of Mixed ethnicity, formed a greater proportion of those restrained than they did of the entire sample, while the opposite was true of people from White European backgrounds. When the BME groups were combined for analysis, people from BME groups were significantly more likely to be restrained than people from White European backgrounds[59].

The use of handcuffs was also raised in meetings with families, with SLAM and a group of approved mental health professionals and section 136 suite multidisciplinary staff, who expressed the view that people usually arrived at hospital or section 136 suites in handcuffs, when it was not always necessary. The degree of injury was very worrying. Service users can become angry and upset about it and remain so. A psychiatrist spoke of an elderly service user who is still in hospital and continues to ask, in distress, 'why did they treat me that way?'

We received anecdotal evidence that race is at the very least an aggravating factor when young black men are involved. One man of mixed heritage described two separate experiences in Brixton in which 4-5 police officers turned up to question him on the street. He describes the experience as very threatening and intimidating. He said the police were agitated and he felt they were prepared to use force as necessary. 'But I stayed calm.' On each occasion he said there was no evidence of an offence taking place.

In one case, involving a man who was of mixed heritage, the jury found[60] an unsuitable level of force, an unnecessary length of restraint, an absence of leadership, unnecessary body weight placed on him and no assessment of his condition prior to him becoming unconscious. They also stated that it was questionable whether police guidelines and/or training on restraint and positional asphyxia were sufficient or followed.

7. Discriminatory attitudes and behaviour

Given the ethnicity of the population of London the inquiry found that a disproportionate percentage of black people and people from minority ethnic groups died in circumstances where the police have been, to some degree, at fault[61].

As stated previously, restraint is a particularly concerning issue in this context, seemingly compounded by stereotyped attitudes to race and mental health issues. There are four cases where a man died after, or during, a

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57 Focus group meeting with residents of Penrose Housing Association, November 2012.

58 INQUEST Briefing to the Commission, March 2013.

59 Deaths in or following police custody: An examination of the cases 1998/99 — 2008/09, IPCC, 27.

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60 Reference to jury's findings in Coroner's Rule 43 report 22 October.

61 Of the 50 cases, 11 involved people from black African or African- Caribbean communities; and 12 involved people known to be from other minority ethnic groups (including four individuals from other white non- English speaking backgrounds and eight from Asian or Arabic backgrounds). There were 29 white people. Two of the five cases involving 'serious injury' involved the restraint of black men. Of the cases of death where in the view of the Commission the most significant errors appear to have been found the disproportionality on grounds of race/ethnicity is greater (60% are from those groups). The 2011 Census states the diversity of London is characterised by 60% White, 13% Black, 19% Asian and 3.4% from Other Ethnic Groups.

prolonged period of restraint; two of these cases involved a black or mixed race man; two cases involved white men. In the first two cases there was a series of particularly significant failings by the police.

There are two separate cases[62], from those the commission reviewed, where the police investigated alleged immigration offences, which proved to be groundless. Both individuals (a Chinese woman and an Afghani man) were arrested and taken into custody. Each committed suicide immediately after leaving police custody. In both cases dismissive, uncaring and racist attitudes were shown towards a person in evident mental distress. In one case the police proceeded without an interpreter despite acknowledging that one was needed and the FME called her 'obtuse' when she was confused and distressed.

There are six cases where a homicide occurred. In two cases the perpetrator and victim were white Caucasian, in two cases they were black; and in two cases the perpetrator and victim were Asian. In each of these cases it is possible to point at some levels of system failures between the police and mental health services. In three instances, all involving people from ethnic minority or black individuals, the police did not act promptly enough either to identify, respond or to alert mental health services or other agencies of the escalating mental health crisis, or they failed to appreciate the risk because of failure to link past encounters with the police involving mental health crises.

In Case 11 involving one black man one family member said the police displayed racist attitudes, both in their use of force, CS gas, batons, numbers of officers deployed (6-10) and in their language ('calling him a nigger.') Although one example of discriminatory behaviour is one too many, there were cases, for example one involving an Asian man where the view of the family was very different; 'No sniff of racism. Categorically no. I've never experienced it and I didn't experience it in relation to my father and my brother.'

In the public survey, there was a view that people with mental health issues from black and minority ethnic communities are treated differently to others.

> Professional: 'Young black people expressed frustration that the police often view them through a filter and thus treat them as a perpetrator, regardless of whether they were the victim. This is important as it can directly reduce any help-seeking behaviour and actually creates barriers.'
>
> Family/friend/advocate: 'Do not treat black people or foreigners with MH needs differently than others, [I have] also seen this.'

Issues of diversity and police behaviour are still heavily contested. However, throughout the Commission's discussions, there is continued discussion and belief that the MPS has not fully embraced criticisms that it operates in ways which discriminate against people from black and minority ethnic communities.

The information from our cases provides relevant, but not definitive evidence of biased attitudes held by some members of the MPS. Other evidence informing this review (conversations with families, discussions with professionals) points to anxiety, unease and scepticism that the MPS operates in a fair manner with people from communities of diversity. This continues to compromise the MPS's ability to work constructively with communities to increase public safety and reduce crime as distrust and suspicion of the MPS continues to taint public relations.

8. Failures in operational learning

Each of the events we have reviewed led to an IPCC investigation or an internal MPS investigation by the Directorate of Professional Standards and on occasions to a Coroner's Rule 43 recommendations after an inquest. In addition, there have been thematic reports on the MPS from Her Majesty's Inspectorate of Constabulary (HMIC), IPCC thematic reports and reports from the leading charity, INQUEST.

There are instances of changes to practice being implemented as a direct result of the reviews of deaths in the MPS and HMIC reports; for instance improvements to pre-release risk assessment forms used in custody suites, Improvements in domestic violence procedures, protocols with the LAS, improved procedures for logging vulnerable people on IT systems. However, there was no evidence, until recently, of MPS taking a systematic approach to learning the lessons from these reports by identifying common themes or exploring underlying issues.

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62   Cases 21 and 22.

The MPS has recently identified 176 individual recommendations from all these sources[63], and has admitted there is limited evidence of action having been taken to implement them. This undermines public confidence in the investigations and the need for the MPS to change as a result of these findings. In cases where action had been taken to implement recommendations by changes to procedures, there had been insufficient attempt to bring those to the attention of officers on the frontline, so the problem persisted.

> The case of Mr Sylvester[64] (1999) identified many of the same issues which are also reflected in one of the cases we reviewed. Mr Sylvester also died following police restraint. Following his death the MPS reviewed its procedures and training with regard to restraint and introduced new techniques on restraint and police procedures for dealing with people suffering from mental illness into its officer safety training. Yet deaths after restraint have continued[65] in the MPS and seven years later, there was another death in similar circumstances.

We also noted examples of poor practice in CCC and custody suites which recurred over the five year period of our review. The Commission welcomes the fact that the MPS is now beginning to taking a more systematic approach to this issue.

However alongside the correction of poor practice there needs to be the spread of good practice that mitigate against deaths occurring. While we found numerous examples of good practice during this inquiry there was little evidence of attempts by the MPS to record or to spread good practice, and certainly no system for doing so regularly. At a meeting with Borough Mental Health Liaison Officers some officers expressed their frustration at the isolation they felt about not sharing the problems and the solutions across boroughs. It is not sufficient, however, for good practice to be isolated and ad hoc. Good practice must be shared, used and continually reviewed. Changes in practice, as we note throughout this report, require systemic responses which can, in turn, lead to ingrained and continuing development and improvement to deliver a professional standard of service to the people of London.

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63 The review of Mental Health themed recommendations over the last decade was an internal MPS review done for Commander Jones and the Diamond Group in 2012.

64 Roger Sylvester died in January 1999 following police restraint at St. Ann's Psychiatric Hospital. In October 2003 an inquest jury ruled that he was unlawfully killed. The verdict was subject to Judicial Review in November 2004, and an open verdict was substituted. The MPS undertook its own review of the Sylvester case in September 2004.

65 For instance the death of Andrew Jordan in 2006.

9. A disconnect between policy and practice

Problems were evident in some cases in respect to the poor adherence to existing SOPs and guidance, particularly around risk assessments and procedures for section 135[66] and poor recording of information.

There were a number of situations in which police failed to follow the correct procedures and policies or did not know about them;

> In Case 9 the Directorate of Professional Standards (DPS) report listed a catalogue of failings: failure to risk assess adequately; failure to record information adequately; failure to link previous events in order to access vulnerability; and failure to use the existing multi agency risk assessment (MARAC) system for referral to multiagency working.

> In the Case 26 the DPS found a series of procedural mistakes in relation to risk assessments and disregard for mental illness occurred in transferring him, an offender with a significant mental health history, to prison contributed directly to his death.

In particular, the DPS reviews found in several cases that standard operating procedures , specifically the Mental Health SOP, the Safeguarding SOP, the Custody SOP and the Domestic Violence SOP were not followed in different cases.

10. The internal MPS culture

Three of the cases reviewed involved the suicide of a serving member of the MPS, one involved a retired officer. The parents of two of the serving officers are critical of the MPS for its failure, in their view, to take care of the mental wellbeing of their child. In both cases they felt there was clear evidence of mental health problems that were not sufficiently addressed. In one of these cases the family stressed the failure of the MPS' duty of care in safeguarding the interests and reducing harm to one of its own officers. They highlighted the 'pull your socks up' culture within the MPS as a key issue.

In case 17 the woman made allegations of homophobic bullying against five officers named in her suicide note. We were told that she was promised ongoing support

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66 Cases 23, 24 and 28.

for a mental health condition when she was recruited, but that this was not provided. Her mother told us of observing her daughter's deteriorating health due to the stress of the bullying culture during her work with the MPS. Her colleagues gave similar evidence of her stress and anxieties and about unfair treatment to the MPS after her death.

Mother: 'The psychological awareness within the police force is nil; and why I'm here today is because my daughter, who did have mental health issues, was a Police Community Support Officer (PCSO), prior to doing her training...She did very well as a PCSO and then she decided she would go on to train. I was very concerned about the pressures. But she had a very thorough psychiatric report which got sent to the police. She went through all the hoops and she got accepted. That was the last I heard of any mental care for my daughter. What happened was that when my daughter died, the police and liaison officer came round; and they were really scared that I would go to the press. Because in my daughter's suicide note she named five police officers who had bullied her. Was that ever followed up? I would like to have heard something about what happened.

'There was one point where she said, "Mum I think I've got to stop..." She was then spiralling down into her depression. She was very strong in a way to get right through to the end and the passing out parade, which she actually didn't attend...We assumed that my daughter would have some form of support. But the baseline is that didn't happen. The thing I was left with and still am left with is; I wonder how many young people have gone in and suffered the way my daughter did. After [my daughter's death], I wonder what changed. I bet nothing changed.'

11. Poor record keeping

It was apparent from the review that the MPS has not been rigorous or systematic in collecting and storing case information, including where a person has died or suffered serious injury after police contact. This poor, non-systematic approach has led to a lack of co-ordination and follow-up. Due to this, the MPS does not have a base of evidence from which to identify trends that give rise for concern. It is also *prima facie* evidence of the importance with which the MPS holds its duties to those with mental health challenges that come into contact with its officers. If the old adage 'what gets measured

gets managed' is true, then there is a clear lack of management in this area which should be of concern at the very top of the MPS leadership.

Further evidence relates to the Commission's own brief regarding this review. Prior to beginning its work, the Commission was reliably informed that the number of cases which came within its remit totalled 11. This proved to be a woeful underestimate.

Mistakes in record-keeping or the failure to check records are evident in the cases, which meant that opportunities were missed. Mid-screen or location based comments[67] in relation to child protection were not linked to criminal incident or CAD reports. In other cases mistakes were made as to the person's name or their location, and forms were not filled in accurately — contributing directly in some cases to the outcome of death or injury[68].

12. Failure to communicate with families

In the course of its work, the Commission has heard from many people who wanted and needed to tell their stories. Families spoke of their shock, bereavement, bewilderment, anger and sadness at being caught up in a system which in some instances regarded them as an irrelevance, in others as a nuisance, and, in some circumstances, with palpable hostility. People talked about failures to provide them with information; about the lack of co-ordination between the MPS and other agencies (specifically the NHS); and about inconsistencies of approach.

Failure to communicate well with families was frequently mentioned. This was sometimes based on the need to maintain confidentiality; but also related to a failure to provide basic information. INQUEST, which works closely with families, said that often families lack information from the outset about what's happening once a death of a loved one has occurred; and that this is compounded by a lack of information about where to go for specialist advice and support. Family liaison officers (FLOs) [69] are meant to provide a bridge to families; and their involvement was raised by some families. In one case this was felt to be helpful; in another it was felt that the liaison officers did not give the family enough information; and

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67 These are comments which are uploaded onto the MPS system, based on information supplied by officers dealing with a particular address. The comments highlight crucial issues of relevance; and should be checked when officers are responding to calls.

68 Instances include the cases 16,19 ,44,18 and 37.

69 The role of a family liaison officer is a specialist investigative function involving the day-to-day management of communication with the family. The FLO acts as a conduit between the family and the enquiry team. FLOs log all contact with the family to enable the relationship to be monitored. The role is carried out by police officers.

in another the independence of the family liaison officer role was questioned, including whether this should have been a person employed by the police.

Even when people were attempting to engage with existing systems and processes in relation to their family members, it was often not easy to communicate with the appropriate agency and with the police. One woman, who is the appropriate adult for her sister, has a contact carer protocol in place with the local mental health trust.

The protocol works well in the instances where hospital staff are aware of and use it, however, attempts to work with the police have not always been successful. In her experience, she has had problems in getting information from the police when her sister was arrested. Though she has found that custody officers are better at managing the relationship, than frontline officers, 'who are not interested in involving carers.'

> Mother: They shouldn't have handcuffed him. He was a voluntary patient; and we left with the understanding that anytime he wanted to leave, he could leave, and they would call me. Well, they said they couldn't find my phone number, which was on several files.

The Commission believes there is a strong case for considering families' needs, as has been called for by INQUEST[70] and the Independent Advisory Panel on Deaths in Custody.[71] This includes provision of information for families, like that available through INQUEST, which details what can be expected when families encounter the inquest process. More of this type of information should also be available through the police and the NHS.

70 Inquest (2011) The Inquest handbook, A guide for bereaved families, friends and their advisors.

71 http://iapdeathsincustody.independent.gov.uk/news/family-liaison-common-standards-and-principles/

Section 3
Areas for Action

Based on the evidence reviewed, the Commission's aim was to identify specific areas for action to improve the MPS delivery of a professional service to the public. Three key themes emerge:

1. Leadership
   - Strategic and operational accountability
   - Changing MPS attitudes and culture
   - Operational learning
   - Understanding vulnerability
   - Race and ethnicity

2. On the frontline
   - Training and guidance
   - Information, data and records
   - Custody; and

3. Working together: Interagency working

1. Leadership

Mental health is a core part of day-to-day MPS business. However, we have found it is not always recognised as such. It is not only a job for the police service, however one police officer noted: 'We're the ones left holding the baby.'

This, therefore, requires an MPS response which is both strategic and operational, equally applicable to street encounters, custody and CC responses. It requires leadership and corporate accountability which demonstrate how the MPS is meeting its duty to protect life. It has to be led from the top of the organisation and permeate through to the officers on the frontline.

It should be a joint approach with partners and involve work with families and service users; embodying and embedding an understanding of mental health as part of the day-to-day expectations of how police officers and staff carry out their roles.

In regards to leaderships and corporate accountability key considerations are:

1.1 Strategic and operational accountability

The MPS strategy for London (One Met Model) will drive and shape the strategic direction of policing in London. The MPS Commissioner is responsible for its implementation. This organisational change programme covers five key areas: neighbourhood policing, Pan London services, control infrastructure, Met HQ and support services. It aims to deliver a professional approach and standards to govern London's policing to 2016. The main drivers are crime reduction, improved performance in frontline and back office functions and more efficient use of resources. At the time of writing work to develop the One Met Model was continuing. It is the Commission's understanding that, during the course of this inquiry, the strategy does now make reference to adults, as either victims, witnesses or suspects, who may be vulnerable or at risk because of mental health issues. This is welcome. The Commission therefore believes that MPS implementation of the strategy must appropriately reflect the impact of mental health on all areas of police business.

> **Recommendation 1:** Implementation of the One Met Model for policing in London should reflect, at all levels, in day to day police business, the impact of mental health for vulnerable adults who are at risk.

Action must start with the MPS Commissioner to lead and drive change in mental health; the MPS Management Board to performance manage it; and continuing work by the MPS Mental Health Team to coordinate delivery. Also necessary is the need for concerted work at borough and local neighbourhood policing levels, with clear responsibilities set out for each.

At borough level, this involves setting out clear roles and responsibilities for mental health liaison officers (MHLOs) and enhancing the role of local policing through safer neighbourhood teams. It also means ensuring they are part of a transparent accountability framework back into MPS headquarters. This will promote opportunities for learning and sharing information and good practice across London.

The Commission is aware of internal strategic structures that have been recently established or re-vamped, such as the Mental Health Programme Board and Diamond Group now working with the London Mental Health Partnership Board. We welcome this work. We believe the emphasis should continue to be on strategy and operations, with greater ownership throughout the MPS, to promote continuing delivery of a professional standard of service to the public.

The strategic context for the MPS' work is through the Mayor's Office for Policing and Crime (MOPAC) priorities for London.[72] MOPAC formally oversees the police service in London. Its current priorities are to: (1) reduce crime (2) improve public confidence in the police and (3) cut costs. It has set 20% targets for improvement in each of these three areas.

The MPS' Diversity and Citizen Focus Directorate (DCFD) has identified a number of areas to drive improvements in public confidence.[73] [74] These include: increasing its effectiveness in dealing with crime (including hate crime); engaging with communities; improving victim satisfaction and promoting fair treatment.

The Commission believes there should be transparent alignment between MOPAC strategic priorities (improving confidence) and MPS operational priorities (public engagement, victim satisfaction and fair treatment) which acknowledges the impact of mental health in day to day MPS business. Addressing issues of mental health can contribute to improved public confidence and satisfaction; help the MPS to achieve its MOPAC targets and result in fairer treatment of people with mental health issues.

> **Recommendation 2:** The MPS should include a mental health-specific indicator as part of performance measurement of the 20% Mayor's Office for Policing and Crime (MOPAC) target for improving public confidence.

> **Recommendation 3:** MOPAC should hold the MPS to account for identification and delivery of a mental health specific performance indicator within the 20% MOPAC target.

In the One Met Model neighbourhood policing is identified as the 'foundation of frontline policing.' The work will see 2,000 officers re-aligned into Safer Neighbourhood Teams. Neighbourhood policing will build on the work of the MPS' local policing model, and progress initiatives under a new structure — Basic Command Units (BCUs). Together these structures will share resources and activities relating to custody, intelligence provision, resource management and performance at local and borough

levels. Evidence from our cases and discussions with police officers and others shows that neighbourhood teams are an important link with local communities.

> Professional: 'When policing and health and social care agencies work together, particularly in the context of community support, positive changes can be made.'

Mental health liaison officers (MHLOs)

The current MPS mental health SOP sets out an approach for liaison and organisational responses in dealing with mental health related incidents. It identifies the important role of mental health liaison officers in relation to grip and pace[75] and territorial policing. MHLOs play a key role both in internal MPS coordination, and in maintaining relationships with external agencies. In its response to the coroner in one case the MPS underlined the importance of its role in implementing the Rule 43 recommendations[76].

However, the Commission's understanding is that the One Met Model does not include specific provision for the role of MHLOs.

MHLOs outlined their multi-faceted role at an MPS training day in November 2012. It includes coordination with other agencies, including crisis and case management; complaint management; dispute resolution and risk management. MHLOs do not receive training for the role. In a brief survey for this inquiry[77], only 12% of borough MHLOs agreed their training effectively prepared them to work with individuals with mental health needs.

We learned that there should be one MHLO per borough, however not all boroughs have an identified lead. Some boroughs had a full time officer and some combine the work with numerous other roles. Therefore links with partners are varied. Some MHLO posts have been lost in the development of the MPS local policing model (LPM).

The Commission believes the MHLO role requires a standardised approach across the MPS. It should be a full-time job in its own right, with clear roles and responsibilities

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72 Mayor's Office for Policing And Crime (MOPAC) Police and Crime Plan 2013-2016.

73 Diversity and Citizen Focus Directorate, Achieving Equality, Improving Confidence, (2012).

74 MPS Diversity Health Check (June 2012).

75 An MPS response function which denotes gripping (i.e. picking up) incidents and determining the pace of how and when they are progressed.

76 Letter to Dr Andrew Harris Coroner, from DAC Gallan 20 December 2012 ,

77 MPS Corporate Development Evidence & Performance (2013) *Mental Health and the Police: Understanding demand and incident management in the Metropolitan Police Service.*

and provision for training and continuing professional development. The role should also be developed in liaison with NHS and other agencies.

It is anticipated that the MHLO role may be replaced by several or fewer 'experts' at area levels, though this is far from clear or assured in current discussions. It is yet to be determined whether fewer MHLOs can embed sufficient expertise to enable frontline officers to have access to the information and intelligence they need on a daily basis.

The Commission is aware of the MPS's need to rationalise resources in a time of financial constraint. However, this must be done in a context and with a consistency which recognises and addresses need. Needs assessment data sets from NHS London indicate rising demand for mental health and other services in respect of vulnerable people. This will vary across London. One option may be to concentrate resources where highest need has been demonstrated. Our evidence indicates that boroughs with high crime incidents and population densities (for example, Lambeth, Camden, Southwark, Wandsworth)[78] also receive the most mental health related calls.

MHLOs can and do play a significant role at local level to improve MPS engagement with other agencies. This expertise should be strengthened, retained and based on assessed needs in a given area. The provision should be adequate for the task required.

> **Recommendation 4:** The Mental Health Liaison Officer (MHLO) role should be full time to at least co-terminous levels with mental health trusts and supported by expert teams based on assessment of local needs.
>
> The MHLO role should have explicit and accountable links with external agencies, including the NHS, Local Authorities and the voluntary sector.
>
> The MHLO role should be integrated and supported throughout the MPS, including with frontline police officers and neighbourhood teams.
>
> The MHLO role should be operationally accountable at senior management level; and should include provision for continuing professional development.

1.2 Changing MPS attitudes and culture

The police duties under the Human Rights Act[79] include a positive obligation under Article 2 to protect life, where there is a real and immediate risk of harm, but also an Article 3 duty to prevent torture, or inhuman or degrading treatment to those in their care or under their control[80]. This is reinforced by the Equality Act which legislates against discrimination on grounds including race, gender and disability (people encountered by the police in an acute mental crisis are most likely to be disabled within the terms of the Equality Act). There is also a duty to make reasonable adjustments in the exercise of police functions to disabled people. Furthermore, as a public sector agency the MPS has a duty to promote equality on grounds of disability and race under the Public Sector Equality Duty. Recognising and promoting equality for people with mental health issues is thus a legal requirement of the police service.

Service users and carers who have complaints about the police have said that a major problem for them is that they felt criminalised[81] They were treated in an unnecessarily heavy handed manner when they were in a medical crisis and taken to hospital. This was, they thought, part of the stigma they faced on account of their mental illness. In the public survey the majority rated their experience as negative or very negative (60 %); while more than a third (37 %) rated the experience as positive or neutral. More than half of respondents felt the police did not understand the mental health issues involved (59 %) and did not offer appropriate care and support (52 %). A significant number (53 %) felt that overall their mental health needs were not met.

With regard to communication during the experience with the police, nearly two thirds felt they did not receive enough information about what was happening (65 %) and that the police did not clearly communicate the situation and actions (62 %). Conversely, just over a third said communications were clear and enough information was provided.

This is frightening for people. Insensitive responses by the police can exacerbate their condition and lead to lasting fear and resentment of the police. In some cases

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78   Only Lambeth, Southwark and Camden have a dedicated MHLO. They attend local meetings on a regular basis with AMHPs/ Ward /Adult service managers and others.

79   Human Rights Guidance for Police Authorities (ACPO 2009).

80   Circumstances in which a mentally ill individual was detained in police custody under s 136 were held to be a breach of Article 3 in MS v UK 24527/08 (2012) ECHR 804,

81   This was evidenced in the Mental Health and the Metropolitan Police service user survey, November/December 2012, the MPA (2005) Joint Review Policing and Mental Health and the Independent Commission on Mental Health and Policing (2013), Online Survey, The Social Innovation Partnership and Wazoku.

cited to us, involving black or Asian young men, it has compounded anger at previous treatment they consider to have been racist. To a large extent this arises because police lack sufficient information about the individual's mental health (which may be due to faults in information management) and there may be no mental health professional available (which raises issues of interagency coordination).

Recognising and promoting equality for people with mental health issues, and protecting their rights not to be subjected to stigma and discrimination, is a fundamental concern for the police service and other public sector agencies. The MPS Diversity Health Check sets out what it considers professional standards for the MPS in respect of public complaints 'that require development.' They include 'making more information and analysis on allegations of discrimination publicly available and regularly reported to the Professional Standards and Equalities Board.'[82]

Some police we interviewed said that there's a view amongst some officers that response to mental health issues is not a legitimate part of their work; and that their primary role is to fight crime. It needs to be made clear that the duty of the police to protect the public clearly involves wider duties to protect life and this applies equally to people with mental health problems.

The MPS approach to handling issues of domestic violence demonstrates how the right structures, systems and resources can change a culture as well as deliver an effective service. The Community Safety Unit has a small team of dedicated staff who receive special training in community relations, including domestic violence. Their training occurs over one week. They are responsible for handling domestic violence cases, assisting and advising victims, ensuring their safety and investigating and prosecuting criminal activity. They provide ongoing community support and referral to other sources of emotional and practical support such as victim services, advocacy support and other partner organisations. They work closely with specialist non- police advisors to assist with other related issues you may have such as housing, injunctions, counselling or financial advice. The MARAC multiagency work is part of their remit.

Recommendation 5: The MPS Commissioner should take personal responsibility for devising and implementing a strategy to ensure that the culture and working practices of the MPS demonstrably promote equality in relation to those with mental health conditions. This should include devising a strategy with key milestones and providing annual reports on progressing this strategy. This report should also detail complaints concerning the treatment of people with mental health conditions and action taken to address them.

1.3 Operational learning

We found the MPS has not shown due diligence in acting on individual recommendations from the IPCC or coroner's Inquests and for monitoring their implementation. Analysis of what went wrong in any single case is often superficial and what lies behind the recommendation seldom explored. Operational learning may simply consist of a notice sent out on the intranet with no examination of whether it is seen, read or heeded, by officers. Several MPS staff members said there is a view within the MPS that 'we have fixed the problem' without acknowledging that without continuing monitoring, review, and action where needed, it will inevitably resurface.

We have seen MPS internal Critical Incident Advisory Team (CIAT) and DPS reports, which take an in depth look at what has gone wrong in an individual case. However, there is no or poor connectivity with day-to-day policing. Frontline officers and custody sergeants have limited opportunities/accessibility for making use of the learning identified. In addition, linkage through a feedback loop to key areas (e.g. CCC, MHLOs, Diversity Directorate, Grip & Pace, Territorial Policing) is ad hoc or non-existent.

The failure of the MPS to operate as a learning organisation is a misuse of public resources. It also reflects badly on the MPS as a professional service.

In the Commission's view, this is the responsibility of MPS leaders. We understand that the MPS now has a plan to unify all operational learning. We were told that all scrutiny of the recommendations of external bodies is to be more searching to identify areas where practice must change. The aim is to form action plans around the recommendations of external bodies, including this report, and to have an inspection team to visit boroughs and escalate responsibility to an ACPO lead (in this case the mental health lead) relevant to the theme. Ultimate

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82   MPS Diversity Health Check Summary and Recommendations (June 2012).

accountability would be to the Commander with the ACPO lead for mental health and not lie within individual business groups. This is being taken forward during the time of our work on this report. We welcome this approach.

However, the Commission does not think this goes far enough. In our experience the external reviews, especially by the IPCC, have been less searching than internal CIAT reviews. Therefore it is essential that the same process be applied to all internal CIAT reviews and reports. Lessons can be learned and these need to be captured and taken seriously by the organisation.

Recommendation 6: The MPS needs to implement an organisational learning strategy in order to give lasting effect to the recommendations of external bodies, and the key findings of internal reviews for any major incident with a mental health component. This strategy should include a named lead and clearly defined timeframe for implementation and review, ensuring that responsibility for the implementation process resides at Commander level and not within each business group.

Operational Learning: Improving work with service users and families

Evidence from bereaved families pointed to the need for better interaction between frontline officers with them. Though some families reported good interactions with the police; others felt frontline police officers should show more empathy and awareness; and should try harder to engage with them. People clearly understand that the police have a difficult job to do; but views expressed to the Commission by some, were that in difficult situations, the default mode for police officers was to behave aggressively.

Some family members said they lacked information and found themselves involved in a system they did not understand, nor were helped to sufficiently navigate. INQUEST said police should think about how they can involve family members, who may be able to help when they are at the scene. Some people told us they regretted ringing the police, because of the events that were set in place.

Cases have revealed some dissatisfaction from the families of the bereaved that the police failed to involve them more actively when they were engaging with their family member who later died.

Bereaved families identified a number of areas whereby improvements could be made in how the MPS interacts with them. This included: a view that family liaison officers should be more impartial or independent of the police; that they should be able to provide more information; and that greater empathy and humanity should be shown.

The broader issue of the role of families and carers is an important area for the police to consider when dealing with people who have physical or mental health problems. We believe that improvements should be made in how the MPS engages with families and carers, provides information (within the bounds of confidentiality), and keeps them updated about developments; as well as in valuing information and intelligence which often, only they are able to provide. Our evidence from people who responded to our surveys shows that this can pay dividends, not only for the families, but by also helping to increase confidence and satisfaction with the MPS.

Service user: 'Last year I attempted suicide for the second time. My Mum did not know where I had gone and called the police the next morning. They helped trace me, took my Mum to the hospital and helped explain the situation in an understandable way. The policeman also spoke to me and although slightly lacking on information about mental health were kind and compassionate. I will always be grateful to the officers for helping me and most importantly my Mum through such a difficult situation.'

People's stories count; and some of the most powerful evidence to this Commission came when families told us their stories. They told us they wanted those experiences to lead to improvement and change where necessary.

Operational Learning: Mental wellbeing in the workforce

Frontline police officers are at the coalface and are the public face of policing. They face difficult challenges on a daily basis and they should be better supported in their work that relates to mental health issues. It was reported to us by police that mental health is not well enough managed as an employment issue. To admit having mental health issues would be contrary to the image of the police as strong and capable. Included in our sample of cases are instances where police officers have committed suicide. Our challenge to the MPS is to

question how the organisation addresses the issue of safeguarding in relation to its own staff, as well as to the public in the service it provides.

> Mother of police officer who committed suicide: 'I'd like to stress the duty of care. What about another young person? If I can make a difference for another young person, I'm happy.'

Due care and attention must be paid to the mental wellbeing of police officers and staff. In the Commission's view this should be part of the basic commitment of a modern and professional police service, which aims to be a good employer.

> **Recommendation 7:** The MPS should ensure that personal issues of mental health and wellbeing are incorporated into staff induction, and ongoing mental health awareness training.
>
> The MPS should ensure that processes for debriefing and supervision enable police officers and staff to discuss issues of concern and stress which may relate to their own mental wellbeing.
>
> The MPS should ensure that occupational health policies and procedures enable all frontline staff to access appropriate mental health support, without recourse to stigma or discrimination, if a need is identified.

1.4 Understanding vulnerability

Changing culture and attitudes requires the MPS to better understand vulnerability. Existing guidance[83] on MPS practice recognises the complexity and the impact of policing in a context of vulnerability.

This should be strengthened to reflect changing and multiple vulnerabilities and to ensure front line police officers are equipped to understand and make the right decision in the right context.

The Commission is also aware that use of the term 'vulnerable' is undergoing a shift in language and concept, as in pan London safeguarding procedures[84] towards 'adults at risk.' We also acknowledge that the term vulnerable is a contested one in social care. Our use in this context is to promote a wider understanding within the MPS about the need for greater awareness, more cohesion and the development of appropriate working practices for identifying and dealing effectively with adults who are at risk.

The work begun through the MPS Diamond Group during the course of this inquiry acknowledges the need for the MPS to improve its response to vulnerable people. People can be vulnerable for many reasons — as a result of mental health issues; through domestic or sexual violence; because of issues of bias; or because of issues of alcohol or drug misuse. They may be vulnerable as victims, as witnesses, as perpetrators or as police officers. This means the MPS response to vulnerability must, at its core, deliver good practice from the top of the organisation (MPS Commissioner and Management Board) through to the officer on the ground.

This will involve re-aligning of the MPS culture, with a view to providing a more subtle, humane and effective response to service users. This can give officers permission to engage with a disturbed person in a non confrontational way.

Proposed MPS vulnerability training for new recruits is therefore a step in the right direction. As well as mental health, the training will cover issues of safeguarding, missing persons, domestic violence and children and could operate to both link the vulnerabilities and address the stigmatising impact of mental health issues. The Commission is also aware of other good practice in policing with regard to vulnerability.[85]

Training is part of the solution, as are attention to attitudes and behaviours; procedures and processes; systems and protocols; relationships and responses.[86] These elements are necessary for delivering a professional public service in which attitudes and culture promote rather than hinder good practice.

However, the Commission also sees a potential risk in this approach. Vulnerability training must not take the place of particular training on mental health which, for

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83   Joint ACPO/NPIA/DH guidance (2010) 'Responding to people with mental ill-health or learning disabilities;' MPS (2011) Policing Mental Health SOP.

84   Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, http://www.scie.org.uk/publications/ataglance/ataglance44.asp One of the aims of this work is to align terminology regarding adults at risk between the MPS, NHS and social care.

85   See for example Leicestershire Constabulary, Odell, I., Contact Management Department, Identification of Repeat and Vulnerable Victims at First Point of Contact, (2012).

86   ABCDE training model (Appearance, Behaviour, Communication, Danger, Environment) is meant to complement existing training models to enable front line officers to recognise, take appropriate action and refer on people who are vulnerable.

reasons discussed below, is itself a distinct and complex area that needs to be expanded, not diluted, under another banner.

Secondly there is a problem of definition. It must be made clear that vulnerability training and policy includes all those people who may be at risk however their illness manifests itself.

A 'vulnerable adult' is defined, by the Department of Health, as:

> 'A person aged 18 years or over who is or may be at risk of abuse by reason of mental or other disability, age or illness and who is or may be unable to take care of him or to protect him or herself against significant harm or exploitation.'

The people whose mental health issues manifest in dangerous behaviour is not obviously protected as vulnerable even though their illness makes them so. This definition is reproduced in the MPS Safeguarding SOP.

We were reassured by MPS staff and officers that their intention was to cover all people with mental health problems. If so that goes beyond the usual understanding of vulnerability and the MPS policies and training on vulnerability needs to make this clear.

1.5 Race and ethnicity

London's ethnic composition[87] has an impact on how people from different ethnic groups experience mental health issues. Many people from black and minority ethnic (BME) communities experience greater social adversity than the majority of the population including urban poverty, discrimination, racism and poor employment prospects which can adversely affect their mental health.[88] New arrivals to the country include people who are displaced from their home environments under situations which may not be of their choosing or which involve

extra stress. There were three examples of such cases in the case review, all of these vulnerable people took their own lives.

The context for our work includes the Count Me In Census statistics[89] which demonstrate a 'consistent pattern' of higher detention rates under Section 37/41 for Black Caribbean and Other Black groups across all six of the annual censuses.

Research into deaths in custody nationally show a high percentage of those who die in custody are from BME communities. INQUEST identified that 'in 2008 BAME deaths accounted for 32% of all deaths in police custody.' INQUEST further reported that in 2009 this... dropped to 27%; reduced further in 2010 to 7%; and rose dramatically to 38% of all deaths in 2011.[90]

The IPCC's statistics on deaths in police custody for 2011/12 revealed that nearly half (7 out of 15) of those who died in or following police custody were identified as having mental health problems.[91]

In our interviews with health and social care professional groups we received a mixed set of views as to whether racist behaviour or attitudes were involved in the police treatment of people from black or minority ethnic backgrounds. On balance, more thought it was likely to be a factor than did not and several professionals gave instances where they believed strongly that was the case[92].

Corporate responses
An MPS internal report (2012)[93] gives a worrying picture about attitudes and behaviours by some officers within the MPS. The report summarised and made recommendations arising from a Health Check on the current MPS approach to diversity. The report considered three 'critical' questions:

1. Why has racism occurred within the MPS?
2. What is the current Management Board action plan to deal with a renewed focus on Diversity especially race?

87   From a current London population of 8,173,941 people (51% male, 49% Female, 36% are from Black, Asian, and minority ethnic groups). There were 574 suicides in 2010 (76% male and 24%, female), with these figures remaining largely unchanged in the preceding years. The diversity of London includes 60% White, 13% Black, 19% Asian and 3.4% from Other Ethnic Groups. Census 2011, cited in Grossmith, L., Franklin-Trespeuch, E. & Dawson, P. (2013) *Mental health & the police: Understanding demand and incident management in the Metropolitan Police Service*, MPS Corporate Development.

88   New Horizons: Towards a shared vision for mental health (2009), Department of Health consultation document, cited in 'Is there a case for change in mental health services in London?' (2010) Commissioning Support for London.

89   Care Quality Commission (2011) count me in 2010, results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales.

90   Inquest (2012) Inquest submission to the Home Affairs Committee Inquiry on the Independent Police Complaints Commission.

91   Ibid, IPCC statistics available from www.ipcc.gov.uk

92   Meeting with Liaison and Diversion professionals, January 2013.

93   MPS Diversity Health Check, Summary and Recommendations, June 2012.

3. Does the MPS have the capacity and capability to implement the required actions?

The report points to 'evidence of...a small number of alleged racist incidents — including complaints, misconduct, Fairness at Work, Employment Tribunals and Civil Actions in comparison to the size of the workforce, and the number of complex and often confrontational interactions that MPS officers and staff have with the public every day.'

It acknowledges, however, that 'even one incident by one officer can have a disproportionate effect on the reputation of the organisation and [that] the seriousness of the current situation is recognised and accepted by the Commissioner and Management Board.'

Key issues stated in this MPS report were:

Complacency — Despite investment in its Diversity and Citizen Focus Directorate (DCFD) and other initiatives the MPS consideration that it may have mainstreamed diversity into the operational heart of the organisation may, in reality, have been too soon. The report points to evidence of removal of diversity from the corporate risk register and dropping of targets for recruitment and retention; no regular chair for the Diversity Executive Board and inconsistent and varying seniority levels who attend; Diversity boards appearing to have lower status compared to other 'operationally focussed ' governance boards; lack of performance and monitoring frameworks.

Backlash — Increasing 'white backlash' as recruitment, retention and progression of female and Black and Minority Ethnic (BME) staff has improved. The report points to a 2009 staff survey, which indicated 'a growing antagonism towards diversity: 15 % of respondents felt it was a waste of time and 13 % were 'angry that time was being wasted on diversity issues.' A number of free text comments reflected a view that 'white, heterosexual males were being passed over for promotion.'

Abdication of leadership through unclear 'ground rules' for ensuring professional standards and service delivery to staff and the public. The report states:

> There may be an issue for leaders dealing with under-performance of protected characteristics staff where there is a tendency to escalate the problem for fear of making decisions which would expose them to accusations of prejudice...Conversely supervisors

> may ignore underperformance for the same reason, which has an effect on other team members and breeds resentment. In dealing with officers or staff who may make prejudicial comments, it should not be discounted that there is [sic] some who would believe that these incidents are minor and part of everyday business. Whichever of these theories is true, the very fact that the questions can be posed implies that the MPS has not made the ground rules for professional standards and service delivery to diverse colleagues and the public absolutely clear[94].

The report also notes that a significant proportion of staff will have joined the MPS since the Stephen Lawrence Inquiry report was published; and after training mandated through the MacPherson Inquiry report was completed in 2002. It continues:

> That corporate memory [of MacPherson] is not ingrained into new recruits or as they become new leaders, as the MPS — along with other UK police forces — does not teach the history of policing. If it were to do so it would include pivotal moments in history such as the Scarman report[95] pre-dating Macpherson, and in the future the lessons of Operation Kirkin.[96] A sound understanding of what policing by consent means and the fact that it is underpinned by winning community trust and confidence is required[97].

The diversity report makes a number of recommendations for improvement. The findings demonstrate that issues of racism continue to be prevalent within the MPS, an observation underscored by the evidence gathered by this Commission in relation to mental health. It is likely that these views will have an impact on how some MPS officers, including frontline officers and custody officers, respond to people from BME communities.

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94   Ibid 96 page 4.

95   (HMSO) The Brixton Disorders, April 10-12 1981: Report of an Inquiry by the Rt. Hon. The Lord Scarman, O.B.E.

96   Operation Kirkin refers to the policing of the riots which occurred in Summer 2011.

97   Ibid 96 page 4-5.

Public Perceptions

The MPS has recorded statistically significantly lower satisfaction levels with its services for victims and victim care by 25-44 year olds, respondents with a BME or Black, mixed ethnic background and those with a disability.[98]

The Commission believes that the relationship between the MPS and London's diverse communities in a mental health context is significant. It requires an MPS approach which: (1) demonstrates an understanding of ethnicity and culture (2) enables front line officers and others to explore their own uncertainties about dealing with difference (3) provides demonstrable evidence of responses based on clear protocols and knowledge rather than on conjecture and fear and (4) complies with the law.

Addressing continuing issues regarding race is about leadership by the MPS. We urge the MPS to implement and monitor the learning and recommendations from previous inquiries and reports, including the MPS' own internal reports and policies so that it can demonstrate continuing professional development and learning in policing and mental health for BME communities.

One staff member said: 'There are no straight lines. It is about complexity. No one is saying it's easy, but we can do some things better. It's not just about being nice to people, it also makes good business sense.'

> **Recommendation 8:** The MPS should establish a high level expert group of stakeholders that can provide the MPS with ongoing and specific advice and review; which are aimed at improvements in outcomes with regard to race, faith and mental health. This group should report to the Commissioner.

2. On the frontline

The major themes from our evidence concern practice throughout the MPS, including street encounters, in custody and the CCC. We have collated these into the following categories: training and guidance, information and data, and custody. Given their importance we discuss each as themes in their own right. The issues are overlapping to some extent and also impact on corporate governance.

2.1 Training and Guidance

In order for the police to deliver a professional service to people with mental health issues they need certain knowledge and skills[99]. In the course of this inquiry, service users, families, professionals and police reports [100] alike have all called for better training in mental health. It is also the view of the front line police themselves. In the MPS questionnaire to police officers only 22% of response officers and 28% of borough mental health liaison officers agreed that their training effectively prepared them to work with people with mental health problems. Of particular relevance is suicide prevention, restraint and mental health awareness, and training on powers and duties.

In the cases of those who died it was clear that some police officers lack confidence in dealing with people with mental health problems. We found instances where the police had failed either to identify that the person before them was in a mental health crisis or, if they had, to know what to do. They failed to properly assess and identify mental disturbance even when others around them did, and indeed told them so.

Some police officers appeared to be nervous of strange behaviour, and to interpret it as dangerous when it was not. However, others did recognise people's vulnerability and responded with calm and reassurance.

The cases include situations in which the frontline police appeared confused about their powers under the MHA, ill prepared to exercise either Section 135 or Section136 powers or were criticised by the IPCC or the coroner for their failure to use these powers correctly[101].

As discussed above, the expertise of some CCC staff is also called into question by some of the cases. We recognise the high pressure nature of the role and it is precisely because of this that the mental health of police needs to be attended to.

Our evidence leads us to conclude that current training provided by the MPS does not achieve the level of awareness or practical skills that is needed, particularly for street encounters and unplanned instances where section 136 applies. Of particular relevance here is the

98 Performance measures for the MPS Diversity and Equality Strategy, report to MPS Diversity Executive Board (September 2012), Diversity & Citizen Focus Directorate, Deputy Commissioner's Portfolio.

99 ACPO (2010) Guidance to Responding to People with Mental Ill-health or Learning Disabilities, Wyboston, UK: National Police Improvement Agency,. Herrington, V. & Roberts K. (2012) .

100 MPA (2005) A Joint Review of Policing and Mental Health by the Metropolitan Police Authority and other partner agencies.

101 Cases 5, 6 and 8.

need for training in suicide prevention, restraint and mental health awareness generally, as well as training on powers and duties and on referral pathways to other agencies.

On the whole, mandatory training on mental health for new recruits is brief, with voluntary refresher training provided only by computer. We reviewed existing and some of the proposed training at Foundation Level and are not persuaded that the content, method of delivery or the time allowed are fit for purpose. This also applies to training for specialist staff (especially in CCC and custody suites) and refresher training. Good post foundation [102] training occurs in some boroughs as does ongoing joint training with mental health trusts. However this is not happening consistently.

As stated previously, there is learning which can be incorporated and adapted from the MPS approach to dealing with incidents of domestic violence. Adapting an approach suitable for mental health and policing should begin as a matter of urgency.

Mental health training
A basic mental health awareness programme is essential for all MPS staff, working on the frontline, at policy and leadership levels. All police officers need basic knowledge about mental health, including training around issues of stigma and discrimination on the grounds of mental health. The Joint Review on Policing and Mental Health highlighted this as particularly vital since stigma remain widespread within the community. Frontline officers must be taught to recognise signs and symptoms of mental health issues and the particular vulnerability that is involved. Officers need to be able to identify someone in distress; to communicate effectively with that individual; and take action when someone is behaving strangely, with aggression or is being very withdrawn. They must be taught the basic principles of suicide awareness and instructed in the National Decision Making Model.[103] They also need to understand the options available to them under the MHA when they attend a person in a current mental health crisis.

The Commission were impressed with the work of the Leicestershire Constabulary's call takers who were trained to operate in accordance with the National Decision Making Model. In their view, while it lengthened the time of a call, it led to better outcomes and ultimately was cost effective. The Model assists police in making decisions in the difficult complex situations arising in mental health cases whether to use Section 136, whether to arrest for an offence or whether to involve other agencies and if so when. It should be included in training packages.

The evidence of persistent stereotyping of some minority ethnic groups, particularly black males, makes it essential for training to address issues of race and culture. This is an issue for all MPS training but impacts particularly heavily on those with mental health problems, where stigma concerning race and mental health are compounded.

Good training takes time. Mental health is multi-faceted with a range of concepts and practical issues to explain and reflect upon, including referral pathways as well as legal powers. We note that foundation training in domestic violence has been a full day, and for Community Support Unit staff a week's training is provided. Training in mental health, however, has been as little as two hours and overstocked with new information. This reflects a failure to recognise the importance of mental health in the work of the MPS compared with other areas such as domestic violence.

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102 MHLOs have a single 2-hour training, which a majority of them consider does not equip them for the role. Custody officers may have mental health awareness training offered but many custody suites do not provide it regularly and a number of POs said they had not received it and would like it. In a review of MPS custody suites in 2011-12 the HMIC recorded that it had only taken place in 3 of 8 suites. The custody training involves a mere 45-minute segment on mental health. It is not known what mental health input is part of mandatory training for other specialist groups, including domestic violence.

103 The National Decision Making Model is an ACPO approved tool. It aims to provide a 'simple, logical and evidence-based approach to making policing decisions.' It has six key elements: statement of mission and goals; information and intelligence gathering; assessing risk and developing a working strategy; consideration of powers and policy; identifying options and contingencies; action and review.

A plea for better training comes from the Mental Health Cop[104]: 'Why do police officers, including senior officers, get far, far less training in mental health issues than they do in public order or personal safety — or for that matter fire marshalling and diversity — given the strategic threat this business represents to the UK police service?

We also know that the legislative framework within which our frontline officers must operate is complex: it is at least as complex as PACE[105] or RIPA[106] and yet we give custody sergeants a one week course purely focusing on custody law; another one week course focusing upon first aid and Safer Detention and custody sergeants have had to pass a detailed law examination just to get promoted to that rank.

Why do we think we can expect officers of any rank to survive contact with all the different situations they can encounter unpredictably on the front line of policing; or within the partnership structures that we will need to invent to make this work, with 4-6 hours of training, a lot of which is often given over to identification of mental illness and diversity? What about understanding these legal topics in terms of what officers can and cannot; and should and should not do'

Lord Bradley's report (2009) recommended that community support officers and police officers should link with local mental health services to develop joint training packages for mental health awareness and learning disability issues. There is indeed merit in joint training at all levels.

Police told us repeatedly that the joint training they received with mental health trusts was the most beneficial, particularly when it exposed them to opportunities to meet patients and service users. Research of short term educational interventions involving police contact with carers and service users has also had positive results.[107] People who responded to our surveys called, above all else, for police to show a degree of empathy or understanding to those with mental health problems and that is promoted by such direct contact. Other studies, in UK and beyond, could be investigated in planning new training programmes to achieve the same goal. For instance role-play training has been shown in one Canadian study to improve empathy and de-escalating skills. The result has been cost effective in defusing situations with people with mental health conditions without the police having recourse to violent physical interactions[108].

Some training materials could promote inaccurate stereotypes of mental illness (particularly the connection between mental illness and violence) and while there is a token mention of this issue it is not explored in any way that could genuinely improve understanding. In some cases the mental health dimension of an issue is simply ignored where it is clearly relevant. The issue of stigma is hardly addressed. Some materials (on legal powers) are accurate and clear but necessarily superficial and lack accessibility for busy officers. It is hard not to see that mental health has been a field that is underestimated in importance.

The Joint Review on Policing and Mental Health[109] emphasises the role of service users in being consulted on, and in providing, training and we heard of numbers of good training providers who do so. This included the Mental Health First Aid (MHFA) course delivered to Camden custody suites. The MHFA programme is an excellent starting point for a bespoke police training, as it provides a basis for developing multiagency approaches/understanding as well as providing quality training in its own right. Other well-evaluated programmes include ASIST[110] for suicide awareness, and END (Education not discrimination)[111].

A specification for training

Mental health awareness should be delivered face-to-face, involve delivery by service users and include realistic scenarios that will give frontline officers practical guidance. It must be a rolling programme for all new officers and staff, including community support officers and volunteer special officers. There must be refresher training at regular intervals, as a part of continuing professional development (every two years). It must include realistic timetables with time for reflective activity and for taking part in practical scenarios.

104   Strategic Command Course mentalhealthcop.wordpress.com/2013/01
105   Police and Criminal Evidence Act 1994.
106   Regulation of Investigative Powers Act 2010.
107   Pinfold, V., Huxley, P., Thornicroft,G., Farmer, P.,Toulmin, H., Graham,T. *Reducing psychiatric stigma and discrimination, Evaluating an educational intervention with the police force in England Soc. Psychiatry Epidemol* [2008] 38 , 337-344.

108   Krameddine, De Marco. Hassel . Silverstone, *A novel training program for police officers that improves interactions with mentally ill individuals and is cost-effective,* Front. Psychiatry, 18 march 2013 doi: 10.3389/fpsyt.2013.00009.
109   Joint Review on Policing and Mental Health para.8.6
110   Applied Suicide Intervention Skills Training www.asist.org.uk
111   www.time-to-change.org.uk/about-us/end/

Frontline officers also need training on the operational issues they will encounter including control and restraint in the context of an acute mental health crisis. The referral pathways need to be explained and explored through cases. This learning should be delivered jointly with health services and include an experiential component from service users or families, explored through scenarios case training.

While we have previously referenced the new vulnerability training that is proposed by the MPS, we are not convinced that it will be adequate in content, delivery method or allotted time to achieve the level of expertise that a professional police force requires. We believe that, like any other professional body, the MPS should open itself to scrutiny on this and other issues and should seek advice, assessment and evaluation from external agencies.

A complete package of training for different parts of the MPS should be commissioned, with the assistance of an advisory group. It should involve outside agencies, including service users and carers, healthcare professionals and voluntary organisations and it should be developed in conjunction with the College of Policing. This could be delivered by the voluntary sector together with the police (as is done with the British Transport Police training.)

The following is a specification we recommend for the core training for the MPS.

Face to face training involving service users, partner agencies and case scenarios with time for reflection. This preferably needs to be a 2-day course.

It must include:

1. Basic mental health awareness training
   - Skills of communication with people with mental health issues
   - Ability to recognise signs and symptoms of mental illness and Acute Behavioural Disorder (ABD)
   - Stigma and discrimination including the stereotyping of people with mental illness, and of people from racial, ethnic groups
   - Vulnerable adults
   - Suicide prevention

2. Practical information about partner services and their respective roles
   - Legal powers and duties and procedures under the MHA and MCA
   - Options for referral — arrest and custody/ Section 136/ liaison and diversion

3. Restraint of people with mental illness or disability
   - This should be delivered to all staff over at least a day and a half and be refreshed bi-annually as part of continued professional development.
   - Specialist units should, in addition, have a specific bespoke programme to cover their particular areas. Custody officers need to understand the mental health pathway, Liaison and diversion options, suicidality, dynamic risk assessment, and the functions of pre release in the context of vulnerable or disabled people. This should include the use of tasers.

Recommendation 9: That the MPS should create a comprehensive suite of mandatory training for staff and officers developed in partnership with experts, including from the voluntary sector, and individuals with mental health needs.

This programme should be developed in conjunction with the London Mental Health Partnership Board; College of Policing and be independently evaluated.

Recommendation 10: The MPS should seek external experts in mental health to assist in the routine review of guidance, SOPs and information materials. This review should be a public report, available on the MPS website and submitted at six-monthly intervals to the London Mental Health Partnership Board.

Frontline police officers need access to practical information on their powers and duties under legislation to ensure a consistent response. This information should be user friendly and should help officers to respond effectively to an incident.

While it was not in the scope of the Commission's work to review all of the SOPs, it was found that neither the mental health SOP nor that on safer restraint were sufficiently comprehensive to be satisfactory. In relation to the issue of restraint there appears to be no mention of the question of the use of tasers or CS spray in cases involving people in a mental health crisis. Use of tasers is relatively new. Data needs to be captured and their application should be kept under regular review.

SOPs were lacking in detail around signs and symptoms, would benefit from a more nuanced treatment of violence, did not cover areas such as welfare visits and suicide prevention. These are all areas where there is expertise outside the MPS and where outside agencies are likely to be involved in the practice that they cover. Officer safety training SOPs might benefit from broader information about acute mental disorder that goes beyond a discussion of ABD, while SOPs in areas such as domestic violence and missing persons could benefit from being reviewed for their coverage and the appropriateness of their coverage on mental health issues.

The MPS should take the lead in improving its engagement with the community it serves and bring them into the process of review. They need to locate the appropriate agencies and work with them — not just consult them — when these policies, guidance and procedures are being reviewed. Where possible there needs to be a consensus on the content.

Suicide prevention

Suicides are rare events but they are traumatic for all.

Most suicide cases we reviewed concerned a death when the police were in attendance. In almost all cases the person had previous contact with health services because of their mental health. We found widely varying approaches adopted by the police who were called to the scene where a person was about to jump to their death. These approaches did not appear to be based on sound operational reasons. This pointed, rather, to a lack of training and expertise.

Evidence from the case review and good practice guidance suggests that as the person will be in a highly agitated state, the police need to be reassuring and calm. The person may benefit from having someone familiar at the scene — whether a family member or a mental health professional and an attempt should be made for that to happen[112]. It is clearly good practice for the attending officers to have access to trained negotiators (as happened in one case we reviewed) but it is not apparent that this expertise is readily available for potential suicide cases, even though it should be available at all times.

There were several cases where police were called on a welfare visit to a person who was mentally unwell and threatening suicide. There was no consistency in the police approach to dealing with the situation and there appeared to be no guidance to assist them. In two cases further questions may have elicited whether there was a family member or mental health professional who might be contacted and could attend and, within reason, the police may have awaited their arrival. It might be seen as part of a duty of care in such a situation for the police to be enjoined to hand over to another health professional or relative where this is feasible. In the cases we reviewed they did not appear to have been taught that this is an obvious preventive action to take.

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112   Personal communication with Professor Louis Appleby, Chair of Suicide Prevention Strategy Advisory Group, Dept of Health; Preventing Suicide, A resource for Police , Firefighters and other First Line Responders, WHO , 2009.

There is no specific training on suicide prevention in the MPS nor is it covered in SOPs. There is no strategic approach despite its relevance to police work. The written police guidance is helpful but superficial[113]. We were impressed with the approach taken by the British Transport Police (BTP) who have a strategic suicide prevention team at headquarters and a tactical team for the area of highest demand in north London. They include police specialists and they work alongside a mental health professional. They provide advice on the ground in emergencies and in custody suites and they help with case management. [114] (the PIER plan). The BTP have a Standard Operating Procedure (SOP) on suicide prevention[115], a joint training programme with the Samaritans and Oxford University, and accessible guidance for frontline officers.

This is an approach that should be urgently adopted for the MPS as it combines a corporate centre of strategy and expertise, together with teams to assist frontline officers, as required by demand. Suicide prevention training for frontline officers is clearly needed as well as is accessible guidance for the police attending the scene. The Samaritans, the Oxford University Research Centre in Suicide Prevention and the BTP should be engaged in this work. The MPS should become a model of good practice in this area.

> **Recommendation 11:** The MPS should adopt a corporate approach to suicide prevention with both a strategic and operational focus. Suicide prevention training and guidance must be put in place immediately with the advice and assistance of external stakeholders.

Restraint and the use of force
Statute and common law provide that police use of force against an individual must be necessary and reasonable. Restraint must be proportionate to the situation, applied for the minimum time required and used as a last resort as part of a range of various de-escalation strategies. In addition under the Mental Capacity Act (MCA) the restraint of a person who lacks capacity must be in the person's best interests.

> The Court of Appeal ruling in the case of Mr ZH sets out clear principles for the use of restraint when, in similar circumstances, the police interact with a person with a mental health problem. Whatever the information they had received the police needed to reassess the situation on arrival before deciding that there is an emergency requiring restraint. Before immediately restraining Mr ZH police should have tried to communicate with him, identify a plan to address the situation and implement it. They should have 'sought, listened to and responded to advice from his carers as the situation developed, and adopted a calm, controlled and patient approach at all times, having realised that using force only served to frighten him and escalate the situation'[116]. They could indeed have handed over to carers and the lifeguards and not intervened at all. Their response was 'overhasty and ill informed'.

The police frequently come into contact in an emergency with an individual who has a mental health condition. There needs to be restraint training that is designed specifically for such a mental health emergency[117]. The potential for the situation to escalate into violence with tragic results is shown by the cases. Given the specially damaging psychological and physical impact of physical restraint on a person in a mental crisis the MPS might usefully explore experience from overseas[118] in devising and providing special training for officers faced with people in a mental health crisis and how to use non-violent conflict resolution skills to avoid the need for physical restraint.[119]

We were told by Professor Richard Shepherd, a leading expert in the field, that it is difficult for the person(s) leading the restraint from the start to step back and hard for them to change their mind-set as they may be frightened and feel as if their safety or life is under threat. In the case of Mr ZH the Court opined that the police were simply caught up in a process which they had started, continued to be involved in and felt unable to stop or control. In all cases where death occurred these basic safeguards were not followed. We were told that officers so rarely encounter such a situation that their normal

113 MPS White notes.

114 Suicide Prevention Aide-Memoire — Collaboration between British Transport Police, Kent Police and Oxford University Centre for Suicide Prevention.

115 British Transport Police Suicide Prevention: Approach to threats, attempts and completed acts of suicide — Standard Operating Procedure (SOP).

116 ZH v Cmer of Police for the Metropolis [2012]EWHC 604; Commissioner of Police for the Metropolis and ZH (a protected party by GH his litigation friend) [2013] EWCA Civ 69.

117 See Mental Health Cop, Restraint , posted April 26 2013
http://mentalhealthcop.wordpress.com

118 Coleman T, Cotton D, Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing, Mental Health Commission of Canada , 2010.

119 Krammadene Y De Marco D Hassel R Silverstone P, *A novel training program for police officers that improves interactions with mentally ill individuals and is cost-effective* Frontiers in Psychiatry doi: 10.3389/fpsyt.2013.00009.

tactics for asserting control when arresting suspects who resist arrest may simply take over. The Commission believes that with appropriate training, including specific awareness of restraint in regards to mental health, they would be better equipped and this would have been prevented. This must be included in all officer safety refresher training courses. We support new initiatives, such as a DVD on restraint practice being prepared jointly by the MPS and South London and Maudsley NHS Foundation Trust (SLAM).

We also believe, the ACPO Safer Detention Guidance needs amendment. It should take into account the requirements in the MCA as to the concept of best interests, including he need to consult with carers or others if feasible. The guidance needs to give greater emphasis to communication skills with people with mental health issues, de-escalation for such situations, alternatives to restraint and to ways of ending restraint. Closer attention to NICE Guidance and to the Mental Health Act Code of Practice would be beneficial. It is important to note there are particular risks in restraining people with a mental health condition, which means even more caution needs to be used. In particular the risk of excited delirium appears to be more significant for people with a severe mental illness; and certain antipsychotics can make people more vulnerable to cardiac arrest. It should also make mention of the use of tasers with people who are in a mental health crisis.

The Officer Safety Training syllabus[120] should also be amended to include sufficient information and training on communication skills for people with mental health issues or learning disabilities, including autism. It should also usefully deal with the issue of tasers in the context of mental health.

Our analysis of the HMIC reports of custody suites demonstrates inconsistent practice both in the use of restraint (e.g. handcuffs) and in both recording and collating of records of the use of force. The use of force must be recorded just as is required in other professions where a judgment has to be made about this issue. The Independent Advisory Panel on Deaths in Custody (IAP) has stated also that they believe that:

> The lack of central monitoring and analysis of the use of force makes it difficult for police forces to identify the circumstances leading to the use of force. This in turn means that the effective identification of lessons and trends is difficult to achieve. Furthermore, lack of centrally collated statistics presents difficulties in achieving a rigorous cross sector analysis of use of force statistics[121].

The Commission is aware of the work being undertaken by the IAP to provide a set of principles for safe restraint all professionals could adhere to. We are also aware that stricter guidelines on prone restraint have been adopted for the Prison Service. Based on our inquiry, the Commission proposes that the following principles should be built clearly into policy, training and practice and the particular issues of restraint for people in a state of mental disturbance.

A set of principles for restraint

The national personal safety manual[122] provides guidance to police in terms of restraint however based on the Commission's review of the evidence, is not being followed consistently. The Commission therefore recommend the following principles are followed to ensure the safe use or restraint when it is deemed necessary:

1. The use of restraint should be considered in accordance with the national decision making model. Generally it should be the last resort for the police when dealing with a person in a mental crisis only to be used after relevant de-escalation techniques (such as those outlined in ZH) have failed or if there is a genuine emergency. The maximum information compatible with the emergency nature of the circumstances must be sought before a decision is made about the nature and extent of restraint.

2. The use of force must be proportionate, lawful, accountable and necessary to the risk that is perceived at the time. What is disproportionate force must take into account that the person is ill — whether it is cocaine induced Acute Behavioural Disorder (ABD) or a psychotic episode is not relevant except to alert the police to the heightened risk of physical harm. The person's agitation may arise from delusional fear and distress which is likely to be exacerbated by the force involved in restraint.

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120   Book G17 Officer Safety Training.

121   *Independent Advisory Panel on Deaths in Custody*, Report of the Cross-Sector Restraint Workshop held in May 2010

122   Guidance on Personal Safety Training, National Policing Improvement Agency (2009), http://www.acpo.police.uk/documents/uniformed/2009/200907UNPST01.pdf

'Officers should be aware that a person exhibiting acute behavioural disturbance may experience beliefs which will cause them to resist in an abnormally determined or desperate manner. For example the person may genuinely and strongly believe that they are going to be killed, eaten, raped, have body organs removed from them. Officers should be aware that the act of restraining them will strengthen and confirm these beliefs.[123]'

3. Careful attention must be paid to each stage of restraint. This includes whether it is necessary for the person to be handcuffed, whether they are to be physically restrained and in the prone position, Restraint in an upright sitting position should be preferred when the context permits it.

'If someone puts you in a position where you can't breathe, you're going to struggle to get out of that position. One of the things that's going to happen is the people restraining are going to perceive that as a renewed attempt to escape', leading them to apply even more force. In fact, if you were able to question the person, they would tell you 'I wasn't trying to escape, I just couldn't breathe[124].'

4. A safety officer must be responsible for the restraint throughout the period. The role of the safety officer is to take immediate charge of the incident, monitor the health of the person being restrained and actively control the restraints being applied'. The wellbeing of the individual being restrained must remain the central concern and continuous efforts by one person to communicate with them, listen to them and to calm them must persist throughout the restraint. This person should be an officer not directly involved who can take the role of 'taking a step back' objectively to consider the safety of all.

5. The individual's medical situation must be carefully monitored and a maximum period of time should be followed as being medically safe. A person who is restrained in a prone position should be moved as soon as possible.

6. The person should be transported by the London Ambulance Service (LAS) and handed over to a medical team as soon as possible. If the person is to be restrained during the transportation continued communication by the safety officer is critical.

7. The use of force including the methods used and the time involved must be recorded and records retained for analysis and report.

> **Recommendation 12:** The MPS has to work with ACPO and the College of Policing on policy and training on restraint to ensure that the principles outlined in this report are enforced or utilised.

2.2 Information and data

The process of gathering information through this inquiry has also underscored the inadequacy of the MPS recording of routine data, and its storage and use.

We found that information on case files was often either not available or incomplete. We also found that some important data relating to mental health (for instance relating to the use of the Mental Health Act) was not collected, or if so, not easily collated. Therefore, information was never analysed nor lessons learned. This means that continuing action to identify trends in police activity where improvements are needed has not occurred. There is a need for central storage of records, files and information relating to mental health issues so that corporate learning and research can be effective and ongoing.

There was also difficulty in accessing information on mental health via the MPS intranet. This means that up to date information on policies and operating procedures is barely accessible for frontline officers. This accounted partly for the gap between policy and practice that we identified in some cases. Officers need easy access to information or expertise when responding to an incident, however, standard operating procedures relevant to dealing with mental health are hard to find on the MPS intranet. There is scope for a more expansive approach to the intranet, for example the use of links to other websites and information from wider sources of expertise.

Frontline police officers are unduly dependent on the knowledge, time and skills of Mental Health Liaison Officers (MHLOs), many of whom consider they lack the knowledge they require, and have mental health liaison as only part of their brief. We trust that the new MPS intranet resource, the Mental Health Toolkit, will partly remedy this deficiency. The Commission previously highlighted the need for full time and expert MHLOs to share expertise across the MPS.

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123   Dr. J Parkes — communication with the Commission.
124   Dr J Parkes, cited on the Mental Health Cop Blog.

The work of CCC

The Commission's review of case files revealed a serious endemic pattern of shortcomings in handling calls in the CCC system and in the relationships between CCC and the operational level in the Borough Command Unit. Outdated technology and poor training mean that accurate information is not available from the outset. This means that calls to CCC can result in officers following false paths that are hard to remedy once an operation has begun. It also means that deaths that are preventable, do occur.

Case 2 is a graphic illustration of the problems. There were a total of nine calls made to CCC over the period of three days. Had these calls been linked, a true picture of her state of mind and of the very high risk she posed would have been apparent, as they are now in hindsight. In other cases information had not been properly updated as new intelligence was received, relevant information was not recorded; repeat callers and prior information was not identified; calls were not linked and in some cases the level of urgency at which the call was graded was at fault.

The system for recording information specifically on mental health and related issues seemed scanty compared to other areas of police concern. Mental health is only a secondary coding. It provides few fields and prompts for the call taker to probe for, and include the most minimal information of a mental health problem/ mental health related incident and the nature of risk involved. 'Violent man with knife /criminal damage' sets up the wrong expectations when it is in fact a mental health patient with a knife. Violence is different to agitation or mentally disturbed behaviour. In incidents where violence is an issue with a person with mental health issues, a menu of further questions should be available to record more precisely the nature and the level of risk. There should also be scope to differentiate between callers' relationship with the vulnerable person, so that a health professional, carer, relative or bystander can be distinguished. Room to designate basic information about their access to health services might also be recorded. In short there needs to be devised a process to give a positive enhanced understanding to responding officers without creating unrealistic burdens on call takers.

Shortcomings are also reflected in manuals on procedures and protocols, giving inadequate guidance on such issues as grading of calls. Solutions need to be found to the systemic failings in the CCC systems for capturing, recording and linking relevant information about incidents involving a person with mental health problems. This must be done in a manner to ensure that repeat callers are flagged up as vulnerable within the Merlin system, (the system used for recording cases involving children but now being piloted to cover vulnerable adults).

We understand that some of the issues above will be remedied by extending the Merlin system used for recording data on children to vulnerable adults and we support this move. However, it is unlikely to be fitting for the full range of situations where mental health is relevant. Also, it does not come into play until or unless a responding officer decides to create a Merlin report.

Leaving aside human errors and those that arise from resource management, we learned that the problem lies largely with the outdated technology that powers the information systems in the MPS. The Commission believes this is a surprising and unfortunate weakness in a modern police force. It affects outcomes and individual performance of staff at CCC.

The Commission, during the course of its work, came to the view that the obstacles to achieving an efficient call system with the current technology were formidable. We heard from several members of the MPS that the only way forward would be to invest in up-to-date technology that

can effectively identify, capture, link, upgrade and refer on relevant information. This is preferable to attempting to bolt on improvements to an outdated system, which is not designed for police purposes.

> **Recommendation 16:** The MPS should invest in technology for CCC which is fit for purpose.
>
> Guidance and protocols on vulnerable persons and mental health at CCC should be reviewed in collaboration with external sources, including service users and carers, as well as voluntary sector agencies, to improve their effectiveness at identifying relevant issues. Training for call handlers
>
> Information about carer/ family member and a health support person should be captured, respecting confidentiality.[125]

2.3 Custody

A significant number of people detained in police custody have mental health issues.[126] They may have self-harmed or be suicidal. In one study of MPS custody suites 39 % of people were found to have a clinically observed mental health problem with either a psychotic condition, depressive disorder or other disorder or learning disability. HMIC inspections reported that, on average, around 25 % of detainees had a mental health problem recorded on their custody file.

The IPCC Report (2008) on Near Misses in Custody Suites in London was undertaken with FMEs who found 121 near misses over a 12 month period[127]. Forty seven percent (47 %) of detainees in these incidents had a known mental illness (34) or personality disorder (7), and 50 % of the cases involved people who self harmed or were suicidal. A key intervention that drives the outcome of individuals with mental health issues in custody is the process of risk assessment.

Risk assessment

Reception screening of detainees by the police staff incorporates a risk assessment. This should be refreshed in a dynamic process responding to changes in the individual during the stay in custody and completed by a pre-release risk assessment.

Risk assessment tools should collect enough information to provide a full picture of the person's medical and mental health condition including information from family members.

They should not be limited to self-reporting. In particular police officers should record their own observations and include information from carers where possible/ appropriate. However, the forms currently used may not sufficiently capture the necessary information for people with mental health needs.

Recently, researchers at Newcastle University have demonstrated the shortcomings of the current risk assessment tools. These missed a quarter of cases of a significant mental illness, a third of cases of moderate/ severe depressive disorder and half of those with ongoing suicidal ideation. Researchers developed a more robust health screen that promotes more open dialogue and open questioning. This assessment tool was piloted in a London custody suite.[128] It has been shown to be more accurate. The revised screen not only increased the detection of mental illness and suicidal ideation, but more importantly, resulted in an increased likelihood that it will be flagged and appropriate action taken. Other research on risk assessment tools is ongoing.

Pre-release risk assessments

In the case review there were numbers of occasions where pre-release assessments were not undertaken or were considered, in retrospect, to be poor. The MPS amended the requirements for a Pre-release Risk Assessment (PRRA) in 2009 as a result of high profile cases in which a person has died after release from custody. It is apparent from more recent cases (e.g. Case 8) that this is still not clearly embedded into practice. In that case the role of the appropriate adult to take part in that assessment and any resulting care plan was outlined. In addition, the Annual Report of Prison Inspectorate for England and Wales (2011) on inspection of police custody suites noted:

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125 The Commission recognises that issues of confidentiality will need to be balanced. However, families told us that obtaining information from agencies about their family member with mental health problems was an issue.

126 McKinnon I, Grubin D, *Health Screening of people in police custody — evaluation of current police screening procedures in London*, Eur.J Public Health 2012; McKinnon I , Risk Assessment Full Recommendations presentation(2013) A study of all 8 MHIC Investigations of MPS custody suites during 2011-12.

127 'Near misses' refer to where a person suffered serious injury after police contact or in police custody.

128 McKinnon I , Risk Assessment Full Recommendations presentation (2013).

> 'Pre-release risk assessments were completed, but they were basic and many were poor. The assessments rarely resulted in sufficient action being taken to assist the most vulnerable detainees. An exception was in Sutton, where the force carried out detailed pre-release assessments which prompted sergeants to consider a range of relevant issues, particularly for vulnerable detainees being released.'

The ACPO Guidance on Safe Detention provides advice as to referral to other agencies, and the right to keep a person in custody for a limited time prior to release in order for arrangements to be made for their safe transfer. The pre-release risk assessment requires a care plan to be put in place where a person is recorded as a risk. Improved procedures of this kind could have mitigated against the suicides that occurred in two cases reviewed, once the person was released from custody, to no fixed abode. Detention in custody especially on the first occasion is disturbing and upsetting for most people and could be more so for a person already in a distressed mental state.

A person known to be vulnerable because of mental health issues, recent self harm or who is suicidal, and for whom custody was in itself stressful and frightening, should not be released without a genuine attempt to address their immediate needs, including to link them to family and carers (when they were known to be concerned)[129]. Providing a leaflet to list voluntary agencies is one step forward but falls far short of the care that would be beneficial.

The MPS has a duty of care under the Corporate Manslaughter and Corporate Homicide Act[130] to any person who is in custody; and they could be liable if a person known to be suicidal is released without the measures required by the pre-release risk assessment (PRRA) being implemented. The PRRA also states that borough commanders must ensure that PRRAs are being completed.

Health care in custody

Case reviews indicate that the attention given by the FME can be limited to deciding whether the person is fit to be interviewed or fit to be charged. In some cases the attention given by the FME is cursory. In one case

(Case 19), the FME who arrived after a four-hour wait, was able in four minutes to make a detailed assessment of his condition and report on this. Other visits of FMEs were also very brief and appeared cursory, given the circumstances and record of the person being assessed[131].

HMIC reports (2011-12) regularly indicated that the clinical governance structure of some FMEs was inadequate, response times were poor due to the enlarged areas, and, in some cases, that the standard of care was unsatisfactory. FMEs were said by those we consulted to vary in quality. The result falls below the health care standard that should be achieved in a professional service. It hinders the police in producing the best outcomes for themselves and for the individual if it results in an opportunity for referral to another agency being missed.

The MPS is currently recruiting nurses for custody suites but acknowledges that they do not require them to have existing training in mental health. Training in mental health would be provided once they are in post. Clearly this should occur before they engage with people who are detained.

We are concerned that the professional standards and standards of care for people with mental health issues, alcohol and drug issues needs to be equivalent to that provided in the NHS. This would help to ensure that problems are not missed or, conversely overestimated and that correct pathways are identified. Their training should be delivered by the NHS and their competence to deal with mental health issues should therefore be signed off by the NHS.

The opinions we received from the police, AMHPs, and service users was that forensic psychiatric nurses should be available to custody suites. Whether or not they are employed in the custody suite will depend on demand. There does, however, need to be such a person available, including out of hours and with access to AMHPs, and drug and alcohol services. This is necessary so that the skills available to do a mental health assessment are at hand.

The key issue is that staff in police custody suites should identify and implement the proper pathway referral for the individual. This would reduce risk and save police resources. The police do not have the resources to set up pathways themselves, but they could be commissioned, jointly or solely by the NHS. What is needed is the ability

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129 The PACE Code of Practice provides for delays in release that are justifiable and reasonable (PACE Code of Practice 1.1A).

130 The Corporate Manslaughter and Corporate Homicide Act 2007 is a landmark in law. For the first time, companies and organisations can be found guilty of corporate manslaughter as a result of serious management failures resulting in a gross breach of a duty of care. http://www.hse.gov.uk corpmanslaughter/about.htm

131 The attention of the FME is also an issue in relation to the care of the man in Case 1, case 12, 21,22,8 and 50.

to work in a way that is seamlessly linked into mainline services. This would be much improved if there was also a systematic approach to liaison and diversion. It would also raise the competence and confidence of the police.

'I have a better understanding of mental illness now, assisting the nurses and being involved has given me a better understanding of the difficulties faced by some of our detainees.' Custody Officer Police Sergeant MPS.

A key factor in improving this whole system would be to have the NHS commissioning the services in police custody suites, whether or not on a co-commissioning model with the MPS. A particular advantage would be that it would enable access by health professionals to NHS medical records; and custody staff to receive information about the medical history that was relevant to the case. At present FMEs and nurses are hampered by their lack of access to these records.

The Bradley Report recommended in 2009 that the NHS and the police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS. The work is being taken further through the Department of Health sponsorship and its establishment of pilots in custody suites. The HMIC also believes that FMEs should be part of medical practice that is NHS governed, with performance reviewed on a regular basis.

This view was supported by all we consulted and we believe that this should now occur at the earliest opportunity.

Recommendation 17: Mental health nurses with experience related to offenders must be available to all custody suites. The MPS should conduct a 360 degree review every six months to ensure that they are accessing the proper advice from psychiatric nurses in the delivery of health care in custody suites.

Recommendation 18: Practices and policies in custody suites must acknowledge the needs of vulnerable people as part of pre release risk assessment and take steps, as appropriate, to refer them to other services and to ensure their safe handover to relatives, carers or professionals.

Recommendation 19: The MPS should adopt the Newcastle health screening tool or one that meets the same level of effectiveness for risk assessment in all custody suites.

Recommendation 20: The MPS Commissioner should publish a public report on the care of people with mental health and drug or alcohol conditions in custody suites, the referral pathways and the outcomes of pre release risk assessments.

Recommendation 21: The MPS should transfer commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS.

3. Working together: Interagency working

Effective interagency working is of major importance to the lives of service users and to the police. Our evidence indicates that the need to improve clear care pathways is imperative.

Many families said they could not understand why there was not better liaison between agencies. Similar points were made by some professionals who gave evidence via the commission's public survey.

One consultant psychiatrist described the relationship between mental health trusts and the MPS in their view as 'defined by paranoia.' Issues include continued silo working; failure to share information; incompatible information systems; unclear or non-existent protocols for joint working.

Areas of confusion and potential dispute between the MPS and the NHS include transport, paperwork and where roles and responsibilities begin and end.

Two particular areas were highlighted in the review of cases; waiting times and confusion in regards to roles and responsibilities.

Waiting times are a serious frustration for the police. There were examples of police being required to wait for several hours at a hospital, whether in A&E or in a Section 136 suite, while a mental health assessment is arranged and we heard that this is not uncommon. There was one tragic case where the person walked out of A&E before there was an assessment and ended their life soon after the police had left believing the person now to be in safe hands.

The man in Case 8 was found wandering the highway trying to kill himself by standing in front of traffic. He was incoherent and very distressed. He was taken by police officers to A&E. The police officer stayed with him and explained his mental state to medical staff. He was seen by a doctor and a nurse. It was recognised that he needed a mental health assessment. He appeared both to be suicidal and to talk of why he needed to live. The officer left the hospital, after staying from 7pm until 1am and he was promised an assessment by 6am. This did not occur. He finally walked out at 6:10am and killed himself by stepping in front of a lorry on highway.

There is some indication that A&E staff wished he had been put on a section 136 as they have a section136 suite at the hospital. The police officer said he took him to A&E, and not as a section 136 because he needed attention for his wound and A&E would not take him as a section 136 patient. In A&E, if police have gone, there is no way to prevent a person leaving if the options for applying Sections 2, 3 or 4 of the MHA are unavailable. The MCA may apply in situations like this but A&E staff may not always think the urgency of situation warrants this or they may not have easy means to prevent a person from leaving without the police present or the practitioner support from a MHA assessment team available.

The confusion about roles and responsibilities is also demonstrated in the use of restraint; that is the 'safe and therapeutic response to disturbed behaviour[132]'; or control and restraint for potentially violent situations.[133] The difference in language itself manifests the different perspectives of NHS and the police. We received evidence at a SLAM meeting that there is a knowledge gap between NHS and police in terms of techniques. The NHS rule of thumb is to isolate and restrain with the aim of engaging the patient. The police technique is to use pain control. The NHS does not use pain control and nurses are always in charge of the restraint process.

This issue arose most tragically in one case reviewed in which a man died while being restrained by the police in a hospital setting. The restraint took place over two lengthy periods and issues now remain controversial as to where

the responsibility for restraint lay in that situation and, also in the context of how the NHS and MPS should have communicated to prevent the outcome.

In one mental health trust, we found confusion between police officers and mental health staff in the section 136 suite about who would provide the basic assessment form used by the MPS to detain people under section136. However, in discussions during police liaison meetings, it was agreed that the MPS would regularly deliver forms to the mental health trust for use by the police. This is a small, though important, example of how solutions can be found when agencies work together.

Delays and misunderstandings are costly, affect staff morale and can perpetuate negative beliefs about mental health not being police business. Better and more mutually productive work with other agencies, can lead to more efficient time and workload management for police and other services. It can also lead to improvements in police knowledge and confidence in dealing with the legal and policy issues involved.

There are examples, including the one given of Harrow, of good working practice between police and the NHS where this has been recognised. However, there is no consistency across London.

Northwick Park Hospital, Mental Health Unit (Harrow). The Commission attended a joint meeting between Central and North West London (CNWL) and North West London Hospitals (NWLH) and Brent and Harrow police officers. It focused on issues relating to the admission, treatment and management of section 136 Mental Health Act and voluntary admission patients brought to Northwick Park by Harrow police officers.

The meeting explored partnership solutions to issues faced by practitioners & users, including how to have a more efficient system for the admission of mental health patients. The meeting provided a useful context for both health and police to discuss, understand and arrive at mutually effective approaches for handling Section136 patients in A&E and in psychiatric assessment suites. Key areas included: joint training; increasing the frequency of Section 136 meetings to include better information sharing; de-briefing; identifying ways to pool resources; and identifying approaches for the use of security within NHS premises.

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132 The MHA Code of practice, Chapter 15.
133 ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody (2012).

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Tri–Borough Mental Health Team for Barnet Enfield and Haringey. This work was part of the Joint Mental Health Policing Unit (JMHPU)[134]. The unit included staff from the Haringey mental health community engagement team, one officer from Barnet and two from Enfield borough command units. Its boundaries mirrored those of BEH Mental Health Trust.

The unit offered a specialist and co-ordinated police response to a range of interventions including section 135 assessments, breach of community treatment orders and court protection. It provided a single point of contact for healthcare professionals and improved information sharing and protocols; ensured police attendance at safeguarding adult meetings and deprivation of liberty assessments; offered pan-trust proactive policing; surgeries and drop-ins; and special- ist advice to Pan-London policing units establishing procedures to deal with mental health issues.

The team's focus was economy, efficiency and effectiveness; and building trust and confidence with partners and customers. It operated within four key aspects:

1. Treat everyone with dignity and respect;
2. Access to police services at times that are rea- sonable and suitable;
3. Response to vulnerable victims; and
4. Keep victims of crime informed about progress at least once per month.

PS Shawn Goodchild, who headed the tri-borough unit said of its work during its operation:

'We would say that a dedicated unit is best placed to uphold the victim's code of practice, MPS investiga- tive standards and offers the luxury of time, always remembering that either victim or suspect may be in crisis and have reduced or limited mental capacity .'

Brother of service user who committed homicide: 'GP we begged her for help. She said she couldn't. He had to ask for help himself. She said [brother] was capable of making decisions. I dragged [brother] to the GP. She said: 'No, he's an alcoholic.' I said: 'He's got mental health issues.' He'd been in rehab three times. The GP eventually got the community mental health team to send him for a Mental Health Act assessment.'

[When brother was in the hospital] 'I spoke with the staff nurse on the evening of [my brother's] discharge. I begged her to leave him in hospital. I said I was 250 miles away and wouldn't arrive until morning. She said: 'No, he's been examined. We need the bed.' They called a private minicab firm and discharged him.'

The root causes of some of these problems undoubt- edly lie in the financial constraints that lead to gaps in NHS, MPS and local authority services. However, it is also about culture and working practices. The good practice examples demonstrate that a more coherent and con- sistent relationship between MPS and other agencies is achievable.

In the Commission's view there is a compelling mandate for closer, more effective relationships between the MPS and the NHS at all levels.

The NHS has a requirement to promote parity of esteem for physical and mental health services. [135] Evidence gathered through this inquiry points to disparities in how mental health is regarded at the strategic (e.g. accounta- bility across London) as well as operational (call handling, transport, use of section 136, out of hours provision) levels. Demonstrable parity of esteem for mental health will require a number of areas and issues to be addressed systematically through concerted work with partners. The Mental Health Partnership Board aims to coordinate strategy and practice in mental health across London. The Board has developed and is continuing to develop the necessary relationships. It is putting in place processes which can help to maintain overview and linkage across London in mental health.

Emerging relationships with NHS England (nationally and in London), Clinical Commissioning Groups and Public Health England have the potential to help counter

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134 The JMHPU operated been April 2009 and January 2013. An informal assessment concluded that it involved a considerable saving of police time but no formal evaluation was undertaken. It was disbanded because of financial constraints and the advent of the One Met local policing model. The work has now reverted to local borough practice.

  A business case for taking forward the model was developed, but to date has not been implemented. Its key strengths were outlined as:
  • A centralised focal point for police and NHS staff with increased resilience and capacity in crime investigation, engagement activities and warrant enforcement;
  • Improvements in facilities, service delivery and resilience;
  • Better quality assurance;
  • More effective use of resources;
  • Income generation;
  • Continued retention for each borough of a dedicated mental health unit without multiplied cost implications.

135 HM Government, *No health without mental health*, A cross-government mental health outcomes strategy for people of all ages (2011); see also s1 Health and Social Care Act 2011 where the Secretary of State must continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England.

historic and continuing problems of variation and inconsistency across London; and should help to drive up standards for interagency co-ordination and co-operation to meet assessed need.

Given the pace of change in the NHS and social care, and the new configuration for health service commissioning it is vital that clear London wide protocols are in place for the provision of crisis mental health services. In the Commission's view, the work of the Mental Health Partnership Board, has laid a good foundation, and requires formal recognition and mandate for public accountability at strategic and operational levels.

This should be reflected in the implementation of the MOPAC strategy and/or through the proposed Mayoral Health Board. It should include establishing formal reporting mechanisms for the Mental Health Partnership Board.

> **Recommendation 22:** The Mental Health Partnership Board should have formal recognition and mandate specifically agreed with NHS England, the MPS, the Association of Directors of Adult Social Services (ADASS) and Mayor's Office for Police And Crime (MOPAC) as part of the Mayor's accountability for health. This would constitute a central oversight mechanism for improving mental health and policing in London.

Transport: Relations between the MPS and LAS

Transport has emerged as a major issue in this inquiry. There is broad agreement that people in an acute mental crisis should not be transported to hospital in police vans. However, the Commission has learned that day to day circumstances mean that many times people are transported in this way. Indeed at a meeting with SLAM we were told that 90% of the time police bring people in without the London Ambulance Service (LAS), mainly in police vans. This was also the evidence we received from service users. It contributed to their objection that they were being treated as criminals. The families we interviewed have also raised their concerns about this method of transport for people experiencing a mental health crisis. One family believe that police action in the police van exacerbated their son's fears. Most alarming however were the several cases where death ensued when or after the person had travelled in a police van and been highly agitated and distressed during the journey.

In the Commission's view parity of esteem for physical and mental health means that a person in a medical crisis due to mental health issues should be no more likely to be transported in a police van then should a person in a physical health crisis. It is unacceptable for police vans to be used.

This issue is a major part of a troubled relationship between the London Ambulance Service and the MPS. The MPS is the London Ambulance Service's biggest customer.[136] However it appears that the relationship between the services is not optimum and there are causes for frustration and misunderstandings on both sides which impact on mental health. There are no regular specialist mental health response units within the LAS. LAS paramedic responders receive very minimal mental health training, and we were told that in fact, they regard the MPS as more qualified to handle mental health related calls than they are. This situation is also reflected in the MPS complaints about the delays and the prioritisation system for mental health crises. The LAS in turn complains about MPS expectations, unnecessary calls and the quality of information received through the Computer Aided Despatch system (CAD). These issues are documented in the review undertaken by MOPAC in 2011[137]. The MPS/ LAS liaison group is at present working to improve communications and cooperation. This is clearly essential.

Regarding issues of Section 136, the LAS views its role as primarily one of transport. Steve Lennox said: 'The LAS has to take the patient to where the police tell is. That doesn't feel like a partnership. That doesn't make it feel important, or us feel valued.'

We learned about LAS demand management practice which downgrades mental health CAD calls referred on by the MPS, because they contain poor mental health information. Conversely, 999 calls (including mental health calls) which go directly to the LAS have a greater chance of receiving a timely response. This points to the need for clearer LAS/MPS protocols regarding transport and management of 999 calls.

Cardiac arrest, stroke and trauma are the three areas which generate an LAS emergency response, within eight minutes, as being life threatening[138]. Mental health calls to the LAS are responded to on the basis of capacity of

136   Interview with Steve Lennox, LAS Nurse Director & Director of Health Promotion (January 2013).

137   *The Future of the London Ambulance Service , a Strategic Review*, London Assembly December 2011.

138   Interview with Steve Lennox.

the service to respond. Largely, this is because it is considered, if the MPS is in attendance, that there is already a professional at the scene and the individual is safe. This fails to acknowledge that a mental health crisis, particularly when there is evidence of Acute Behavioural Disorder (ABD), is immediately life threatening. The LAS has in 2012 upgraded its response to a situation in which the police are using physical restraint on a person to an emergency response. This is welcome but does not provide an assurance that all people in acute mental health crisis will receive a sufficiently prompt response to prevent the police from needing to use a police van as transport.

The LAS told the Commission that they are not adequately funded for mental health cases. They need a funded dedicated response to mental health based on demand data. This needs to be free of pressure on the LAS to release it to other areas. There has been a joint initiative between the MPS and LAS consisting of a dedicated paramedic in a car provided to the MPS across 10 boroughs. It provides frontline interaction between the LAS and MPS with the paramedic attending police briefings to build relationships. Although not formally evaluated, it is showing a day to day cost saving. The funding ended at the end of March 2013 but at the time of writing a business case was being developed to extend it.

In addition there is agreed national guidance between the Department of Health and ACPO stating individuals should be transported in ambulances.

A specification for a joint MPS/LAS protocol should include clarity about: what constitutes an emergency (999/CAD) in a mental health context; the basis for downgrading a call; the process for mental health information checks during 999 call handling and what information is given to frontline officers; clarity about handover; boundaries for transport and built in guarantees for what can be expected of the service.

In the Commission's view, it is the responsibility of those commissioning NHS services to ensure they are fit for purpose to meet identified needs, whether these are physical or mental health needs. In discussions with the Care Quality Commission (CQC) this was identified as a joint responsibility between commissioners and providers to deliver services needed by the communities

they serve. Health and Wellbeing Boards[139] and the local Joint Strategic Needs Assessment will support this coordinated approach.

NHS England's mandate[140] calls for it to 'work with clinical commissioning groups to ensure that providers of mental health services take all reasonable steps to reduce the number of suicides and incidents of serious self-harm or harm to others, including effective crisis response[141].'

> **Recommendation 23:** NHS England should work with Clinical Commissioning Groups, health and wellbeing boards and the CQC to ensure that:
>
> No person is transferred in a police van to hospital;
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> Funds are made available through an appropriate dedicated response for mental health, for instance provision of a dedicated paramedic in a car; and
>
> That demand management systems of the LAS be reviewed, and changes implemented in order to ensure parity of esteem between mental and physical health.

Section 135/136 Protocols

It was evident from the case reviews that police and also mental health professionals do not always understand when the MHA powers under Section136 and Section135 can or should be used. There are also differences in interpretation and approach to their use across London depending on local protocols with NHS Trusts. Police officers in these cases stated that this was a source of frustration for them. The British Transport Police, for instance, told the Commission of their use of a multi-agency approach at this stage to divert some people to other services rather than to hospital under Section136, thus saving police time and resources.

Urgent attention is needed to improve day-to-day protocols between the NHS (LAS) & MPS for 999 and Section136 call management. A best practice critical pathway for handling calls where mental health issues

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139 From 1st April 2013 local authorities assumed responsibilities for public health. Health and wellbeing boards have been established as statutory committees responsible for encouraging integrated working and joint strategies on health and wellbeing. Their main functions are: to assess the needs of their local population through the joint strategic needs assessment process; to produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant; and to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

140 Department of Health, *The Mandate: a mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015.*

141 The NHS Mandate (2012) p.20.

are known or suspected must be put in place, with up to date information on the roles of NHS, social services and MPS personnel, and clear demarcation which prevents people with mental health problems falling through the net.

AMHPs from several Boroughs met with the Commission at South West London and St George's Mental Health Trust and indicated that, while relationships with the police with regard to Mental Health Act Assessments had improved over the years — through regular meetings and joint training — this was not uniformly the case. It was perceived to be a fragile improvement that could be lost with turnover of liaison officers and unilateral actions by the MPS that negatively impacted on AMHP and Council services. For instance in Wandsworth, the MPS is opening a large custody facility to serve several boroughs. This will pressurise the local AMHP (and NHS) services, but this has occurred without strategic discussion with local health and social services. The joint work of the Mental Health Partnership Board has resulted in *principle* agreement for Section136 protocols across London to improve practice across London. [142] The action plan makes a number of recommendations to improve the operation of places of safety, including, significantly, in the Commission's view, having a designated senior Section 136 coordinator, with responsibility for identifying places of safety that will accept patients; as well as responsibility for negotiating access to the nearest A & E department. This is to be welcomed.

The Mental Health Partnership Board report highlighted inconsistencies in the management of section 136 beds across London. This was also raised as an issue in the Commission's discussions with NHS London and with mental health trusts. We were told that gaps continue to exist in provision of a joined up service.

The Commission learned that the leadership of section 136 psychiatric suites can be patchy and inconsistent. There is a fragmented service; with no regularity. It was unclear what the approved clinical pathway is for such cases and who was in charge when people are brought to section 136 suites by the police.

In the Commission's visit to South London & Maudsley NHS Foundation Trust, (SLAM) we learned from clinicians and professionals that a psychiatric Section 136 is a slow pathway to medical services; and that the process can also lead to increased risk to staff. In SLAM, the place

of safety sits alongside other services (using an on call rota system), but it is not a service. The Section 136 suite is not staffed by a consultant or team, as in a psychiatric intensive care unit (PICU). This means that mental health does not have parity of esteem.

The term 'a place of safety' is problematic. The notion of a 'suite' in some cases is a misnomer, when in fact the experience is of a room (or two at best). The Commission considers that the same approach to emergency care for cardiac crisis should be applied to mental health, with fewer, well-resourced clinically led centres, with highly trained staff who can reliably respond to the police in emergencies, and build credible relationships with MHLOs. It is also important to have strategic and physical links with A&E to enable access to PICUs. The location of such specialist resources should be considered in relation to ease of access and demographic demand for such services.

One consultant psychiatrist said that better section 136 places of safety would include:

- A police liaison officer linked specifically to the NHS site;
- Senior clinical leadership available on the ground; and
- Senior executive leadership with responsibility for improving the Section 136 environment.

Improvement in police officers assessment skills was also identified as important.

> One mental health trust staff member said: 'Most people who come to Section 136 suites are acutely disturbed and need specialist assistance.'

Emergency response where section136/135 are not used

One issue which emerged from the Northwick Park Hospital visit is the lack of clarity about voluntary patients, and how the police should respond if a person is not admitted to hospital as a section136 patient. One police inspector said security for the patients was also an issue, and queried where responsibility lies to ensure a patient does not leave the hospital grounds. The police expect that A&E should be able to deal with non-section 135/136 mental health patients. The lack of psychiatric liaison services consistently available means that speedy access to mental health support isn't always forthcoming. The consequence of this can be that the severity

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142   Mental Health Partnership Board (2013) *The operation of Section 136 in London, An Action plan to improve.*

of the case escalates. This can be avoided by commissioning care pathways and having a liaison psychiatrist in place.

A report by the Centre for Mental Health[143] states that 'liaison psychiatry should be regarded as essential to the provision of high-quality and efficient health care.' It calls for a dedicated liaison psychiatry service in every general and acute hospital, which is based on local needs. The Academy of Medical Royal Colleges made a similar case in their detailed report on the issue[144].

In several cases the Commission reviewed when a person was found in acute mental state section 136 was not available to take them to hospital either because the person was entirely willing to attend[145] or because they were on private premises at the time. The police in both cases left the individual in the care of hospital staff in A&E, however one of the people concerned later walked out of the hospital having waited for some time and the fatality occurred. A&E facilities need to provide access to mental health professionals, in particular liaison psychiatrists who have the power to conduct emergency assessments under the Mental Health Act.

> **Recommendation 24:** NHS England should work with Clinical Commission Groups to ensure sustainable liaison psychiatry services are set up, which are based on and reflect the needs of local populations.

Joint agency working for vulnerable adults with mental health issues

Currently, the MPS lacks a comprehensive strategic approach to identify, refer on and contain the risk of vulnerable adults with mental health issues who come to their attention (often as repeat callers) and who may be victims, perpetrators or witnesses to crime or simply needing assistance. These are separate but interrelated matters. While the systems which are set up may overlap, none is comprehensive in coverage and there are areas of confusion and duplication. There is no mental health equivalent to those multi agency procedures for incidents of domestic violence, missing persons and children.

Existing mechanisms to ensure safeguarding and care of vulnerable people or adults at risk include:

1. Safeguarding adults policy and processes. A case management scheme for identifying and assisting vulnerable adults at risk by local authorities. The MPS teams identify these adults and will then create a Merlin entry on the MPS computer system which can then be sent to the local authority.

    The MPS Safeguarding Adults policy is designed to flag up and deal with people who are vulnerable to abuse or neglect and may also be a victim of crime. It aims to ensure that the MPS identifies and calls to account perpetrators of abuse on vulnerable people. It is most likely that vulnerable people come to the attention of Neighbourhood Policing teams in their day to day policing work. It also offers a way of flagging these people up and helping to keep them safe[146].

2. The Merlin system. The Merlin system is designed to capture a broader group of vulnerable people who may be repeat callers to CCC, victims or suspects. They too may be referred on to local authorities but the scheme is only partly in place because some local authorities are reluctant to engage and have not signed information sharing protocols.

3. Multi agency risk assessment for cases involving domestic violence (MARAC). MARAC is part of a coordinated community response to domestic abuse, which aims to share information to increase the safety, health and well-being of victims and survivors (adults and their children); to determine whether the alleged perpetrator poses a significant risk to any individual or the community and to jointly construct and implement a risk management plan that provides professional support to all those at risk, in order to reduce the risk of harm.

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143 Parsonage, M., Fossey, M., Tutty, C., (2012) *Liaison psychiatry in the modern NHS*, Centre for Mental Health.

144 *Managing Urgent Mental Health Needs in the Acute Trust*, Report of the Academy of Medical Royal Colleges , 2008

145 The MPS Mental Health Briefing on s.136 however specifies that s 136 must always be used if the person meets the criteria even if they are willing to go to hospital.

146 Currently, multiagency policies and protocols (Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, http://www.scie.org.uk/publications/ataglance/ataglance44.asp) have been developed by the MPS, NHS, Association of Directors of Adult Social Services (ADASS) and the Social Care Institute for Excellence (SCIE). These are aimed at safeguarding vulnerable adults. Their purpose is to:

- improve inter-agency working
- avoid people falling between the gaps in services
- reduce duplication of work
- gain a better understanding of safeguarding across all agencies; and
- ensure alignment of language used across agencies.

Nationally, there is also significant attention to safeguarding vulnerable adults, in part due to the Winterbourne View residential home scandal. Current initiatives include plans to have one person at senior level who is legally responsible for safeguarding issues in all provider organisations and to ensure adult safeguarding partnership boards are on a statutory footing alongside Local Safeguarding Children's Boards.

4. **Multi-Agency Public Protection Agreements (MAPPA).** Introduced by the Criminal Justice and Court Services Act (2000), these are multi-agency panels whose role is to monitor the health of and manage the risks posed by dangerous offenders released from imprisonment. Key to this is a two-way information sharing process.

5. **Multi agency safeguarding hubs for children (MASH).** The hubs bring together safeguarding professionals from a variety of agencies in one secure location, usually in a local authority's children's services directorate. They are able to share information about vulnerable people in confidence, with nothing leaving the room without their consent. The aim is to protect children's wellbeing and welfare.

Two cases that the Commission reviewed illustrate the gaps in multi agency arrangements and their consequences. Both cases had considerable police involvement in the immediate days and weeks before the incidents occurred. In both cases the level of risk was not appreciated by police, and in both cases the individuals went on to commit homicide.

In one case the DPS report stated;

'The MPS must consider providing guidance at an early stage in recognising mental health issues, how staff should respond and what other services are available to assist in the process.'

'...where persons such as Mr… are identified as vulnerable a system should be developed to ensure that the MPS engages with appropriate agencies and refers them to the correct agency. This would ensure that they receive the correct support and also reduce the draw on police resources.'

Further:

'…the amount of resources that were being directed towards Mr… and identified him as vulnerable, could have initiated procedures that would have reduced the amount of police time spent dealing with him. Also, if he had received the appropriate help his mental state may not have deteriorated to the extent that it had done… '

In the second case, it was the failure to use the current MARAC service, which did apply in the circumstances, which contributed to a tragedy.

In another case the man came to the attention to the police because of his reckless and criminal behaviour. He had mental health problems and was dependent on alcohol. He had suffered with severe depression following his mother's death.

The CIAT review findings in this case found that: while the police had responded adequately on each individual occasion there was a failure to understand the pattern of events and thus a failure to refer to MARAC and an inaccurate recording of risk.'

Both these cases highlight the opportunities for referral to a multi agency team that would have got support to a person who was ill and may also have saved a life. The problem, however, is the piecemeal overlapping and incomplete nature of the existing mechanism.

As put by the Mental Health Cop: One major problem is that an interface between policing and mental health does not necessarily naturally occur within the previous frameworks for inter-agency partnership working. Crime and Reduction Disorder Partnerships, Child and Adult Safeguarding structures; MAPPA and MARAC arrangements: each of these will see the interface in part, but none of them is looking at it from an overarching strategic point of view[147].

Multiagency arrangements for adults at risk with mental health problems are clearly necessary. Adult safeguarding structures, which are now strengthened, and backed up by statute, should provide the required overarching strategic and coordination roles. This system might operate in a similar way to the MARAC one which would bring a single approach, overseen in every locality, to meeting the needs of vulnerable people such as Case 3 and Case 9 who are at high risk.

There are good practice initiatives developing locally as forums for risk discussion and interagency information exchange. In Sutton, the Council and South West London and St George's Mental Health NHS Trust convene a regular risk forum with local police and other relevant agencies to discuss people of concern, who may be vulnerable or may pose a risk to others, but who do not fit the criteria for any of the forums described above. In the

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147   Mental Health Cop, http://mentalhealthcop.wordpress.com

London Boroughs of Wandsworth and Merton, there are structures for multiagency discussion about people who may be at risk of self-harm or neglect for a variety of reasons, including mental illness, where the police may be a key attendee.

> **Recommendation 25:** The MPS should:
>
> Establish joint protocols to identify a basis for effectively sharing information London-wide with partner agencies for adults at risk with mental health problems;
>
> Work with the Mental Health Partnership Board to establish a multiagency mechanism for risk assessing, case managing and information sharing in relation to people with mental health problems who are perceived to be at high level of vulnerability.
>
> Ensure senior and authoritative representation on the Local Authority-led multiagency Adult Safeguarding Partnership Boards.

Liaison and diversion

The Bradley Report (2009) recommended that: 'All police custody suites should have access to liaison and diversion services. These services would include improved screening and identification of individuals with mental health problems or learning disabilities, providing information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system, and signposting to local health and social care services as appropriate.'

Diversion need not replace sanctions for an offence. 'It is particularly cost effective to divert an offender who may otherwise be remanded and then given a prison sentence to alternative non-custodial sanctions, usually a community order, together with a package of community-based support services[148].'

Evidence from the Oxleas NHS Foundation Trust pilot[149] demonstrated the advantages of early identification, early liaison, direct access to mental health professionals and a smoother pathway to acute care. The outcomes in individual cases are impressive:

Example of good practice: A man, who had never previously been in contact with mental health services, but had visited his GP on a number of occasions, was arrested having been involved in a fight. The gentleman's GP had prescribed him with a large dose of anti-depressants. When being booked in the gentleman said he had no mental health issues and that he had not been seen by mental health services. The custody nurse had been given this gentleman's medication, which the CPN noted and as a result assessed him. As a result of the assessment the CPN was very concerned about his mental health she liaised with the custody sergeant and arranged a Mental Health Act assessment. The gentleman was given police bail and was admitted to hospital as a compulsory patient. His condition is now stable and is managed by a community mental health team.

Example of good practice: Previously a woman had used alcohol as a means of coping with her mental health issues, however had remained abstinent for some months following her arrest. In the past this woman had contact with services but had disengaged and due to alcohol misuse was not thought appropriate for treatment. The CPN referred the young lady to the local Intake and Liaison team. She is now receiving treatment — long term psychotherapy and social inclusion — working towards being able to go to college. This young lady was most grateful for the intervention and sent a thank you card to the CPN, informing her of the help she is now receiving, and acknowledging the value of the presence of mental health workers in the police station. The young woman received a community sentence.

Access to diversion services is still patchy in custody suites in London and there is no standard protocol that can provide guidelines to comprehensively commission a service. The Commission believes that the MPS is unclear as to its approach to liaison and diversion at a time of change and development in this area. Several of the cases the Commission looked at and the other evidence it received demonstrate the benefits of such a system in potentially saving life. The following cases would have been good examples of where such a service could have provided a better outcome.

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148 *Diversion: The business case for action*, Centre for Mental Health, Rethink and the Royal College of Psychiatrists , 2011.

149 Paul Lambotte, Early intervention and Assessment in Custody Suites presentation at MPS forum November 2012.

In case 42 the Asian man was booked into custody on an assault charge. He explained that he had previously suffered from mental illness, self harmed and had engaged with an early intervention team in London. He spent 2 days in custody, was taken to a magistrates court charged with assault and released on bail. He immediately went to a high building and jumped to his death. No FME was called and no attempt was made to contact the mental health services.

In case 26 a man hanged himself in prison having been kept in custody on a charge of ABH . He had attempted suicide while in police custody and after pleading guilty to offences of ABH was taken to prison on a short 112 days sentence. The coroner found failings by all the services involved to adequately record, pass on or act on information about his high level of suicide risk.

A new mapping report[150] on liaison and diversion schemes in London identifies the lack of a strategic framework and wide variation in commissioning and funding arrangements. While recognising examples of successful local partnership working and information sharing, the report identifies that a 'structural challenge' of information transfer between agencies across the criminal justice pathway and notes that a key 'reported difficulty for some schemes is around obtaining adequate access to police records and IT systems to effectively identify and assess clients.'

This and other issues on liaison and diversion were raised in our meetings with liaison and diversion professionals who work in custody suites. They spoke of the wide variation in service provision and practice across London. In addition, there is little sharing of information and good practice between boroughs. This view is borne out by the HMIC inspections of custody suites across London boroughs. In inspections undertaken in 2011-12 they recommended that liaison and diversion services should be available in custody suites and commended Bromley for its new pilot diversion and liaison scheme. They noted that police custody staff were keen to ensure that the pilot was made permanent, as it had substantially assisted in providing appropriate care and diversion[151].

The professionals cited frustrating barriers in gaining physical access to stations because there was no protocol for accrediting them and of problems with access to, sharing of and use of information. This reduced their ability to adequately screen for risk. Community Psychiatric Nurses (CPNs) cannot record information onto the police system and do not have their own NHS computer system in custody suites.

They explained their frustration with the variable standard of health care in custody suites and how this hampered their practice. They also noted that many of those arrested are not a cross section of society and may have been arrested numerous times before, explaining that the relationship between some individuals and the police can be antagonistic to begin with and many are likely to be at risk of self-harm in custody, as they may be at risk of this in general due to their existing complex needs.

CPN attached to custody suite: 'Those arrested are not a cross section of society. They're a complex and diverse community who've often been arrested numerous times before. The relationship between such individuals and police is often quite antagonistic to begin with, and many are likely to be at risk of self-harm in custody, as they're at risk of self-harm and/or suicide in general due to their existing complex needs (regardless of arrest).'

There is recognition amongst liaison and diversion professionals that the solution does not lie solely with the MPS and that collaborative and joint working is needed between the MPS and health and local authorities. They cited the need for post-diversion opportunities to help stabilise people in the community.

Better education and training on mental health awareness for the MPS; provision of designated and named individuals to act as contact and co-ordination points in custody suites; coordination of electronic records across different systems (MPS/NHS/Social Services) are all necessary to provide effective pathways of diversion for people to get the help they need whether or not a crime has been committed.

Work is underway as part of implementation of the Bradley Report. A national Department of Health funded programme has been set up to help facilitate and coordinate good practice approaches in liaison and diversion. This will focus on the development of a framework, quality standards and workforce development and

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150 Criminal Justice Liaison and Diversion, London Mapping Exercise 2012, London Criminal Justice Liaison & Diversion Advisory Board.

151 Report on an unannounced HMIC inspection visit to police custody suites in the Metropolitan Police Service Borough Operational Command Unit of Bromley 8–10 May 2012 6.20.

training programmes. Commissioning guidance will also be produced. The work is being undertaken in collaboration with more than 100 services and groups.

The Commission believes that active collaboration and commitment of the MPS with this work is crucial. It is an essential component of an effective system for referring people to health and social care, improving care pathways for individuals and saving lives. It would also have immediate benefits for custody staff and save police time and resources.

> **Recommendation 26:** The MPS and its NHS partners should immediately implement the Bradley Report recommendation so that all police custody suites should have access to liaison and diversion services.

Approved Mental Health Professionals (AMHPs)

AMHPs have a great deal of knowledge and expertise. They are the decision makers about detention under the Mental Health Act in most cases, they are tasked with organising and executing assessments with other professionals and ensuring safe conveyance of people liable to detention to hospital. AMHP services must be provided by local authorities and while AMHPs are often working in teams managed by NHS Trusts, they take their decisions independently and do this on behalf of local authorities under statutory law,

AMHPs identified a number of areas for improved joint working with the MPS. These included more joint training; better relationships on the ground with front line police officers; better information sharing and communication, specifically with the grip and pace systems; the need for strategic as well as operational expertise on the ground; greater involvement of safer neighbourhood teams; and the need for better police awareness of mental health issues.

AMHPs and police work together to undertake pre-planned Mental Health Act assessments. The MPS mental health SOP states that 'all boroughs should have a single point of contact to receive requests from AMHPs' and that police are meant to provide information to AMHPs to inform risk assessments.

Evidence in our cases indicates that where police risk management supersedes AMHP risk management, the safety of a person may be compromised. The Commission believes that it is therefore vital that risk management plans in urgent situations and decisions about 'who leads' consider the AMHPs' welfare and social care perspective.

The Mental Health Partnership Board report on the operation of Section 136 in London[152] identified the difficulty of securing attendance of an AMHP in a timely fashion out of hours. It noted: 'Delays in excess of four hours are frequently reported.' The lack of access to AMHPS on weekends was said to have led to fatal delays in 2 cases we reviewed.

The Mental Health Partnership Board report further noted that such delays contravene Royal College of Psychiatrists and Mental Health Act 1983 Code of Practice national standards on the availability of AMHPs for Section136 assessments. The former sets a standard of three hours, with an aspirational target of two hours; while the latter requires local authorities social services departments to have AMHPs in place on a 24 hour basis.

The report notes good practice for AMHP attendance in some boroughs (including East London, Oxleas and West London Mental Health Trusts), as well as outside of London. In Brighton, the Commission found evidence, in the existing on-call operations, of the availability of AMHPs within one hour of being called by a social worker.

In the Commission's discussions with AMHPs, they described day-to-day arrangements with the MPS across London as:

- Variable, depending on the influence and interests of borough commanders and/or the expertise of mental health liaison officers;

- Marked by differing procedures between boroughs for grip and pace and CAD handling;

- Hampered by difficulty in getting appropriate responses from the centralised MPS system;

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152   Mental Health Partnership Board for London (March 2013).

- Hampered by a lack of mental health out of hours services, for example some mental health emergency assessments may be picked up by Children & Families out of hours services; and

- In need of better protocols relating to section136 so that appropriate pathways can be developed for people who are drunk, as opposed to having a mental health problem.

One AMHP said a key test, is how many people are admitted as a result of being brought in under a section 136 by police. He noted that in his borough 51% of people who are brought in this way are not admitted as inpatients. Equally, however, it is important to point out that section 136 is a mechanism for assessment. That means that, in this instance, the remaining 49% who were brought in were able to access services based on the assessment undertaken.

> **Recommendation 27:** The MPS should urgently work with local authorities and mental health trusts to ensure existing protocols and procedures for information sharing; risk assessment and management are adhered to and monitored. This should include taking account of local authority led strategic safeguarding structures to promote public safety and wellbeing.

> **Recommendations 28:** The MPS should agree protocols for joint working on service provision with reference to AMHPs, emergency duty teams and wider social care services.

Section 4
Summary of Recommendations

Indicated beside each of the recommendations made in the report is a suggested timeframe, by which the Commission's recommendations should be implemented.

Recommendations and suggested timeframes

RECOMMENDATION 1

Immediately

Implementation of the One Met Model for policing in London should reflect, at all levels, in day to day police business, the impact of mental health for vulnerable adults who are at risk.

RECOMMENDATION 2

3 months

The MPS should include a mental health-specific indicator as part of performance measurement of the 20% Mayor's Office for Police and Crime (MOPAC) target for improving public confidence.

RECOMMENDATION 3

6 months

MOPAC should hold the MPS to account for identification and delivery of a mental health specific performance indicator within the 20% MOPAC target.

RECOMMENDATION 4

12 months

The Mental Health Liaison Officer (MHLO) role should be full time to at least co-terminous levels with mental health trusts and supported by expert teams based on assessment of local needs.

Immediately

The MHLO role should have explicit and accountable links with external agencies, including the NHS, Local Authorities and the voluntary sector.

6 months

The MHLO role should be integrated and supported throughout the MPS, including with frontline police officers and neighbourhood teams.

6 months

The MHLO role should be operationally accountable at senior management level; and should include provision for continuing professional development.

RECOMMENDATION 5

Immediately

The MPS Commissioner should take personal responsibility for devising and implementing a strategy to ensure that the culture and working practices of the MPS demonstrably promote equality in relation to those with mental health conditions. This should include devising a strategy with key milestones and providing annual reports on progressing this strategy. This report should also detail complaints concerning the treatment of people with mental health conditions and action taken to address them.

RECOMMENDATION 6

12 months

The MPS needs to implement an organisational learning strategy in order to give lasting effect to the recommendations of external bodies, and the key findings of internal reviews. This strategy should include a named lead and clearly defined timeframe for implementation and review, ensuring that responsibility for the implementation process resides at Commander level and not within each business group.

RECOMMENDATION 7

Immediately

The MPS should ensure that personal issues of mental health and wellbeing are incorporated into staff induction, and ongoing mental health awareness training.

The MPS should ensure that processes for debriefing and supervision enable police officers and staff to discuss issues of concern and stress which may relate to their own mental wellbeing.

The MPS should ensure that occupational health policies and procedures enable all frontline staff to access appropriate mental health support, without recourse to stigma or discrimination, if a need is identified.

RECOMMENDATION 8

Immediately

The MPS should establish a high level expert group of stakeholders that can provide the MPS with ongoing and specific advice and review; which are aimed at improvements in outcomes with regard to race, faith and mental health. This group should report to the Commissioner.

RECOMMENDATION 9

12 months

That the MPS should create a comprehensive suite of mandatory training for staff and officers developed in partnership with experts, including from the voluntary sector, and individuals with mental health needs.

Immediately

This programme should be developed in conjunction with the London Mental Health Partnership Board; the College of Policing and independently evaluated.

RECOMMENDATION 10

6 months

The MPS should seek external experts in mental health to assist in the routine review of guidance, SOPs and information materials. This review should be a public report, available on the MPS website and submitted at six-monthly intervals to the London Mental Health Partnership Board.

RECOMMENDATION 11

12 months

The MPS should adopt a corporate approach to suicide prevention with both a strategic and operational focus. Suicide prevention training and guidance must be put in place immediately with the advice and assistance of external stakeholders.

RECOMMENDATION 12

Immediately

The MPS has to work with ACPO and the College of Policing on policy and training on restraint to ensure that the principles outlined in this report are enforced or utilised.

RECOMMENDATION 13

6 months

The MPS information systems need to be improved to provide:

- a central intranet depository to collect policies and protocols information, advice, news on mental health issues to be a resource to police officers and staff; and
- a centralised database and paper based collection of all internal and external case reviews involving mental health.

RECOMMENDATION 14

6 months

A new process needs to be introduced in the review of standard operating procedures and policies with relevance to mental health so that stakeholders from the statutory and voluntary sectors are involved as partners in the process

RECOMMENDATION 15

Immediately

Establish a system on Merlin for vulnerable adults which includes both a mechanism to record and a mechanism to refer incidents involving adults in mental distress.

RECOMMENDATION 16

12 months

The MPS should invest in technology for CCC which is fit for purpose.

Guidance and protocols on vulnerable persons and mental health at CCC should be reviewed in collaboration with external sources, including service users and carers, as well as voluntary sector agencies, to improve their effectiveness at identifying relevant issues.

Within the bounds of confidentiality information about carer/ family member and a health support person should be captured.

RECOMMENDATION 17

12 months
Mental health nurses with experience related to offenders must be available to all custody suites. The MPS should conduct a 360 degree review every six months to ensure that they are accessing the proper advice from psychiatric nurses in the delivery of health care in custody suites.

RECOMMENDATION 18

6 months
Practices and policies in custody suites must acknowledge the needs of vulnerable people as part of pre release risk assessment and take steps, as appropriate, to refer them to other services and to ensure their safe handover to relatives, carers or professionals.

RECOMMENDATION 19

12 months
The MPS should adopt the Newcastle health screening tool or one that meets the same level of effectiveness for risk assessment in all custody suites.

RECOMMENDATION 20

12 months
The MPS Commissioner should publish a public report on the care of people with mental health and drug or alcohol conditions in custody suites, the referral pathways and the outcomes of pre release risk assessments.

RECOMMENDATION 21

Immediately
The MPS should transfer commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS.

RECOMMENDATION 22

6 months
The Mental Health Partnership Board should have formal recognition and mandate specifically agreed with NHS England, the MPS, the Association of Directors of Adult Social Services (ADASS) and Mayor's Office for Police And Crime (MOPAC) as part of the Mayor's accountability for health. This would constitute a central oversight mechanism for improving mental health and policing in London.

RECOMMENDATION 23

12 months
NHS England should work with Clinical Commissioning Groups, health and wellbeing boards and the CQC to ensure that:

- No person is transferred in a police van to hospital;
- Funds are made available through an appropriate dedicated response for mental health, for instance provision of a dedicated paramedic in a car; and
- That demand management systems of the LAS be reviewed, and changes implemented in order to ensure parity of esteem between mental and physical health.

RECOMMENDATION 24

12 months
NHS England should work with Clinical Commissioning groups to ensure sustainable liaison psychiatry services are set up, which are based on and reflect the needs of local populations.

RECOMMENDATION 25

6 months
The MPS should:

- establish joint protocols to identify a basis for effectively sharing information with partner agencies for adults at risk with mental health problems;
- work with the Mental Health Partnership Board to establish a multiagency mechanism for risk assessing, case managing and information sharing in relation to people with mental health problems who are perceived to be at high level of vulnerability;
- ensure senior and authoritative representation on the Local Authority-led multiagency Adult Safeguarding Partnership Boards.

RECOMMENDATION 26

Immediately
The MPS and its NHS partners should immediately implement the Bradley Report recommendation so that all police custody suites should have access to liaison and diversion services.

RECOMMENDATION 27

6 months

The MPS should urgently work with local authorities and mental health trusts to ensure existing protocols and procedures for information sharing; risk assessment and management are adhered to and monitored. This should include taking account of local authority led strategic safeguarding structures to promote public safety and wellbeing.

RECOMMENDATION 28

6 months

The MPS should agree protocols for joint working on service provision with reference to AMHPs, emergency duty teams and wider social care services.

Section 5
Conclusion

The central focus of the work of the Commission was the 50 cases where people died in custody or after police contact; and the five cases where there was serious injury. From examination of these cases we found common themes and patterns of behaviour in the MPS that needed to be addressed.

This involved looking at the MPS as a whole system and thus our recommendations are necessarily directed to action at strategic and operational levels. Although the Commission's remit was for London only, many of the recommendations made in this report are relevant to forces across the Country.

They aim to improve the service that the public — as victims, suspects, and as vulnerable people — receive from the police when mental health is an issue.

They aim to help the police, working in custody, on the street and in Central Communications Command (CCC), to be better trained and equipped to do their jobs effectively and with confidence.

They aim to help the MPS institute a better working environment to safeguard the health and wellbeing of its officers and staff.

Implementation of these recommendations means that we would expect to see the following:

1. that a person in a critical mental state who is found by the police in public and who needs medical care is escorted safely to hospital in an ambulance;

2. that the police and NHS staff know what their respective roles are with respect to that individual and that they are treated throughout with respect and without exacerbating their condition;

3. that a person in the community who is at high risk of causing serious harm to themselves or another person on account of their mental ill-health and who comes to police notice is referred to partner agencies. If need be, a care plan is put in place for that individual through a multi agency approach in which the police participate;

4. that the public can be confident that the MPS has a fully professional approach to the protection of life of suicidal individuals, so that any suicidal individual who comes to the notice of the police gets the attention and timely support of a trained professional;

5. that the front line police officer working on the street and in custody has clear and consistent procedures to follow for both planned and unplanned instances involving people with mental health conditions, including access to negotiators where needed and clear referral pathways to other services;

6. that a person with a significant mental health problem who is taken into custody has their health care needs dealt with to the same standard as in the NHS; and that during custody, and before their release from custody, they are assessed for suicidality and mental health needs, and provided with referral and support, where appropriate, to liaison and diversion services;

7. that a vulnerable person is not released from custody without a positive effort to link them to a carer, relative or professional and place to stay; and that this is recorded in the custody record;

8. that the police are trained and provided with accessible guidance and information to assist them to use referral systems efficiently;

9. that any person with a significant mental health condition is treated without being stigmatised or discriminated against for their ethnicity or race;

10. that mutually productive relationships, based on respect and good communication exist between all relevant agencies as well as with relatives and carers of people with mental health problems and the police.

We would expect that the police are provided with the training, guidance, information and access to expert advice required to deal confidently with the range of situations, when people with significant mental health issues come to their attention. We would also expect that protocols are put in place across London so that the roles and responsibilities of the police, the NHS and local authorities are clear and joined up for both planned and unplanned situations.

If all our recommendations are implemented, it is the view of the Commission and the collective conclusion from our recommendations, that the events that informed this inquiry, are far less likely to happen in the future.

For the delivery of all of this, we would expect that the MPS Commissioner accounts directly to the people of London.

**Independent Commission on
Mental Health and Policing**
May 2013

Appendix 1
Terms of Reference and Members of the Commission

Independent Commission on Mental Health and Policing

Lord Victor Adebowale (Chair)

TERMS OF REFERENCE

The purpose of this Commission is to carry out an independent examination of cases, within the last five years, of death or serious injury of people with a mental illness, after contact with police. It will make recommendations that seek to assist the Metropolitan Police Service response and actions where mental health is, or is perceived to be, a key component, to minimise the risk of adverse outcomes in such circumstances in the future and inform improvements in the response to mental health related call outs.

The review will address the following matters:

- The roles and responsibilities of the Metropolitan Police Service in dealing with issues of mental illness:
  a In custody.
  b At street encounter, to include what are the realistic expectations of how front line officers will act when they meet or are called to deal with a person who may have a mental health condition.
  c In response to calls made to police and the process of call handling within Central Communications Command (CCC) when dealing with:
    · Members of the public calling to report an incident which has some connection with or indication of mental health.
    · People that appear to have a mental health condition.

- The review will focus on the available evidence relating to the cases referred to above, to see if there are any features, or combination of features that contributed to the adverse outcomes. It will also consider the interface between policing and mental health services and look at the roles and responsibilities of partner agencies giving emphasis to current Service Level Agreements, both local and corporate, to ensure that they are sufficient and fit for purpose and will include consideration of how information is shared between the Metropolitan Police Service and partner agencies.

In carrying out the review, Lord Adebowale and his team will:
- Have access to all relevant policies and standard operating procedures held by the Metropolitan Police Service in the management of incidents involving people with mental health issues; with a view to commenting on such in order that the Metropolitan Police Service can make the appropriate changes to improve its service to those experiencing mental health issues.
- Have access to any files that the Commission considers necessary to carry out their review (with full confidentiality).
- Be able to speak to anyone that they wish to within the Metropolitan Police Service.
- Seek information from sources outside the Metropolitan Police Service, including specialist representation groups.
- Take account of any representations made by or on behalf of families involved.
- The Commission has no legal standing and therefore will not be able to overturn any Coroners' findings. In addition the Commission will not be undertaking a review of the Mental Health Act.
- The findings and recommendations will be made public.

PROCESS

The Commission met monthly from October to April 2013. Regular meetings were augmented by information gathering which included:

i   meeting with service users, their families and members of the public;
ii reviewing MPS policies, practices and procedures, including good practice where we found it;
iii listening to the views of police officers;
iv calling for evidence from the general public;
v   seeking the views of NHS organisations, including London Ambulance Service, mental health trusts, and others;
vi taking evidence from organisations in the voluntary sector; and
vii commissioning original research through online surveys.

October 2012

MEMBERS OF THE COMMISSION

Commissioners

- Lord Victor Adebowale (Chair) — Chief Executive of Turning Point
- Dr Ruth Allen — Director of Social Work at South West London and St George's Mental Health NHS Trust and Chair of the Faculty of Mental Health at the College of Social Work
- Professor Louis Appleby — Professor of Psychiatry at University of Manchester and National Clinical Director for Health & Criminal Justice
- Chief Constable Simon Cole — Chief Constable of Leicestershire Constabulary and ACPO lead for mental health (advisor to the Commission)
- Paul Farmer — Chief Executive of Mind
- Professor Tony Maden — Professor of Psychiatry at Imperial College London
- Dave Mellish — Chair of Oxleas NHS Foundation Trust, Chair of the London Mental Health Chairs Group and Chair of the Mental Health Partnership Board
- Claire Murdoch — Chief Executive of Central and North West London NHS Foundation Trust
- Lucy Scott Moncrieff — President of The Law Society and specialist in mental health law
- Professor Betsy Stanko — Assistant Director of Corporate Development at MPS (providing research support and advice)
- Patrick Vernon — Expert in BME health and social care and equalities issues

Researchers/Writers

- Dr. Rowena Daw — Independent consultant
- Melba Wilson — Independent consultant

Appendix 2
The Case Review and Criteria

How we worked

The commission's work was governed by the following aspects:

1. **The incidence of mental health information or issues was determined by:**

   - the Mental Health Act 1983
   - risk assessment
   - self report by the person
   - information from families
   - information available in records held by police
   - knowledge of the person being a patient of a mental health trust or information from a health professional
   - whether the person's behaviour at the time gave reasonable cause to believe there were mental health issues present.

2. **Definitions**

This report uses definitions from the Metropolitan Police Standard Operating Procedures (SOP)[153] as developed through the MPS Directorate of Professional Standards (DPS).

Death

The MPS definition of death is based on Home Office Circular 13/2002 which categorises death following police contact as:

1. Fatal road traffic incident involving police
2. Fatal shooting incident involving police
3. Deaths in or following custody
4. Deaths during or following other types of contact with police (e.g. where a person is attempting to evade arrest and death occurs other than as the result of a road collision, e.g. jumping from a building)

The Police Reform Act 2002 requires the police to refer to the IPCC incidents where persons have died or been seriously injured following some form of direct or indirect contact with the police and there is reason to believe the contact may have caused or contributed to the death or serious injury. These are cases that do not involve a complaint or conduct matter when first identified and categorised.

Serious injury

The IPCC definition of serious injury is a 'fracture, a deep cut, a deep laceration or an injury causing damage to an internal organ or the impairment of any bodily function.' [154]

The MPS post incident procedure can be applied in situations where the injury may be capable of causing death or serious disability and includes serious injury to mental health. This includes injury that can be considered 'life changing.'

A review of all cases provided by the MPS where, within the last 5 years (September 2007-2012) , a person with a mental disorder has died in police custody or following police contact (within 48 hours).

This will cover all those which have been subject to review, that is those covered by:

- internal review by MPS (Department of Professional Standards),
- external reviews by the IPPC cases and Coroner's Rule 43 reports.

Cases were located through searching the records held by the DPS and the Legal Services Directorate at the MPS. A request for other cases was also sent out to boroughs.

The review also covered 'near misses', where a person suffered serious injury after police contact or in police custody, but the difficulties in locating such cases made it impossible to do a systematic review . It was decided to take into account only those that were brought to our attention and raised serious issues.

INTERPRETING THE CRITERIA

Mental disorder — this term is broadly in line with the legal definition in the MHA ('any disorder or disability of the mind'). It covers all acknowledged mental health conditions but also the temporary condition of ABD (acute behavioural disorder) whether or not there was an underlying mental illness. It excludes people who were simply intoxicated or under the influence of drugs.

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153   DPS Policy Unit, Professional Standards (Standard Operating Procedure) Death & Serious Injury Following Police Contact — Post Incident Procedures

154   IPCC Statutory Guidance, p. 41

The Commission included all cases of suicide within 48 hours of police contact. In almost all instances the deceased person had been in contact with mental health services prior to their death or there was evidence of a mental disorder from family members.

The aim was to identify typical themes and patterns of events when deaths occurred. Therefore all cases were included whether or not the reviews found, or the Commission believed that the police response was at fault unless the police involvement was insignificant to the outcome and the major role was taken by the NHS.

SOURCES OF INFORMATION

We were dependent on the information that the MPS could provide in the time. The sources, quality and extent of available material varied among the cases and the conclusions that could be drawn were at times limited as a result. Nevertheless we were able in many instances to acquire access to the MPS files as well as to the external or internal reviews of the case in question. Background documents included CADs generated by CCC or responding officers, witness statements, custody suite records, medical notes, policies and standard operating procedures.

Results

A total of 50 cases fit the criteria. There were 38 males and 12 females. Twenty seven were white British/Irish; ten were black African or Afro-Caribbean, and one mixed race; twelve were from other ethnic minority groups (6 Asian, 2 Middle Eastern and 4 eastern European origins).

They are in the following categories

1. Suicide within 48 hours after police custody (14 cases)

In all cases the police knew of the person's mental disorder or ought to have identified vulnerability on grounds of mental health from the person's behaviour while in custody.

2. Suicide within 48 hours after police contact (13 cases)

   • Police attended the person's home on a welfare visit. The person died immediately or soon after they departed.
   • Police were called to attend a mental health assessment but there was a delay and the person died before they arrived or
   • Police failed to attend to a person in acute crisis.

3. Suicide when police in attendance (8 cases)

   • Police were called to the scene of a person about to commit suicide or
   • Police attended a section 135 mental health assessment with an AMHP and the person died while they were attempting entry or in attendance.

4. Death in police custody, or while police in control or after restraint (5 cases)

In 4 cases the person died after a period of police restraint, in one case the person died from a gunshot wound during a struggle with police.

5. Death of third party at the hands of someone in contact with police (6 cases).

In all cases the person had been involved with police immediately prior to the homicide.

6. Suicide of police officers while in MPS employment (4 cases)

Serious injury involving people with a mental disorder (5 cases selected). Two of these cases involve men who were involved in a struggle with police and were injured in the process, one young man with autism was restrained and suffered a long period of physical and mental trauma as a result, one woman attempted suicide after contact with the police.

Appendix 3
Summary results of service user surveys

An online survey was distributed to Mind networks to gather people's experience with the MPS over the last 5 years.

There were 70 replies. Approximately 58% were 30-50 and two thirds were female. 86% were white. The largest group of those responding were the person who had mental health problems (31), the remainder were responding as mental health professionals(19) or as family members/carers/friends (14). Of those who had come into contact with the police as a result of a mental health matter approximately 60% had been involved on more than one occasion.

Around half the respondents answered the other questions and 20 provided extra comments. Most incidents involved the MHA, and of those most were taken under s136, and by police car/van. Over 70% respondents did not feel that enough information was conveyed to them and 56% did not feel that the police communicated with them in a way the could understand. Overall, around 28% found their experience with the police was very positive or positive and 47% were negative or very negative, the remainder were neutral. In regard to their competence the following results were obtained.

The first figure represents excellent or good, the second neither good nor poor, the third is poor or very poor. The highest statistic is in bold. The remaining figure is for 'don't know'.

Helpfulness: 31%/37%/35%

Demonstrating dignity and respect: 28%/28%/44%

Understanding of mental health issues: 19%/22%/56%

Understanding of mental health service provision: 19%/25%/50%

Level of mental health first aid: 9%/28%/49%

Changes

Asked what changes they would like to see the MPS make in working with people with mental health problems the most important change by far was better mental health training for staff (85%), more helpful attitudes (70%), increased ability to offer better support (58%) better knowledge of the impact of diversity (49%) and greater involvement of carers (27%).

Comments included less arrogance, training in how mental illness can make people feel and not to be treated as time wasters or criminals. Fuller understanding and being willing to listen to victims and asking individuals what they could do to help. However they also reported instances of kind and helpful care.

Quotes from respondents

They pinned me down and restrained me with male police. At the time i was having severe flashbacks of abuse i suffered as a child. I became more aggressive because they were reconstructing the abusive restraints i fear.

Also i would of responded better to female officers. Please dont restrain me as when you are called to attend me it is usually when i am disturbed by horrific flashbacks of abuse. You scare me more. I had a breakdown nearly 4 years ago and tried to take my own life, someone contacted the police and they took over the situation with a rather abrupt and uncaring attitude. They were very rough in every sense, showed very little compassion and reduced me to tears.

I was locked in a cell over night following a break down/crisis in my mental health. I asked for help & explained to the police my situation yet they treated me like a drunk because I had had a couple of drinks. I was utterly disgusted by the way I was spoken to 'Come on love, we've all been there' one female officer said as she slammed the door shut in my face.

Picked up several times on a S.136 in a very vulnerable situations. Often taken in the back of the van and sometimes an ambulance. Very intimidating. I was terrified.

I was on leave from hospital and I was a couple of hours late back. The police rang my doorbell at midnight and said 'come on, let us in'. They didn't even say they were the police. The police broke my door down and took me back to hospital in handcuffs, although I was offering no resistance…They were very rude and disrespectful.

Multiple crisis and sections under 136 then on to 136 suite/custody because of being deemed danger to self. Restraint/use of physical force still leaves me scared of police.

Based on a malicious complaint from a neighbour, my home and allotment were raided by ten policemen armed with a search warrant. They were surprisingly civil; no force or violence was used; their search was complete in half an hour with nothing to report but a small amount of cannabis for personal use, about which they issued a warning…I was treated reasonably by the police and was pleasantly surprised by how they conducted themselves.

Last year I attempted suicide for the second time. My Mum did not know where I had gone and called the police the next morning. They helped trace me, took my Mum to the hospital and helped explain the situation in an understandable way. The policeman also spoke to me and although slightly lacking on information about mental health were kind and compassionate. I will always be grateful to the officers for helping me...through such a difficult situation.

Why not have crisis intervention plans kept on system so where you are called i could write a plan of how best to deal with me when in a distressed state. That way you would not treat me the way you do which makes things ten times worse. Please speak to people and there families before going in so heavy handed. I have had bruises all over me from your techniques of restraint. Yet when suffered restraint by trained hospital staff have not had any. You are rough and treat me like a criminal.

I think the problem here was not with the police, but with the psychiatric unit where my partner was being treated …From conversations I had with the police at the time (just a few months ago),patients — including those sectioned under the Mental Health Act, regularly went missing from the unit. Sometimes the police were not informed for quite a long time of the patient's disappearance unless family members intervened (as happened in the situation I have described to you). I was very impressed by the police as they were called out on three separate occasions when my partner went missing. All the police officers I came into contact with during those horribly stressful times, were without exception, courteous, sensitive and helpful. I cannot thank them enough for their patient and sensitive handling of the case. I wish I could say the same for the staff [at the psychiatric unit].

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Appendix 4
Summary of Public Survey Responses

An online survey to the public was set up in January 2013. It asked general questions about people's experience of the MPS in dealing with people with mental health conditions. There were 322 replies with a roughly equal response rate from service users and their families, from professionals and from the general public.

A total of 109 people had either come into contact with the MPS themselves or knew of someone who had, within the last five years. Of these, 95 people rated their overall experience. The majority rated their experience as negative or very negative (60%) whilst over a third (37%) rated the experience as positive or neutral. More than half of respondents felt the police did not understand the mental health issues involved (59%) and did not offer appropriate care and support (52%). A significant number (53%) felt that overall their mental health needs were not met.

With regards to communications during the experience with the police, nearly two thirds felt they did not receive enough information about what was happening (65%) and that the police did not clearly communicate the situation and actions (62%). Conversely, just over a third said communications were clear and enough information was provided.

A significant proportion (87%) felt that more and better healthcare should be provided to people with mental health issues in MPS custody.

Treating people with dignity and respect was considered the most important aspect for the MPS to consider when coming into contact with people with mental health conditions.

The main themes that emerged from the free text response from mental health professionals, people with mental health issues and their friends, family and advocates were the following:

1. There is a need for greater understanding of mental health issues, and related behaviour, to ensure that the police can control rather than inflame situations.

2. Professionals gave examples of effective joined up working between the police and other agencies to ensure people with mental health issues are dealt with appropriately in custody although this was not mirrored in responses from people with mental health issues and their families.

3. There is a lack of clearly defined roles for the police and other professional organisations which leads to inconsistency in treatment.

4. There is a need for training on mental health across the MPS, rather than just leaving this with one or two designated officers.

5. The police are often forced to deal with failures elsewhere in the system and are likely to have to do so even more in the future.

6. There are positive examples where a personalised approach has promoted a positive relationship between police and people with mental health issues, even sometimes as a preference to mental health agencies.

7. Health issues should be dealt with by the health system not the criminal justice system.

8. People with mental health problems from BME groups are treated differently to others.

9. There is a need for greater work in prevention and detection earlier to avoid people presenting at police stations with mental health needs.

10. A blame culture is not helpful and there are systemic difficulties that contribute to a lack of appropriate provision and understanding.

Appendix 5
Acknowledgements

The work of the Commission could not have been completed without the cooperation and support of the MPS staff. Members of staff gave us full access to all the materials we sought and gave freely of their time and knowledge. Those we consulted are listed below. However we wish to express our special gratitude to DI Frankie Westoby who supported the work throughout the time of the project, to Sarah Winfield and to Alex Gibbs for their assistance and advice. We would also like to extend thanks to Rowena Daw, Melba Wilson, Sarah Cameron, Sarah Kennedy and Sarah Reed for their invaluable expertise and assistance throughout the project.

MEETINGS AND VISITS

Members of the Independent Commission on Mental Health and Policing met with the following people and organisations as part of this inquiry;

British Transport Police
- Mitch Bateman, Crime Reduction Officer
- Dave Howell, Inspector NW BTP

Carers
- Camden Carers Centre

Care Quality Commission
- Philip King, Director of Regulatory Development
- Heather Hurford, National Policy Lead MHA/MCA
- Alex Baylis

Central Government
- Lord Harris, Independent Advisory Panel on Deaths in Custody
- Members of the Department of Health Ministerial Working Group on Equality in Mental Health
- Lord Bradley, House of Lords

Community
- Mental Health & Policing it's time to talk about it public event — South London and Maudsley NHS Foundation Trust and Black Mental Health UK

HMI Constabulary
- Mark Ewan, Chief Inspector & Specialist Staff Officer, Criminal Justice and Custody

HMI Prisons
- Nick Hardwick, HM Chief Inspector of Prisons
- Paul Tarbuck, Deputy Head of Healthcare Inspection

Independent Police Complaints Commission
- Dame Anne Owers
- Dr. Silvia Casale

Independent
- Gill Arupke, Chief Executive, Penrose
- Dr. John Parkes, University of Coventry
- Andy Bell, Deputy Chief Executive, The Centre for Mental Health
- Dr Iain McKinnon
- Sophie Naftalin, Solicitor
- Helen Stone, Solicitor
- Inspector Michael Brown, The Mental Health Cop, West Midlands Police
- Professor Richard Shepherd, Member, Independent Advisory Panel on Deaths in Custody
- Sola Afuape, Chair of the Afiya Trust

INQUEST
- Deborah Coles, Co-Director
- Victoria McNally, caseworker
- Daniel Machover, Chair, Board of Trustees

London Mayor's Office for Policing and Crime (MOPAC)
- Stephen Greenhalgh, Deputy Mayor for Policing and Crime
- Helen Bailey, Chief Operating Officer
- Amobi Modu, Head of Business Management

London Assembly Police and Crime Committee
- Joanne McCartney AM, Labour, Chair of the Police and Crime Committee
- Jenny Jones AM, Green Party, Deputy Chair of the Police and Crime Committee
- Caroline Pidgeon AM, Liberal Democrats, Deputy Chair of the Police and Crime Committee

Meetings with members of the Metropolitan Police Service
- Commander Christine Jones
- Commander Simon Bray
- Commander David Martin
- Dr Meng Aw-Yong
- Alex Gibbs, Head of Operational Learning
- Chief Superintendent Chris Bourlet, MPS Mh Programme Board
- Mike Partridge
- Sarah Winfield, Directorate of Legal Services
- Denise Milani, Director, Diversity & Citizen Focus Directorate (DCFD)
- David Skelton, Head of Delivery, DCFD
- PS Shawn Goodchild, Head of Mental Health Team — Barnet, Enfield & Haringey
- Ian Read, Head of Officer Safety Training
- Supt Annette Whiteman, Head of Custody Directorate,
- DC Maria Grey, MPS Safeguarding Lead
- Chief Insp Paula Light, Directorate of Professional Standards
- DS Tany Murray, Directorate of Professional Standards
- Trish Lincoln, Dave Scott, John Hampshaw — Central Communications Command
- Daniel Thorpe, Ealing Borough command Unit
- DI Paul Gardner, Critical Incidents Advisory Team
- DI Frankie Westoby, MPS Mental Health Team
- Rebecca Field, Coaching Supervisor, Bow CCC
- Borough Commander Dal Babu, Harrow
- Inspector Stuart Ward, Harrow
- Inspector Rob Webb, Brent
- PC Dan King, Brent
- Southwark Police Officers who the Chair accompanied on an observational shift

We met with many other police officers and staff. The numbers are too numerous for us to list entirely. However, we are grateful for the help that everyone provided in giving evidence and information to the Commission.

NHS
- Dr. Geraldine Strathdee, Associate Medical Director for Mental Health, NHS London
- Nicola Vick, Project Manager, Mental Health, NHS London
- Northwick Park Hospital, Harrow — Mental Health Service Walk Through
- Natalie Hammond and staff of section 136 assessment suite, South London & Maudsley NHS Foundation Trust
- Dr. Nick Broughton, Medical Director, West London Mental Health NHS Trust

- Steve Shrubb, Chief Executive, West London Mental Health NHS Trust
- Dr Ify Okocha, Medical Director, Oxleas NHS Foundation Trust

London Ambulance Service
- Steve Lennox, Nurse Director & Director of Health Promotion
- Staff at LAS Emergency Control Centre visited by the Commission
- Staff from Ilford Ambulance Station who the Chair accompanied on an observational shift

Mental Health Partnership Board (London)
- Dave Mellish, Chairman of the Mental Health Partnership Board
- Claire Murdoch, Chief Executive, Central North West London Mental Health Foundation Trust, Mental Health Chief Executives Group Policing lead
- Mike Partridge

Seminar Discussions, Visits & Events
- Approved Mental Health Professional Leads Network representatives from four London Boroughs and multi-disciplinary section136 practitioners from South West London and St George's Mental Health NHS Trust
- Liaison and Diversion CPN meeting London
- Borough Mental Health Liaison Officers Training Day
- Leicestershire Constabulary

Service users
- Penrose Focus Group
- Mind

Appendix 6
Glossary of Acronyms

ABD	Acute Behavioural Disorder
ACPO	Association of Chief Police Officers
A & E	Accident and Emergency
AMHPs	Approved Mental Health Professionals
AWOL	Absent Without Leave
BEH	Barnet Enfield & Haringey NHS Mental Health Trust
BME	Black and Minority Ethnic
BCU	Borough Command Unit
BOCU	Borough Operations Command Unit
BTP	British Transport Police
CAD	Computer Aided Despatch
CCC	Central Communications Command
CCTV	Closed Circuit Television
CIAT	Critical Incidents Advisory Team
CMHT	Community Mental Health Team
CNWL	Central North West London NHS Foundation Trust
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CRIS	Crime Related Incident System
DCFD	Diversity & Citizen's Focus Directorate
DI	Detective Inspector
DPS	Directorate of Professional Standards
FLO	Family Liaison Officer
FME	Forensic Medical Examiner
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
IAP	Independent Advisory Panel on Deaths in Custody
IBO	Integrated Borough Operations Office — now Grip and Pace
IPCC	Independent Police Complaints Commission
JMHPU	Joint Mental Health Policing Unit
LAS	London Ambulance Service
LPM	Local Policing Model
MAPPA	Multi Agency Public Protection Agreements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hubs
MCA	Mental Capacity Act
MH	Mental Health
MHA	Mental Health Act
MHLO	Mental Health Liaison Officer
MHU	Mental Health Unit
MOPAC	Mayor's Office for Policing & Crime
MPS	Metropolitan Police Service
NHS	National Health Service
OSC	Overview and Scrutiny Committee
OST	Officer Safety Training
PACE	Police and Criminal Evidence Act
PIER	(approach) Prevention Intelligence Enforcement and Reassurance
PO	Police Officer
PCSO	Police Community Support Officer
RIPA	Regulation of Investigatory Powers Act (RIPA) 2000
SLAM	South London & Maudsley NHS Foundation Trust
SO	Special Operations
SOP	Standard Operating Procedure

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