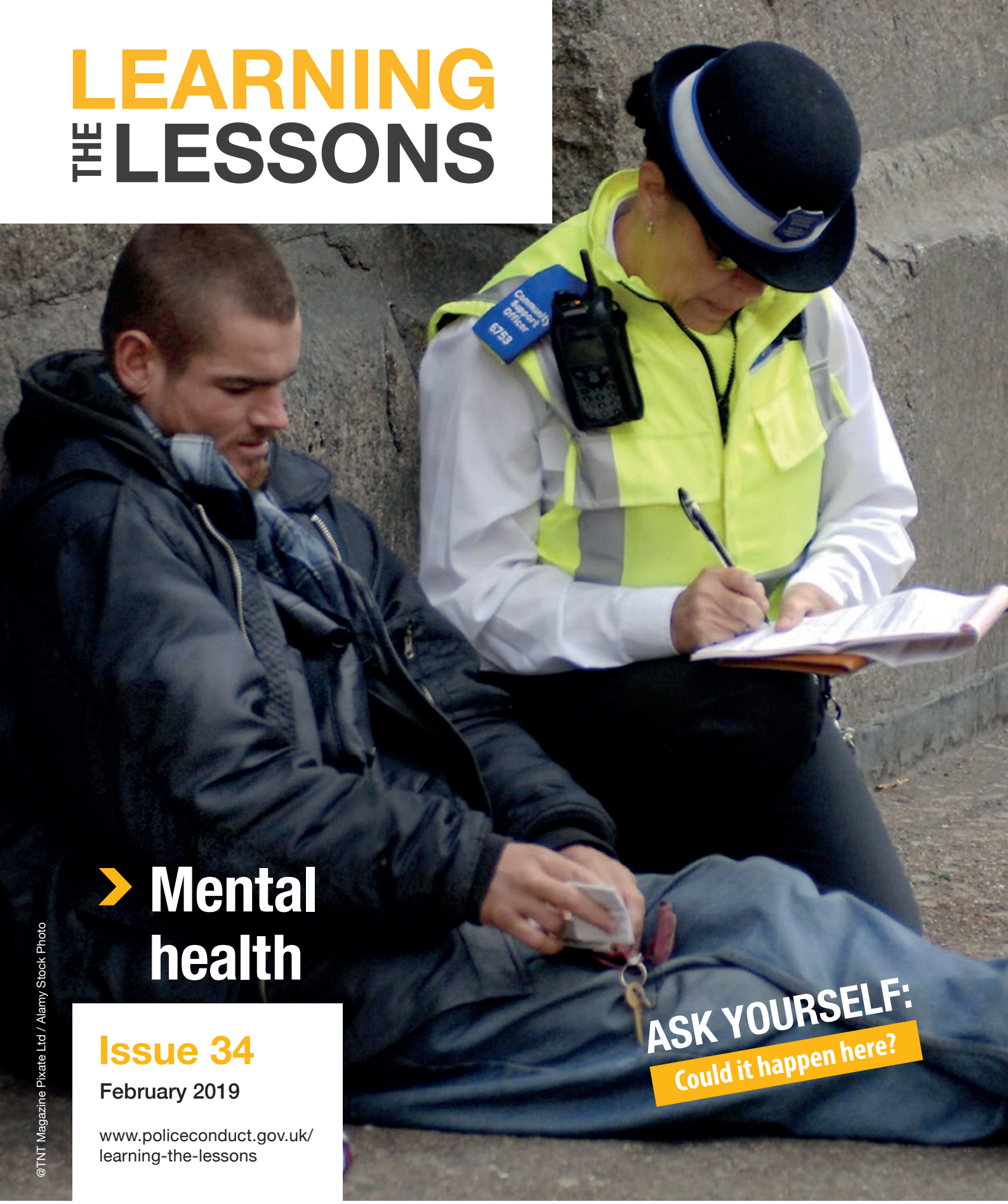
LEARNING THE LESSONS



Mental health

ASK YOURSELF:
Could it happen here?

Issue 34
February 2019

www.policeconduct.gov.uk/
learning-the-lessons

Improving policing policy and practice

College of Policing
HMICFRS
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
Home Office
IOPC Independent Office for Police Conduct
NPCC National Police Chiefs' Council
Police Federation
Police Superintendents' Association

FEEDBACK ON ISSUE 33

In November 2018, we published issue 33 of Learning the Lessons on stop and search.

The top 10 words used to describe issue 33 were:

REFLECTIVE EASY TO READ
focused DETAILED
informative
balanced USEFUL
text heavy ENGAGING
ACCESSIBLE

> "As well as the PCC's oversight and strategic governance, the PCC's independent panels help discharge this role and use the IOPC's Learning the Lessons, such as the stop and search magazine, as critical friends to question and challenge constabulary practice. There are positive comments from the panel members on the content of Learning the Lessons."

> "I am the local policing sergeant for a diverse and challenging area. The guidance/advice around stop and search will help how I deliver practical advice/guidance to staff. It will allow them to be aware of incidents across the national picture that may be slow in coming out through internal training mechanisms."

Content and structure

81.5%
said the mix of cases and feature articles felt about right

88.5%
said the case summaries were clear and easy to understand

97.2%
said the feature articles complemented the cases featured in the magazine

60%
said they wanted to see more examples of good practice

Feedback on impact

45%
said they will think differently about how they use stop and search powers

45%
said they will consider making changes to any policy, guidance or training they are responsible for to reflect any learning

52%
said they will look at one or more sections of APP signposted in the issue

38%
said they will think differently about how they communicate with people during a stop and search encounter

OUR NEXT ISSUE IS ABOUT CUSTODY. Please get in touch if you have any thoughts about articles you would like to see included.

FOREWORD

Michael Lockwood
Director General of the IOPC

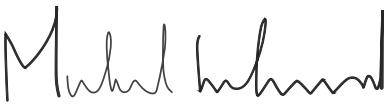
Welcome to this latest issue of Learning the Lessons which focuses on the complex area of mental health. I know from the many discussions that I have had with police officers that this is one of the most difficult areas where the interaction between other services such as health is so crucial.

We, at the IOPC, see a lot of cases which involve a mental health element. Mental health is one of our key themes and in line with our wider approach, we are really keen to see if we can identify and share more learning from these cases. We have developed a mental health subject matter network to help us progress this work and you can read more about this from its chair, Neil Moloney, on page 13.

Other themes covered in this issue include the importance of recording and sharing information with different agencies, identifying mental vulnerability, dealing with detainees who have autism, and making sure PACE Code C safeguards are complied with. As always, there are some really interesting articles and insights offered by a range of leading voices in this field.

I would also draw your attention to our Learning the Lessons development panel which we first mentioned in issue 33. We have had a good amount of interest but there are still opportunities for more of you to get involved. The back page contains all of the information that you need.

I hope you find this issue useful. We really are interested in any feedback you have, so please do get in touch.



Michael Lockwood

CONTENTS

1 MAN FOUND DEAD FOLLOWING CONCERN FOR WELFARE/NOISE COMPLAINT

An on call recovery worker for a supported living accommodation for people with mental health issues called the police. He said that he had received a call from a resident making a noise complaint about one of the other residents.

The recovery worker told the police that the man being complained about was known for making lots of noise and had been sectioned recently. The customer contact advisor (CCA) who took the call said that he would record the concern, get officers to check on the man, and that he had called an ambulance as a precaution. The CCA switched the incident log to the radio operators (ROs) to allocate officers. Information about the man was automatically populated in the incident log.

The ambulance service was unable to allocate an ambulance. It had graded ambulance attendance at 'green two'. This meant it could take several hours.

On several occasions, different ROs delayed allocation of officers while waiting for an update on an ambulance. The force policy on escalation said that all vulnerability related incidents should be escalated.

Three officers went to the address around two hours after the original call. The officers did not check for any further information about the man, other than what was on the incident log. Officers had access to handheld devices. This gave them access to the Police National Computer (PNC) and the force intelligence system.

The officers looked around the accommodation and tried to get in using the buzzer system. They could not see any sign of a disturbance so they decided to leave. One of the officers also told a RO that they felt it was more of a noise complaint than a concern for welfare. They said that the ambulance should be cancelled.

The following morning, police received a call from a woman saying that she had received a voicemail from her son (the man who was allegedly making a lot of noise the night before) and he was talking about dying. An officer at the force heard this incident come in. They recalled going to an incident a few weeks before where the man was suicidal and was sectioned. No warning markers were added for this incident.

The officer who remembered the incident a few weeks before, contacted the woman who had received the voicemails. They arranged to meet her at the property to check on the man. Other officers were told to wait nearby in case they were needed.

When the officer and the woman arrived, the officer knocked on the door but there was no answer. He tried the door handle and found it was open. He asked the woman to enter first as she had a relationship with the man. The woman found the man dead in the living room and became extremely distressed. The officer asked other officers to come and help.

The other officers who arrived were not aware who the woman was or what had happened when they arrived. The woman refused to leave the address. One of the officers took hold of the woman. The woman dug her nails into the officer's arm and a struggle happened.

It was acknowledged by both officers and the woman that the officer who took hold of the woman during the struggle called her a 'whore'. The officers later found out that the woman was the dead man's mother.

Key questions for policy makers/managers:

- How does your force make sure that all officers and staff are aware that mental health means vulnerability?
- How does your force make sure that all warning markers are accurate and up to date?

Key questions for police officers/staff:

- What would you have done differently to prevent, as much as possible, distress?

Action taken by this police force:

- The force has expanded upon and invested in access to mobile devices available to officers and staff which can be used to carry out PNC and other intelligence checks.
- The force is in the process of updating its strategy and intelligence policy. It has carried out a review of its process regarding warning markers to improve accuracy going forward.
- The force has formed a new vulnerability support unit within its command and control setting. This gives deeper research and risk assessment support to ongoing incidents.

Outcomes for the officers/staff involved:

- The ROs who did not carry out background checks or escalate the incident were found to have a case to answer for misconduct and received training.
- The officer who used inappropriate language was found to have a case to answer for misconduct and received management advice.

- Read full learning report

2 SUICIDE FOLLOWING CONCERN FOR WELFARE

PSD

A man with bi-polar disorder was arrested by police after a domestic incident with his partner. He was released on bail with conditions not to contact her or their children and to stay at his mother's house.

A month later the man's partner called the police via 999. She had received seven missed calls and several texts from him telling her that he loved her. The woman was concerned for the man's welfare because he had a history of self-harm and overdose. The man's mother was out of the country, so the man would have been at his mother's house alone. The man had also been due to pick up his daughter from work but had not turned up and she was unable to contact him.

Officers went to the house where the man was living, arriving within 15 minutes of the initial call. They found the man fully clothed under the duvet in bed. The man denied making contact with his partner and said that he could not find his phone. No action was taken against the man because his partner explained that she had only called out of concern for his welfare, and she did not want to make a statement. The man told officers that he was under the treatment of mental health services in the area where his partner lived, but was now receiving care in the area where his mother lived. He told officers that he had no scheduled mental health appointments and had no GP in the area. Officers made contact with the crisis team (who spoke to the man on the phone) and completed a vulnerable adult form (VAF). This information could be shared with partner agencies. The force policy stated that a VAF form should be completed each time a person comes to the notice of officers or staff who appears to be at risk of or suffering from abuse or harm.

The man's partner called the police a couple of weeks later. She said that the man had spoken to her a few minutes earlier saying that he was going to commit suicide. She also indicated that the man's daughter had received several messages from the man saying that he was suicidal. The woman said that she was willing to give a statement about the man's breach of his bail conditions this time.

Officers went to the house and arrested the man for breach of his bail condition not to contact the woman. Officers found a swimming pool rigged with an electric cable. They believed this to have been preparation for a suicide attempt. The man's mother was also at the house and was described by officers as 'extremely distressed'. She told officers that her son had electrical cables wrapped around his wrists and was talking about wiring himself up to the fuse box.

The man was taken to custody. There was a delay of approximately three hours in authorising the man's detention. This was due to delays in the force getting details of the bail conditions set from the force area where the man's partner lived. While booking the man into custody, the officers decided that he would require a mental health assessment as they believed he had been preparing to make a suicide attempt. A health care professional (HCP) was requested and the man was placed on 15 minute observations until his assessment.

Later, the on-duty police sergeant spoke to the force from the force area where his partner lived. They asked the police sergeant to re-bail the man as they said no enquiries had been progressed as the officer in charge was on leave. The police sergeant refused to re-bail the man under these circumstances, but had no grounds for continued detention. The police sergeant noted his concerns about the risk the man posed to himself. A pre-release risk assessment was carried out which assessed the risk as 'very high'.

Officers decided to release the man before detaining him under Section 136 of the Mental Health Act outside the police station. There were no other grounds for his continued detention.

HCPs arrived in custody and transferred the man to a local mental health facility where a bed was available. Person warning markers were added to the man's record, including 'self-harm'. No warning marker for suicide was added but information about suicide preparations was included within the self-harm warning marker. No VAF form was completed, as was required by force policy.

Weeks later, the man's partner called police saying that she was concerned for his welfare. She said that she had been in touch with the local crisis team and was contacting the police on their advice. She explained his bail conditions had been lifted the previous Wednesday, and that he had contacted her and her son in an emotional state. She also told them that he had told his mother that it was inevitable he was going to kill himself.

The call handler did not record any persons of interest (POI), as is required by force policy when a call is about someone other than the person making the call. When this is done, it is transferred across to the force case management system and is searchable. When it is transferred, it and all other information about the call must be linked to the incident. This was the responsibility of the crime recording bureau. It was not done until 28 hours later. No VAF was submitted, as was required by force policy.

At 4am the following morning the man's mother called the police. She explained that her son was in the swimming pool in the garden, making grunting noises, and that he had previously said that he was going to commit suicide. The call operator asked whether her son was violent or whether it was 'literally his mental health that is being an issue at the moment'. His mother explained that he was not being violent but she felt that he was a danger to himself. The call operator explained that they would not send officers but would call an ambulance.

The call operator did not access the warning markers under the man's record on the case management system.

Some time after the ambulance was dispatched, a log was entered onto the record stating that the man had drowned and gone into cardiac arrest. The force changed the grading of the incident so that officers would be sent. The man died approximately an hour later.

Key questions for policy makers/managers:

- How does your force make sure that information which could help to inform incident grading and officers' response is added to systems quickly so that it becomes visible and searchable?
- How does your force make sure that information about vulnerable adults is recorded and passed on to other agencies where appropriate?

Key questions for police officers/staff:

- What questions would you have asked the man's mother to help you understand the situation and make a judgement about the level of risk?

Action taken by this police force:

- The force have adapted their forms to make them easier to share with partner agencies.
- Training around person warning markers was reinforced.
- It was reinforced that in cases involving mental health/wellbeing, POI forms should be submitted.

Outcomes for the officers/staff involved:

- The call operator who took the call from the man's mother was found to have a case to answer for misconduct and received management action.

- Read full learning report

Experiences of people with mental health concerns when in contact with the police complaints system

Written by **Professor Eddie Kane**

Professor Eddie Kane is the Director for Health and Justice at the Institute of Mental Health. He recently carried out research on experiences of people with mental health issues when coming into contact with the police complaints system.

Last year the IOPC asked the Institute of Mental Health (IMH) to conduct research into the perceptions and experiences of people with mental health concerns in the police complaints system in England and Wales. We did this through a targeted survey and focus groups.

Our work involved speaking to people about their contact with the police when they were experiencing mental health concerns and their confidence in the police complaints system.
People with mental health concerns often find it particularly challenging to make a complaint against the police. The participants in this research described a number of negative experiences that could have formed grounds for complaints against the police, but most of which were not brought forward as formal complaints.

Individuals told us about a number of reasons for this, including not being aware of the complaints system or what they could complain about; a feeling that their complaint did not match the high-profile media cases associated with the IOPC; a lack of trust in the police complaints system; and a worry that there would be a long, uncertain and complicated process of making a complaint that would be harmful to their mental health. Nearly half of the participants said that they were unlikely to complain even if they had grounds to. Many were also fearful of the consequences of making a complaint and believed that it could lead to harassment or victimisation.

We found that the present system assumes that people have knowledge of what they can reasonably make a complaint about; who to complain to; how to make the complaint; what information they need; knowledge of what to do if they are unsatisfied with the outcome of their complaint; and an awareness of the time limits involved. Many people that we spoke to did not have this knowledge.

People need to be aware that they have a right to complain, what they can complain about, to whom, how, and how to follow up if they are not satisfied. For many people in society, making a complaint about their experiences of contact with the police is challenging enough. When overlaid by sometimes debilitating mental health concerns, complex lives, and feeling personally overwhelmed, the challenge becomes magnified and often defeating.

The key area of change that the police complaints system should focus on is to acknowledge this reality and begin to redesign its processes within the statutory responsibilities in such a way that these people no longer feel excluded and unsupported. We have made recommendations for consideration under three areas:

1. IMPROVING KNOWLEDGE OF THE IOPC AND THE COMPLAINTS SYSTEM

A campaign to increase the awareness of the right to complain, including case studies of people with mental health challenges who have used the system.

Clarity on the process of making a complaint, including roles and responsibilities, the relationship of the IOPC to the police, expected timelines, and a list of support available when making a complaint.

Targeted engagement with a wide range of stakeholders, including voluntary and advocacy organisations, to further educate about the IOPC and the police complaints system.

2. IMPROVING ACCESS AND SUPPORT IN THE COMPLAINTS SYSTEM

IOPC and Professional Standard Departments (PSDs) should work closely with other organisations that could provide advocacy and support through the complaints system, developing a directory/ network in each IOPC area that people could refer to for support.

3. IMPROVING ACCESS AND SUPPORT IN THE COMPLAINTS SYSTEM

Mental health awareness training for all IOPC staff to recognise the complexities in making a complaint when experiencing a mental health condition.

Actively seek to employ more investigation staff with mental health knowledge and expertise. Appoint at least one specialist case worker for the most complex and challenging cases in each IOPC office.

Any approach to a complainant experiencing a mental health condition should be bespoke, considered and respectful to their individual needs. It should be recognised by the IOPC and other partners within the police complaints system that this particular group should have a tailored, informed experience that is reflective of their needs.

We are pleased that the research will form part of the IOPC's plan to continuously improve their systems, reduce complexity and create a complaints system that can sensitively handle the needs of someone living with mental health concerns.

Find out more online: www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/Research_into_Public_Confidence_of_People_with_Mental_Health_Concerns_in_the_Police_Complaints_System_Nov2018.pdf

3 RESPONDING TO A CONCERN FOR WELFARE

Around 3.30pm a member of staff from the mental health team called police to say that she was concerned about a service user. She said that a friend of the woman had made contact earlier in the day. He had raised concerns as he had not seen her for the past couple of days. She said that she had visited the woman's address but there was no answer. She had also not answered the phone.

She went on to tell the call handler that the woman's liver was failing, that she was an alcoholic, and that she was concerned about her welfare. She said that it was not unusual for the woman not to answer the door. However, the man had described it as unusual for him not to see her for a couple of days as he had contact with her every day.

The customer contact advisor who took the call advised her to call an ambulance. He did not create an incident log, check force systems or request any other information from the caller.

When explaining this he said that the caller did not appear to know a lot about the woman, and seemed to be reading from a file that was not familiar to her. Secondly, the mental health team had noted that it was not unusual for the woman not to answer the door. He said that he felt that as their main concern was for the woman's physical health, calling the ambulance service would be the most appropriate response.

In interview he recognised that with hindsight he should have created an incident log. He recognised that without one there was no way for other police staff or police officers to know that the call had been received, or be aware of the concerns that were raised in the call.

At 8pm, the woman's friend who had made contact with the mental health team earlier in the day, called police to report his concerns.

The man told the customer contact advisor that the woman suffered from mental health problems and that he had not spoken to her for two days.

An incident log for a concern for welfare was created.

The man said that he had been to the woman's address but that there was no answer. He described this as "very, very unusual" and said that he was genuinely concerned for her.

He was told that they would get an officer to visit the woman.

Once the call ended the customer contact advisor checked whether the woman had been admitted to hospital. She had not and this was recorded on the incident log. The demand management unit (DMU) were made aware of the log and recorded "genuine concern for welfare – deployment should be made".

The DMU is a group of sergeants based in the control room who help with the allocation of resources. If there are incidents that can be passed to other agencies, such as social services, the DMU will identify these and take action to share information.

Around 8.30pm, an officer working in the force's mental health car updated the log with information from the woman's mental health team records.

At 8.54pm, an officer was sent to the woman's address. He heard the incident over the radio and was aware from the airwaves that there were no response officers free to attend. He was a neighbourhood officer working close to the woman's address and volunteered to go. He went but there was no answer.

He updated the log with the actions he had taken, including speaking to the neighbour and trying the contact numbers for the woman. He explained that he considered forcing entry to the address but was aware that not all lines of enquiry had been used. He liaised with the officer working in the mental health car over the radio and was aware that she was going to visit the woman's next of kin to get further details. He then finished his shift.

The officer in the mental health car visited the woman's father who was her next of kin. He said that he did not have contact with her, but that her grandmother did. The officer then spoke to the woman's grandmother

on the telephone and gave an update on the incident log. This is not the usual role of the mental health car (to visit family and gather information). However, they did this because they were close to the area and to assist the response. The officer recorded on the incident log that the woman's grandmother had spoken to her the day before. They also recorded that she had changed her number so that her friend, the man who contacted mental health services to report concern for her, could not contact her. The officer then asked the DMU to review the log.

A sergeant in the DMU reviewed the incident log at 11.48pm.

He explained to the IPCC that the role of the DMU is to review incident logs and cut down on unnecessary deployments.

The sergeant recommended the log be deferred to the morning. He noted his reasons for this decision. He assessed the call as low-risk as there was information from the family that the woman was avoiding her friend which could explain her not answering the phone or door. He also noted that there were no markers for self-harm, she had not stated any intention to harm herself, and her grandmother had no concerns at that stage. He noted that the following morning further attempts should be made to contact the woman to confirm that she was ok.

The next morning the incident log reactivated on the dispatcher's screen. A timer had been set for this to happen around the time the police officers' day shift started.

The dispatcher sent the log to the facilitator and asked them to phone the woman. They did so at 8.20am. They left a voicemail as the call was not answered.

Around 9.30am another officer working in the mental health car updated the log advising that he had phoned the mental health team as a follow-up from the previous evening. He documented on the incident log that the mental health team planned to contact the woman that day and he had advised them to update the police once they had contacted her. He then asked that his update be reviewed by the DMU to check that they were happy with his actions.

The update was reviewed by a sergeant in the DMU. They agreed to allow the mental health team to make their enquiries and to contact the police if they had any more concerns. The mental health team timeline does not show that they raised any further concerns during the call.

The woman's friend phoned the control room for an update around 11.30am. He was told that enquiries were ongoing and he would be updated.

There were no further actions detailed on the incident log until around 5.45pm that day when the officer working in the mental health car documented an update from the mental health team. They advised that they had tried to contact the woman by phone and visited her address, but that they had been unable to make contact. They also told the officer that they had last had contact with the woman five days before. On that day she had been told that her liver was damaged due to alcohol use and that if she continued to drink this could end her life. The officer noted on the incident log that the DMU should review the update.

Around 6.10pm a sergeant in the DMU reviewed the log and tried to contact the woman by phone. She left a voicemail as there was no answer. She also telephoned the woman's grandmother and wrote on the log "Gran . . . is not too worried. However, as she has not had any contact with family and we are unable to contact her, we will need to try and establish her welfare."

At 9pm, an inspector reviewed the incident log. She was made aware of it by the dispatcher. Having read the log she documented her decision not to continue to try and contact the woman on the incident log. She noted that "At this time with the information available to me I recommend that we do not continue with trying to chase [the woman] . . . should any other information arise that necessitates a review then this is proportionate and should be undertaken." In addition, she noted "[the woman] is an adult and has a mental health problem which is being managed. She has told a relative that she is actively avoiding the informant due to feeling that he is stalking her. Family have spoken to her since the initial report . . . There are no concerns that she has harmed herself . . . she has clearly made an informed choice to not respond to the information . . . my preferred option is not conduct any further enquiries and allow her to go about her business as an adult who has not raised any concerns this far."

When interviewed by the IPCC the inspector initially said that the woman's grandmother had spoken to her since the incident log was created. After re-reading the log, she said that she had not meant to write on the log that the family had spoken to the woman since the report to the police.

The inspector admitted that she did not consider that the mental health team could not get in touch with the

woman either as an issue. She advised that it is not uncommon for other agencies that work 9am to 5pm to raise concerns at the end of their day if someone has missed an appointment, for example, as they would want to make another agency aware of their concerns.

The inspector was asked in more detail about her concern that the woman's friend may be stalking or harassing her. She described the information on the log and her own professional experience as informing this view. Had there been a history of police incidents between the woman and her friend, she said that she would have considered this in her decision at the time.

The inspector concluded her entry with a direction to inform the family and the woman's friend of the decision. The incident log was closed around 9.15pm after the woman's father had been contacted.

The rationale and decision made by the inspector were contrary to the advice of every DMU sergeant that had written on the incident log. They all wrote that the woman needed to be spoken to and that attempts to do so should continue. The inspector does not appear to have considered this when making her decision.

The mental health team records show that after they were informed the log was closed they continued to visit the woman's address. There is no mention of any further interaction with the police.

Five days later the woman's care coordinator from the mental health team returned from a week of annual leave. He was advised that his colleagues had been trying to contact the woman over the past seven days with no success. He was concerned that it was very out of character not to hear from her as she usually made contact with the team daily. He contacted her housing officer and arranged access to her address. On gaining entry they discovered the woman's body.

Key questions for policy makers/managers

- Does your training for call takers reinforce the circumstances in which incident logs should be created?
- Has your force created a formal procedure setting out how concern for welfare calls should be handled?
- Has your force provided officers with clear guidance or training on when they can force entry following concern for welfare calls?

Key questions for police officers/staff:

- As a call taker, what other questions would you have asked the initial caller from the mental health team?
- What action would you have taken to respond to the initial call from the mental health team?
- Would you have considered following up with the woman's friend who called police to report his concern for her welfare if you had still been unable to reach her?
- Would you have taken any action to respond to the comment that the woman was being stalked by her friend?

Action taken by this police force:

- Following the incident a number of changes have been made to working practices in the control room.

  A more formal procedure for dealing with concern for welfare calls has been introduced. These changes include:

- Incident logs of this nature are now monitored by sergeants in the DMU. Concern for welfare incidents cannot be closed without a supervisor's authorisation.
- Near miss reports are completed monthly to identify learning points.
- A concern for welfare process is being drawn up.
- The force has completed training in the control room which reinforces the importance of creating incident logs in similar circumstances.

Outcomes for the officers/staff involved:

- The customer contact advisor who took the initial call from the mental health team, in which they expressed concern about the woman's welfare, was found to have a case to answer for misconduct. This was for his failure to create an incident log following the call. He received a written warning following a misconduct meeting.
- The inspector who reviewed the incident log and decided that no further enquiries should be made, was found to have a case to answer for misconduct. This was for recommending the incident log be closed and the rationale for this being based upon factual inaccuracies. She received a written warning following a misconduct meeting.

Read full learning report

Introducing the IOPC Mental Health Subject Matter Network

Written by **Neil Moloney**

The IOPC Mental Health Subject Matter Network consists of about 50 IOPC staff with a special interest in collecting and disseminating best practices in connection with policing and mental health. We have been up and running for less than a year. There is a lot more that we want to achieve but I am proud of what we have achieved so far. This is thanks to the energy, commitment and talents of people connected through our network. You get to realise when you get involved with this subject matter that people across many different organisations are similarly motivated to collaborate and share knowledge.

You might have come across one or two of our people if you have participated in any of the following events during 2018:

> Professor Sir Simon Wessely's Review of the Mental Health Act
> Mental Health East Conference hosted by Matthew Scott, APCC lead for mental health
> The NPCC's Mental Health and Policing Conferences for 2018
> Respond - a multi–agency simulation training package for professionals involved in mental health care
> Mental health training for front line officers provided by Connect, the University of York and North Yorkshire Police
> NPCC and South Yorkshire Police's event on the subject of Acute Behavioural Disturbance
> N8 PRP Policing Innovation Forum – Policing Mental Health: Improving services, reducing demand, and keeping people safe

Occasionally we host events internally and through that we have heard from experts including some of the guest contributors to this magazine: Professor Eddie Kane and Dr Roxanna Dehaghani.

Our membership includes people with professional backgrounds working in mental health settings and people who are keen to share insight from relevant lived experience. Others are just interested and motivated to learn more. We draw from each of them, for example by consulting them as an internal reference group when we develop staff guidance. We also look for lessons from the IOPC's investigations and casework.

As with most large organisations, we have specialist teams responsible for developing policies, learning and development, stakeholder engagement, legal and so on. Our network is lead by representatives drawn from each of these specialisms. We come together to spur collaboration and unlock value. We find that working horizontally across functions is effective. Staff networks like ours can be great vehicles for innovation.

Our aims are aligned with the IOPC's strategic objectives. We are a learning organisation and we look to contribute to a wider cycle of learning through the policing and healthcare sectors we are connected to.

Neil Moloney is a Lawyer at the IOPC and Chair of the Mental Health Subject Matter Network.

Observations on PACE C safeguards and defining vulnerability

Written by **Dr Roxanna Dehaghani**

An appropriate adult is required for people who are considered 'vulnerable', according to Code C to the *Police and Criminal Evidence Act 1984* (PACE).

However, research has consistently shown that there are issues with how the appropriate adult safeguard is carried out.[1] Through a research method called ethnography – which involved observation of and interviews with custody officers over six months – I was able to explore in more detail the reasons why.

The first reason that I have found is that of definition: vulnerability in adults can be interpreted in many ways. Some suspects that could be considered vulnerable according to Code C were not considered in this way by custody officers. Custody officers often found the terms 'mentally vulnerable' and 'mentally disordered' difficult to describe. Indeed, these terms can be narrowly or broadly interpreted. Custody officers also separated out those who were genuinely vulnerable and those who were pretending to, for example, gain sympathy or manipulate custody staff during their detention. Those who 'presented well' were thought to not need additional support. Such assumptions were reinforced by healthcare staff.

To further complicate matters, vulnerability was seen as difficult to identify. This is what many previous studies have found. The risk assessment is not necessarily geared towards identifying mental health issues and is limited when identifying learning disabilities or difficulties (see McKinnon and Grubin 2010). Certain questions also lean towards misguided stereotypes such as whether the suspect went to a 'special school'; many vulnerable people go to mainstream schools and would therefore not 'tick' this particular box (see Bradley 2009). Suspects may be reluctant to give personal and sensitive information in the, often busy, police custody environment or may give flippant answers if they are intoxicated. The observation that custody officers are not mental health workers, while tired, is nevertheless accurate.

Finally, custody officers will also consider whether the case is likely to be examined; the likelihood of this is lower if the case is unlikely to go to the Crown Court. It must also be recognised that custody officers are often working within a busy and pressurised environment.

Cuts to frontline staff are increasing, thus increasing pressure on staff. Appropriate adults can often be difficult to find. This may stop a custody officer from flagging the issue. The law is also vague and often quite difficult to understand; as custody staff probably know, Code C is a longwinded and complicated piece of soft law with many cross-references, annexes and notes.

It remains to be seen whether changes to the Codes of Practice will result in changes to how the appropriate adult safeguard is used in practice.

It is possible that the functional test (see Code C) could lead to positive changes. However, many issues remain: appropriate adult provision is not consistent across England and Wales, the safeguard for adults does not exist on a statutory basis, custody suites are busy and pressurised (and cuts to the police budget will do nothing to help this), and custody officers may not have the adequate knowledge or training to tell whether a person is vulnerable. The changes to Code C may serve only to complicate matters.

1. (Bean and Nemitz 1995; Bradley 2009; Brown, Ellis, and Larcombe 1992; Bucke and Brown 1997; Dehaghani 2016; Dehaghani 2017; forthcoming; Gudjonsson et al 1993; Irving and McKenzie, 1989; Medford, Gudjonsson and Pearse 2003; National Appropriate Adult Network 2015; Palmer and Hart 1996; Phillips and Brown 1998. See also Bradley 2009; Cummins 2007; McKinnon and Grubin 2010).

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www.policeconduct.gov.uk/sites/default/files/Documents/LearningtheLessons/34/observations_on_pace_c_safeguards_further_reading.pdf

4 FAILURE TO GET MEDICAL TREATMENT FOR A MAN WITH LEARNING DIFFICULTIES

A man went to a local pub one evening. One of the staff members at the pub knew the man and said that he became increasingly drunk as the evening went on. He also said that he had been engaged in conversation with two girls and was becoming aggressive towards them. The staff member asked the man to leave the pub.

The staff member said that he heard a window smash in the lounge in the pub within seconds of the man leaving the pub.

The man made several calls to the police. He asked if anyone had reported a smashed window at the pub, that his friends were going to brick or petrol bomb the police station, and eventually admitted on the phone that he had smashed the window at the pub. The call taker advised the man to walk to the nearby police station and use the external telephone outside the station.

The officer on duty at the police station said that she heard loud banging coming from the front area of the police station. When she checked what the sound was, she saw a man who she believed to be drunk banging on the front door. When she used a window to check if the man was on his own, she saw him walking away from the station. This officer used the radio to request help to search for the man. The control room operator told the officer that the man had autism and ADHD. However, the officer said that she did not hear or acknowledge this comment specifically in response to the operator. Autism is a mental health disorder for the purposes of the *Mental Health Act (1983).*

Another officer arrived at the station to pick up the officer who requested help. They went to look for the man. They found the man at around midnight. When they arrived, one of the officers took the man by the arm and arrested him under suspicion of mis-use of the 999 system and threatening to commit criminal damage.

The officers decided to handcuff the man to the rear. The man became violent and abusive as soon as the handcuffs were used. The officer who arrested the man asked him to get into the back of the police car. He said that the man threw himself into the back of the car on his front. The man told the IOPC that he hit his eye on the frame of the car when the officer put him into the vehicle. There was insufficient evidence to decide whether the man was pushed or threw himself into the car.

The arresting officer told the man to turn onto his back but the man refused. This officer tried to turn the man onto his back. As he did this, the man kicked him in the face and upper body. The officer said that he then lunged forward to try and put his bodyweight onto the man. The officer told us he then threw a compliance strike at the man's head as this was the only area visible. The officer said the man continued to kick out, so the officer punched him twice slightly harder to the head. The officer told us this stopped the man from kicking. The officer applied a leg lock to the man to restrain him while they waited for a police van.

The National Autistic Society: A guide for police officers and staff

Do:

> Keep physical contact to a minimum, avoiding use of handcuffs or other restraints if possible.

> Check whether the person carries any information about their needs: read it and follow it.

> Explain simply and calmly where you are taking the person and why. Tell them what they should expect on arrival at the custody suite.

> Call ahead and warn the custody staff if the person is distressed. Ask if arrangements can be made to avoid having to wait in a busy reception area.

> Tell the custody sergeant that the detainee is autistic and explain any related concerns.

> Deliver the caution slowly and clearly.

Do not:

> Rush into making an arrest unless it is the only option.

> Raise your voice or rush the person, unless absolutely necessary.

> Use sirens and flashing lights, if you can avoid them.

> Detain or transport an autistic person unaccompanied in the back of a police van. They could become distressed and require your immediate attention or first aid.

> Try to stop the person from rocking or making repetitive movements – these are self-calming mechanisms and are likely to be beyond their control.

> Remove 'comfort' items, such as pieces of string or other small items, unless essential. This may raise anxiety.

Find out more online:
www.autism.org.uk/products/core-nas-publications/autism-a-guide-for-criminal-justice-professionals.aspx

Once they arrived at custody, the senior custody and detention officer (CDO) completed an initial risk assessment with the man and a police national computer (PNC) check was completed. The senior CDO was not able to complete most of the questions on the risk assessment because the man was violent and not engaging. Shortly after, she viewed several PNC screens for the man. She recorded on the custody computer system that the man had been diagnosed with autism and ADHD previously.

The man was taken straight to a cell after being booked in. The custody sergeant placed the man on level two observations. This meant that he had to be checked every 30 minutes.

The senior CDO said that a health care professional (HCP) was not requested at this time as the man was behaving violently and there was no sign that he had taken anything but alcohol. The custody sergeant said that it is the responsibility of CDOs to flag any warnings to the sergeant which may be relevant to the care plan. Shortly after booking the man in, the custody sergeant viewed the custody computer system which had the warning markers for ADHD and autism on it.

» *Police and Criminal Evidence Act (1984):* Code C states:

"vulnerable' applies to any person who, because of a mental health condition or mental disorder:

(i) may have difficulty understanding or communicating effectively about the full implications for them of any procedures and processes connected with:

- their arrest and detention; or (as the case may be)
- their voluntary attendance at a police station or their presence elsewhere (see paragraph 3.21), for the purpose of voluntary interview; and
- the exercise of their rights and entitlements.

(ii) does not appear to understand the significance of what they are told, of questions they are asked or of their replies.

(iii) appears to be particularly prone to:
- becoming confused and unclear about their position;
- providing unreliable, misleading or incriminating information without knowing or wishing to do so;
- accepting or acting on suggestions from others without consciously knowing or wishing to do so; or
- readily agreeing to suggestions or proposals without any protest or question."

and

Clinical treatment and attention, paragraph 9.5 states that:

The custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practicable if the person:

(a) appears to be suffering from physical illness; or
(b) is injured; or
(c) appears to be suffering from a mental disorder; or
(d) appears to need clinical attention."

Find out more online: www.gov.uk/government/publications/pace-code-c-2018

Checks were carried out every 30 minutes as required. The senior CDO carried out a cell check around an hour and a half after the man was booked into custody. She lowered the cell hatch to speak to the man. The man asked to speak to the custody sergeant and asked for a phone call. He also mentioned that he had epilepsy, autism and diabetes. The CDO noted this on the custody record but noted that she was not sure if these medical conditions were true, or whether the man was using them as a distraction.

A few hours later, an inspector reviewed the custody record. The inspector told the IOPC that he was not aware of the entry on the custody record which detailed the man's claim that he had autism, epilepsy and diabetes. He said that if he was aware, he would have reassessed the risk assessment and care plan.

Soon after, the custody sergeant reviewed the man's care plan. He made no mention of the man's claim about autism, epilepsy and diabetes. This suggested that he had not checked the custody record during the last few hours.

College of Policing Authorised Professional Practice (APP): Detainee Care states:

"The custody officer is responsible for managing the supervision and level of observation of each detainee and should keep a written record in the custody record. They should specifically check that officers and staff are adhering to the timing of levels of observation and carrying out rousing."

It was the opinion of the IOPC investigator that, in order to meet the requirements of this APP, a custody sergeant would be required to thoroughly read the entries made on the custody record by the custody staff.

Find out more online:
www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/

Key questions for policy makers/managers:

- How does your force make sure that officers and staff are fully aware of the PACE Code C definition of mental vulnerability?
- What training does your force provide to officers/staff on autism/ADHD?
- What processes does your force have in place to make sure that all custody staff are able to review the custody record regularly throughout a shift, even during busy times?

Key questions for police officers/staff:

- At what point would you have made contact with a HCP or appropriate adult?

Outcomes for the officers/staff involved:

- The custody sergeant received management action. This involved a support plan for performance and included a dedicated custody inspector reviewing custody records for detainees where this custody sergeant has authorised their detention.
- The inspector received management action. This involved a support plan for performance which included a dedicated custody inspector reviewing custody records for detainees where this inspector has carried out inspector's reviews.
- The CDO received management action. This involved a support plan for performance being implemented to address the issues in this case.

- Read full learning report

5 A FAILURE TO SAFEGUARD THE WELFARE OF A MAN AND WIFE

One evening two officers and a special constable were called to the address of a man and his wife following reports that the man had damaged a neighbour's car.

Around 15 minutes after arriving at the address, the special constable arrested and cautioned the man for criminal damage. The special constable made the arrest as they wanted the experience to apply to become a regular police officer. All three officers said that the woman was shouting and swearing while this was happening and was verbally abusive towards the officers. Several neighbours confirmed this.

The man said that he told officers that his wife could not be left at home alone as she would self-harm. He asked if she could go with them to custody. Both the man and his wife alleged that the female officer said something like "tough, not my problem." The female officer denied this.

The man said that he told the female officer that he had a card with emergency contact details for the mental health service his wife was in contact with. He said that he tried to call the number on the card before leaving the address but there was either no answer or no signal. This could not be proved either way by the investigation.

Both the man and his wife said that she had been able to go with him to the police station before. They also said that the female officer involved in this incident would usually find a room for her to wait in as she was aware of the woman's mental health issues. The man said that this had happened on at least three occasions. The female officer acknowledged this but said that this was because they had gone to the station voluntarily before.

The female officer said that the man never mentioned his wife's mental health and that if he had she may have arranged for someone to check on her. However, the female officer had been in contact with the man and his wife before, and was aware of the mental health and self-harm issues. The female officer told the investigation that she was the local beat officer for the area, was aware that both the man and his wife had mental health issues, and that there had been incidents where the woman had self-harmed in the past. She had also been involved in the development of a share point plan to address incidents involving the man and his wife.

Eventually the man was taken out of the house and into a police vehicle. The man's wife was still shouting and swearing at officers.

Shortly after the officers left the address with the man, the woman took a razor blade and cut her left forearm. She told the IPCC that she realised that she had cut her arm very deeply and had wrapped it in a tea towel and put cold water on it.

The man was booked into custody by the custody sergeant. The custody sergeant determined the man's mental health issues through the risk assessment process. The man told the custody sergeant that he had depression, anxiety and mild schizophrenia. It also noted that the man had a long history of self-harm. The man told the custody sergeant that he was a carer for his wife and that she should not be left at home alone. As part of the risk assessment the custody sergeant asked the man if there was anything that he could do to help. The man said that they could contact his wife because she self-harmed when left alone. The custody sergeant said that they moved on quite quickly and he took no further action because he did not believe that the man made the point particularly forcefully.

The custody sergeant said that the man "didn't present to me as being mentally vulnerable or suffering from a mental disorder at that time." This led the custody sergeant to decide that the man did not require an appropriate adult or a medical assessment. He also said that the Police and Criminal Evidence Act Codes of Practice wording meant that requesting a medical assessment was at the discretion of the custody sergeant, rather than being a requirement.

Police and Criminal Evidence Act (1984) Codes of Practice: Code C

Paragraph 3.15 states:

"if the detainee is a juvenile or a vulnerable person, the custody officer must, as soon as practicable, ensure that:

> The detainee is informed of the decision that an appropriate adult is required and the reason for that decision (see paragraph 3.5(c)(ii) and;
> The attendance of the appropriate adult at the police station to see the detainee is secured.

Paragraph 9.5 states:

"The custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practicable if the person:

> Appears to be suffering from physical illness; or
> Is injured; or
> Appears to be suffering from a mental disorder; or
> Appears to need clinical attention.

Find out more online:
www.gov.uk/government/publications/pace-code-c-2018

The man said that the custody sergeant asked him whether he required an appropriate adult. The custody sergeant said that he responded by saying that he did not want one because he was in a rush to get home to his wife, despite having an appropriate adult on previous occasions on the advice of his solicitor.

The man was interviewed by the female officer who was involved in his arrest and the special constable who arrested him. After the interview, the female officer signed the custody record confirming that PACE and the codes of practice had been complied with during the interview. The female officer told the IPCC that she did not believe it was her responsibility to make sure that the man had been deemed fit for interview via a medical assessment, and that this was the responsibility of the custody sergeant. She also said that the man did not appear to be someone who would need an appropriate adult. However, all officers carrying out relevant duties are responsible for making sure PACE and the codes of practice are met.

Later, the man's wife called the station to ask when her husband would be home. The custody sergeant said that this phone call lasted approximately one minute. The woman did not mention her injuries during this phone call. When asked whether he considered asking the woman about her welfare, he said that the phone call was so short and abrupt that he did not consider asking her any questions. He also said that the woman calling to ask when her husband would be home justified the decision not to send anyone to check on her.

Early the following morning, the man was released from custody and taken home by the female officer and the special constable involved in his arrest. The man said that in the car he told the officers that he hoped his wife was ok because he was concerned nobody had checked on her. He said that neither the special constable nor the female officer offered to go into the house to check on his wife. Both officers denied that the man expressed concern for his wife's welfare in the car.

The man described finding his wife in the kitchen covered in blood after injuring her arm.

Key questions for policy makers/managers:

- Does your force give officers guidance on how to respond when someone being arrested has caring responsibilities for someone who is vulnerable?
- Would you routinely ask officers to document where an individual brought into custody has caring responsibilities for someone who is vulnerable, to help inform future contact?
- How do you ensure information obtained in risk assessment questions is adequately factored into decision making processes when dealing with vulnerable detainees?
- Does your force make clear to officers that it is a requirement that someone considered to be mentally vulnerable have a medical assessment and be provided with an appropriate adult, in line with PACE Code C?
- How do you make sure that officers and staff are aware that they are responsible for ensuring compliance with PACE Code C, as well as the custody sergeant?

Key questions for police officers/staff:

- Where you are planning an arrest and you know that the person who is being arrested is responsible for the care of someone who is vulnerable, what action would you take to make sure that measures are put in place to support this individual and protect them from harm?
- Would you have arrested the man and taken him into custody without first making sure that plans were in place to make sure his wife did not come to harm while he was away?
- When the man's wife made contact following his arrest, would you have used this as an opportunity follow up on how she was?
- How do you decide when someone is mentally vulnerable?

Action taken by this police force:

- Staff were reminded to make careful assessments of individuals in custody to provide appropriate medical care for those who have a mental health disorder and an appropriate adult. Previous history of the detainees should also be considered where an appropriate adult has been called before to assist them.
- Officers and staff were reminded to make sure that the caring responsibilities of persons arrested are considered as part of the risk assessment. Where it is found that the detainee is a carer and responsible for the welfare of a person left at a premises alone, with a mental illness, consideration must be given to the information, action taken where necessary and the rationale documented.
- Risk assessment questions that ask about dependents at home should be probed fully. Dip sampling of custody risk assessments has taken place.

Outcomes for the officers/staff involved:

- The custody sergeant received unsatisfactory performance for failing to act on information which indicated that the woman would self-harm, and for failing to make sure that the man received an appropriate adult and medical assessment.
- The female PC received unsatisfactory performance for failing to make sure the safety and wellbeing of the woman, and interviewing the man without the presence of an appropriate adult or a medical assessment taking place.
- The special constable received unsatisfactory performance for interviewing the man without the presence of an appropriate adult or a medical assessment taking place.

- Read full learning report

Force practice highlighted in recent HMICFRS inspections

Feedback on previous issues of Learning the Lessons has consistently shown that readers want to see more examples of 'good practice' accompanying the case studies which feature learning from investigations and appeals.

HMICFRS
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

In November **2018 HMICFRS** published its first thematic report into Policing and mental health: Picking up the pieces. In our inspection of all forces we found that the police approach to people with mental health problems is generally supportive, considerate and compassionate.

We found many examples of joint working with partners, creativity and innovation to help support people in crisis and those living with mental ill health. I tried to include as many examples as possible in the report to encourage and share best practice and encourage new ways of thinking. I have included some of those examples here for your reference.

Hannah Wheeler Assistant Portfolio, Director – Prevention, HMICFRS

CALL HANDLING

Many of the call-handling systems have in-built checklists or prompts to help call handlers identify mental health problems. Cheshire constabulary's call handlers have access to 'evergreen logs' that contain data from triage crews (including nurses). They use them to help identify mental health concerns.

In Cumbria constabulary, all control room staff are trained in identifying mental health indicators at the first point of contact. They use a 'keep me safe' checklist to help them understand their responsibilities. Humberside police has a mental health practitioner from the charity Mind in the control room three evenings a week. The practitioner helps officers and staff identify vulnerabilities and manage risk when people with mental health problems call. They also review the calls that come in to check the quality of the responses.

MENTAL HEALTH TRAINING

New probationary officers in Nottinghamshire police work for a day in a mental health setting. This can be on an in-patient ward, crew with the street triage team, or community work with an approved mental health professional. This gives them first-hand experience of the often challenging nature of mental ill-health. Mental health training reinforces their understanding.

North Yorkshire police has developed a collaborative approach with the University of York and the College of Policing on policing and mental health. This is known as the Connect Partnership. This was created after evaluating existing training available for professionals who were not involved with mental health. It showed that there was not a proven, effective training product that was suitable for the police service. Connect has given all officers and staff tailored, multi-agency training. It is presented by mental health professionals from the local NHS Trust, based on College of Policing learning objectives. Evaluation and feedback has shown that this training is effective. It will be provided for all officers and staff.

Read more about the Connect Partnership: www.connectebp.org/

MENTAL HEALTH POLICIES

The Metropolitan Police service has a particularly effective toolkit policy for officers and staff. It gives clear direction with flowcharts for each step that officers are likely to encounter in a mental health situation. The force has a central mental health team that provides training and information on legislative changes. It is delivered through a network of borough-based mental health liaison officers of all ranks and grades.

Read more online:
www.justiceinspectorates.gov.uk/hmicfrs/publications/policing-and-mental-health-picking-up-the-pieces/

Want to get involved in the development of Learning the Lessons?

We are creating a new virtual panel, bringing together a range of stakeholders from the police, the community and voluntary sector, and academia, to support the development of future issues of Learning the Lessons.

If you are interested in joining the panel, please complete our online registration form to register your interest.

Panel members will be invited to review and provide feedback on drafts around six to eight weeks before publication.

For more information email learning@policeconduct.gov.uk