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INQUEST submission to the Home Affairs Committee Inquiry into Policing and Mental Health

May 2014

INQUEST's expertise

1) INQUEST is the only independent charitable organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths, their investigation and the inquest process to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. It has a proven track record in delivering an award-winning, free, in-depth complex casework service on deaths in state detention or involving state agents. It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability.

2) Our specialist casework service gives INQUEST a unique perspective on how the whole system operates through our monitoring of the investigative and inquest process. We work with bereaved families from the outset, facilitate their legal representation and work alongside them until the conclusion of the investigation, inquest and other legal proceedings. It enables us to identify systemic and policy issues arising from avoidable deaths and the way they are investigated and ensure this is fed through to government, policymakers and parliamentarians. Our evidence to this HASC draws on this expertise.

3) INQUEST participates in the Ministerial Council on Deaths in Custody through representation on the first tier, the Ministerial Board on Deaths in Custody. INQUEST's co-director Deborah Coles is also a founding member of the cross government sponsored Independent Advisory Panel on Deaths in Custody, the second tier of the Ministerial Council.

Policing and mental health: why a priority concern for INQUEST

4) INQUEST has noted a significant increase in police related deaths involving people suffering mental illness or in some form of mental health crisis. Occurring nationwide, these disturbing and contentious cases are marked by a similarity of facts and issues. All involve the use of force and restraint.

5) There is little evidence of collective learning from these cases. Despite a plethora of recommendations arising from investigations, inquests, inspectorate reports and reviews, the same failures and problems are being repeated. This appears to have been starkly illustrated with the deaths in November 2013 of Leon Briggs and Terry Smith. These two vulnerable men died within nine days of each other. Both men were restrained and detained by police under section 136 of the Mental Health Act. Both were taken to police stations and not to hospital. The outcomes of the IPCC investigations are awaited in both cases.

6) The IPCC's published statistics on deaths in police custody provide further evidence of this rise. Figures for 2011/12[1] and 2012/13[2] revealed that nearly half (7 out 15) of those who died in or following police custody were identified as having mental health problems.

[1] Available from www.ipcc.gov.uk
[2] see page 8 of the 2012/13 IPCC report at: www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report2012-13.pdf.

7) INQUEST has documented the double discrimination faced by people with mental health issues from BAME communities, who continue to be disproportionately represented in INQUEST's casework on deaths involving the use of force or gross medical neglect[3].

8) The sharp rise in mental health-related deaths coincides with significant recorded increases in the number of people in mental health crisis coming into contact with the police. Mental ill health is now described by many police officers as the biggest single issue impacting on policing, with the number of incidents involving people suffering from mental health problems rising at an alarming rate. In its annual report for 2012/13, the CQC reported 21,814 uses of section 136, with over 7,500 estimated to involve the use of a police cell. One police area reported that 41 young people had been detained in police cells over the previous year, the youngest of whom was 11[4]. The urgency of the issue is reflected in blogs such as 'Mental Health Cop'. The theme of this year's annual policing conference was Mental Health and Policing. In a recent interview, Sir Peter Fahy, Chief Constable of Greater Manchester, commented "It is a major concern if you talk to most operational officers. They would say the number one issue for them is mental health"[5].

9) The fact that nearly half of police-related deaths now involve people with mental illness is evidence that policing on the ground is failing to recognise or adequately adjust to the changing nature of this policing demand. This is borne out by evidence across INQUEST's casework which shows near identical issues and problems arising. Many of these issues are not new and have been well documented as a result of previous deaths. It is a tragic fact that deaths are arising as a result of the failure to act on this important evidence base. As many of the families have said, their loved ones have not died as a result of 'mental health' but as a direct result of the way in which they were treated, in many cases as a result of the dangerous and excessive use of restraint.

10) INQUEST has been pursuing significant policy and parliamentary work to highlight these serious concerns, including through the Ministerial Board on Deaths in Custody and in meetings and correspondence with Ministers. It has also briefed parliamentarians for a range of debates on this issue. It has been working with families affected by these tragic deaths to generate media and parliamentary attention and in January facilitated a meeting between families and the Minister of Health, Norman Lamb MP[6].

11) INQUEST believes the development of a national strategy is urgently needed to look at and address the particular challenges and dangers involved with policing and mental health. Unless a strategy is developed which responds to the fact that a significant proportion of policing work now relates to those with mental health issues, INQUEST believes further and unnecessary tragic deaths will follow.

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[3] See INQUEST's submission to the Casale Review: http://www.inquest.org.uk/media/pr/inquest-and-sean-riggs-family-respond-to-findings

[4] See: http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/04/CQC-Mental-Health-Annual-report-2012-13.pdf

[5] See: http://www.express.co.uk/news/health/434649/Police-chief-We-are-not-trained-for-mentally-ill-criminals

[6] See: http://www.inquest.org.uk/media/pr/families-and-inquest-meet-health-minister-to-urge-action-to-prevent-deaths

Deaths in police custody involving mental health: INQUEST'S casework

12) INQUEST's current casework involving policing and mental health include the deaths of:

- **Sean Rigg** (Metropolitan Police) a 40 year old black man diagnosed with schizophrenia who died on 21 August 2008. Sean was arrested for theft of his own (expired) passport. The jury at Sean Rigg's inquest, which concluded in August 2012, returned a damning narrative verdict following his death at Brixton police station in August 2008 and criticised the actions of the police and mental health trust. Section 136 powers were not used. The jury found that the level of force used on Sean Rigg, who was restrained in the prone position for approximately 8 minutes, was unsuitable. They found that the police "failed to identify that Sean Rigg was a vulnerable person at point of arrest" and he was therefore taken to the police station instead of an A&E department or Section 136 suite despite information about him being readily available and accessible[7]. The jury also identified the inadequacy of communication and crisis planning between the police, mental health trust and mental health hostel (where Sean was living). The IPCC is seeking CPS advice on charges of perjury and perverting the course of justice against two officers in connection with the evidence they gave to the IPCC and the inquest. Following a High Court order quashing the IPCC's original investigation, a re-investigation has been started by the IPCC in May 2014 concerning the actions of officers involved in Sean's arrest, restraint and detention.

- **James Herbert** (Avon and Somerset Police) who died in June 2010 after being restrained by police officers, assisted by members of the public. James Herbert had suffered mental ill health for several years and was detained by police after acting strangely in public. James' mental health issues were known to the police. Limb restraints were applied to his ankles, legs and wrists. Despite the pleas of his mother to take him to hospital, he was transported in a police van, not to a hospital but to Yeovil Police Station (27 miles away). On arrival at the station James was unresponsive. He was carried face down on a blanket from the police van and placed in a cell in the custody suite. His clothes were removed and he was left naked on the floor before officers withdrew from the cell. The jury at his inquest in April 2013 returned a highly critical verdict and the coroner wrote to the Chief Constable to raise significant concerns about the treatment of those detained under s.136[8]. Again, a reinvestigation by the IPCC is underway.

- **Olaseni Lewis** (Metropolitan Police) died in September 2010 following prolonged restraint at the Bethlem Royal Hospital in London. Seni Lewis was a fit and well 23 year old black man with an IT degree and plans for further postgraduate study. Over a 48 hour period he began to exhibit uncharacteristically odd and agitated behaviour. Within 18 hours of being brought to hospital he was all but dead, having collapsed in the course of prolonged restraint involving 11 officers of the Metropolitan Police. He never regained consciousness and was eventually pronounced dead four days later. Over three and a half years later, the inquest into his death has yet to take place. In September 2013 the

[7] For more details of the inquest verdict please see www.inquest.org.uk/media/pr/jury-condemns-actions-of-the-police-and-the-mental-health-trust-in-verdict

[8] For more details see: www.inquest.org.uk/media/pr/jury-and-coroner-raise-concerns-about-restraint-related-death-of-james-herb and www.dailymail.co.uk/news/article-2315383/James-Herbert-Family-public-schoolboy-25-slam-police-left-naked-police-cell-floor.html

IPCC announced a fresh investigation into his death (the original investigation having been found by the High Court to be in breach of Article 2 (the right to life) of the European Convention on Human Rights.

- **Thomas Orchard** (Devon and Cornwall Police) died in October 2012 following his arrest and detention by Devon and Cornwall Police. 32 year old Thomas was diagnosed with schizophrenia and was living in supported mental health accommodation. Disruptions to his medication led to a drastic deterioration in his mental health. Police were called by concerned members of the public. It is said by police that Thomas was arrested on suspicion of a public order offence. Section 136 of the MHA was not used. He was restrained face down and limb restraints were applied. He was transported by van to a police station. It is known that Thomas remained in limb restraints and that an "Emergency Response Belt" was applied across his face as a spit/bite hood. An ambulance was called when he was observed not to be moving and he was taken to Royal Devon and Exeter Hospital. He never regained consciousness and was pronounced dead several days later. An IPCC investigation is underway and his case has been referred to the CPS. No inquest has yet taken place[9].

13) Other cases which INQUEST is working on include the deaths of:

- **Colin Holt** (Kent police) died in August 2010, after absconding from the hospital where he had been sectioned. He died of asphyxia following restraint by the police at his home in Gillingham. The CPS brought a prosecution for misconduct in public office against two of the officers involved. In May 2013 the jury acquitted the officers. The inquest into his death is awaited[10].

- **Kingsley Burrell** (West Midlands) a 29 year old black man called the police in March 2011 to express concerns about the safety of his son and was subsequently forcibly restrained by the police and taken to hospital to be assessed under the Mental Health Act. He died a few days later. The inquest into his death is awaited.

- **Leon Briggs** (Surrey Police), a 38 year old black man, died shortly after he was restrained and taken to Luton police station in November 2013. Bedfordshire police have confirmed to the IPCC that he was detained under Section 136 of the Mental Health Act[11]. In response to his death INQUEST's co-director Deborah Coles said: *"INQUEST is dismayed by yet another death of a vulnerable person with mental health problems who is restrained and taken, not to hospital, but to a police station. We also know from our casework that young black men and those with mental health problems are disproportionately represented in deaths following the use of force. This follows a pattern of cases where a policing response to someone in crisis has resulted in death and*

[9] INQUEST has helped the family to generate media and parliamentary attention about this case and publicly available details about Thomas Orchard's death can be found: www.thetimes.co.uk/tto/news/uk/crime/article3888436.ece http://www.channel4.com/news/police-told-to-stop-using-restraining-belts-as-spit-hoods and (www.inquest.org.uk/media/pr/statement-from-the-family-of-thomas-orchard)

[10] See: http://inquest.org.uk/topic/tag/Colin-Holt

[11] See more at: www.ipcc.gov.uk/news/update-ipcc-investigation-death-custody-luton

highlights our call for urgent action to address this national scandal[12]." A criminal investigation is underway by the IPCC and an inquest is awaited.

- **Terry Smith** (Surrey Police) died on November 2013, 24 hours after being detained and restrained by Surrey police. Initially detained by police at around 10pm on 12 November 2013, Mr Smith was taken to Staines Police Station. He is said by police to have been detained under section 136. In the early hours of 13 November, Mr Smith was admitted to hospital in a life-threatening condition and was later pronounced dead. An IPCC investigation is underway and an inquest is awaited[13].

- **Darren Lyons** (Staffordshire Police) died in January 2014. Darren (43 years) had longstanding mental health problems. Armed police attended his home address and Darren was arrested and transported to the North Area Custody Facility in Etruria where he was placed in a police cell. Some hours later he was transferred to University Hospital of North Staffordshire and was later pronounced dead. An IPCC investigation is under way and an inquest is awaited[14].

14) All of these cases involve apparently physically healthy men dying in circumstances involving the use of force and restraint. INQUEST has identified the following as common features:

- Apparent difficulties/failures by officers in identifying people as having mental health issues or undergoing a mental health crisis;
- Little or no attempt to adjust policing responses to a mental health crisis situation;
- Inadequate attempts at de-escalation and safe containment;
- Dangerous use of force and prolonged restraint, including the increased use of restraint equipment;
- Treating a mental health crisis situation as a criminal situation and not as a medical emergency;
- Delays and failures at every stage in calling an ambulance or securing urgent medical care;
- Transferring detainees to police stations and not hospital;
- Dangerous transportation in police vans;
- Poor monitoring of welfare;
- Failures to use or properly use section 136 of the Mental Health Act;
- Failures to link earlier known incidents and information;
- Failures/delays in crisis intervention by mental health services;
- Failures in information sharing and co-ordination of emergency responses between police forces and community mental health services.

INQUEST's key areas of concern

[12] More details, including a family statement, from: www.inquest.org.uk/media/pr/leon-briggs-death-family-statement
[13] See more at: www.ipcc.gov.uk/news/independent-investigation-started-after-death-custody
[14] See more at: http://www.ipcc.gov.uk/news/ipcc-investigation-detention-man-staffordshire-who-has-died

15) INQUEST has identified below some of the key areas it believes should be urgently addressed as part of a review and national strategy. This is by no means a complete list but reflects some of the most pressing issues emerging through current casework.

16) **A different policing approach**
Cases have exposed a fundamental lack of understanding on the part of many police officers in relation to mental health issues and what is required for a safe policing response that protects the health and safety of all involved. INQUEST is continuing to see cases where there has been a use of excessive force disproportionate to the risks posed. A criminal justice approach to people in mental health crisis and delays in securing urgent medical care have been central features of most of INQUEST's cases. The distinct policing needs of a mental health situation need to be understood and a proper recognition of the vulnerability and health risks of someone in a mental health crisis is key to reforming police practices. This should include:

- Proper risk assessments and a managed approach based around communication, calm containment and de-escalation.
- The need to treat someone in a mental health crisis or displaying psychotic symptoms as an urgent medical situation requiring immediate referral to hospital for urgent assessment and medical treatment.

17) **Restraint**
Essential to a changed policing response must be the recognition that the use of force and restraint against someone suffering a mental health crisis or suffering some form of psychosis poses a life threatening risk. Evidence across cases has shown that someone in this situation is in a heightened physical and mental state, with the result that restraint can cause the system to become rapidly and irreversibly overloaded, leading to death.

18) The use of restraint is a central feature of almost every case. Time and again deaths are occurring in circumstances involving poorly controlled, often prolonged and chaotic restraint by many officers. In James Herbert's case it also involved members of the public. Particularly disturbing has been the increased and dangerous use of restraint equipment such as limb restraints, spit hoods and Emergency Response Belts, for example, in the case of Thomas Orchard.

19) A poorly managed approach to restraint has been illustrated by the common failure of police officers to give clear evidence concerning the duration of a restraint. This was starkly illustrated in the case of Sean Rigg where mobile phone evidence at the inquest showed he was restrained by officers for eight minutes rather than for a matter of seconds as they had claimed.

20) INQUEST has no way of knowing of cases involving serious injury or trauma caused by the use of excessive restraint on someone with mental health issues. The recent introduction of new guidance and a two year programme to stop the deliberate use of face-down restraint in health and social care settings reflects an understanding of the dangers and impact of restraint on those who are vulnerable including those with mental health issues[15].

[15] See: https://www.gov.uk/government/speeches/positive-and-safe-reducing-the-need-for-restrictive-interventions

21) INQUEST's view is that police policy, training and operational procedures must urgently change to properly reflect the life threatening dangers inherent in the restraint of someone in mental health crisis. The dangers posed by restraint in this situation should be on the same footing as the dangers posed by face down restraint and the risk of positional asphyxiation, now better recognised than before by the police.

22) INQUEST also urges an urgent review of the police model of restraint to reflect better practise from other custody settings. For example, similar to the prison setting, a lead officer should be responsible for oversight and management of any incident of restraint to ensure compliance with safety, welfare and risk assessments.

23) Finally INQUEST believes a mandatory system of recording incidents of restraint should be introduced into the police setting, similar to the system operating for some years in the prison setting. Such a system would enable essential transparency, auditing, active monitoring and opportunities for learning, something dangerously absent from the current system.

24) **Policies and Practice**
Cases have exposed the lack of consistent practice and systems in place within different police forces across the country in their response to mental health, with significant inconsistencies in approach and understanding of mental health issues and in the development of local policies and operational guidance. While some forces have developed guidance and training in response, for example, to learning from previous deaths, other forces have little in place to inform police action in recognising and safely responding to mental health issues.

25) Review and reform is needed to develop better minimum national standards and to ensure consistency of learning and good operational practice across local forces nationally.

26) **Section 136**
Common to most deaths have been issues and failures around the operation of section 136 of the Mental Health Act 1986. These include:

- lack of effective policies and systems concerning the operation of section 136, for example, there is currently no clear policing process that applies from the moment someone is detained under section 136;
- poor training and understanding concerning the application of section 136 powers;
- the common use of police station as a suitable 'place of safety' rather than as a last resort as per Home Office guidance;
- conflicts and tensions between the NHS and police in the understanding of roles and responsibilities in the operation of section 136;
- local section 136 policies which fall short of Home Office guidance;

- overly restrictive local policies by NHS services concerning disturbed and agitated detainees, despite this being a common feature of someone in need of section 136 assistance;
- shortages of NHS 'place of safety' accommodation provision;
- lack of joint co-ordination and working between the relevant local agencies including to identify and address any emerging problems around the operation of section 136.

27) The clear and effective operation of section 136 is vital to any policing response involving mental health. A review of the current operation of section 136 is critical. It is impossible to say whether section 136 requires reform without first understanding where and why existing arrangements are breaking down. Since many of these questions also touch on resource issues, clear and frank discussions with the police and health services are needed to consider the way forward.

28) INQUEST is aware that the police have referred to difficulties accessing NHS services as a common problem in the operation of section 136 powers, for example, in decisions to take a detainee to a police station rather than hospital. Whilst this may clearly be an issue, it is important to recognise that none of the deaths referred to in this submission involved the denial of access to medical care by health services. With the exception of Olaseni Lewis (whose death occurred in circumstances involving police restraint at a psychiatric hospital) in all other cases either section 136 was not engaged at all by the police or detainees were immediately transported to police stations as 'places of safety' and not to hospital.

29) **Police and Mental Health Services**
Several of INQUEST's cases have exposed poor systems of communication and information sharing between policing and mental health services.

30) In many instances, increased contact with the police is resulting from difficulties and failures accessing urgent mental health care, possibly arising from cuts to front line mental health services. A common problem has been the difficulty for those in crisis securing emergency mental health interventions, for example, a failure to section despite clear and serious signs of relapse.

31) Cases have exposed the lack of systems in place for effective communication, liaison, joint working and crisis planning and response between police and mental health services to anticipate and respond to mental health crises. Concerns around some of these issues were specifically raised by the coroner in his Rule 43 report following the inquest into Sean Rigg[16].

32) **NHS settings**
A number of deaths have involved prolonged and poorly managed restraint by police called to attend NHS settings. The case of Olaseni Lewis is a disturbing recent example. Seni was admitted to the Bethlam hospital and should have been safe under the care of mental health professionals. Within hours of his admission, police were called by staff to attend the hospital. Seni died following prolonged restraint by 11 officers. As well as highlighting again the fatal dangers of using restraint against someone in a mental health crisis, his case

[16] See: http://inquest.org.uk/media/pr/sean-rigg-case-further-developments-after-damning-verdict

and others raise serious questions concerning roles and responsibilities in relation to the safe welfare and management of patients: what if any circumstances justify police being called to an NHS setting, particularly a psychiatric setting? Who between the police and medical staff should take primacy of role to ensure a safe and co-ordinated response?

33) **Discriminatory attitudes**
INQUEST remains concerned that discriminatory fears and stereotyping may be informing an inappropriate and dangerous policing response to those presenting in a mental health crisis. Cases have included police descriptions of the deceased as violent and aggressive, the stereotype of the 'mad, bad and dangerous' when evidence has revealed agitation, distress and disorientation. Discriminatory assumptions may be informing dangerous policing responses to those in mental crisis, including the excessive and dangerous use of force. INQUEST'S casework also points to the double discrimination suffered by men from black and minority ethnic communities, with a disproportionate number dying following the use of force (Sean Rigg, Olaseni Lewis, Kingsley Burrell).

34) Central to any review should be an examination and challenge of discriminatory assumptions that may be coming to play, including in the assessment of risk and the use of force and restraint.

35) **Training**
Common to most cases is poor understanding of mental health and all but the most minimal training around mental health issues. This is impacting at all stages in the policing process: from the moment 999 calls are made by members of the public (with decisions around call logging and level of urgency) through to arrest and detention. A full understanding of where things are going wrong is needed to inform the change needed to training. A detailed look at the issues and learning from recent deaths would provide a valuable source for identifying gaps and problems.

36) Disturbingly, a recent national custody survey of police inspectors (conducted by the Inspectors' Central Committee of the Police Federation of England and Wales over the period 21 October to 22 November 2013) identified that 76% of the 746 respondents had not received training in dealing with the mentally ill in custody[17].

37) Central to the implementation of any change on the ground is the need for more and better training around mental health. Training must be regular enough to ensure sustained learning and to ensure emerging and better practice is incorporated into day to day policing. Historically, some police forces engaged the help of mental health service users in their mental health training. INQUEST's view is that this must be re-introduced to enable a better understanding of the issues and to help break down some of the fears and assumptions that may be informing poor practice.

38) **<u>Initiatives underway</u>**
Mental health and policing is rightly drawing increasing policy and parliamentary focus and

[17] See: http://www.polfed.org/newsroom/1750.aspx

concern. INQUEST is aware of several schemes and pilots underway, many in response to controversial deaths that have occurred.

39) INQUEST has been working on the cases of Sean Rigg and Olaseni Lewis that were pivotal in the decision of the Metropolitan Police to commission Lord Victor Adebowale's review resulting in his *Independent Report on Mental Health and Policing*. INQUEST made detailed submissions to the review. INQUEST also worked closely with the family of Sean Rigg to ensure that the original, flawed IPCC investigation into his death was subject to a thorough, independent review by Dr Silvia Casale to which INQUEST made a detailed submission[18] and which has impacted on the way in which they approach investigations.

40) The recently published Mental Health Concordat is also an important joint statement of what should occur when someone in mental health crisis requires help, including in accessing urgent and crisis care. INQUEST is aware of other reviews underway including by the National College of Policing (a review was announced following the announced re-investigation into Sean Rigg's death, although no details have been made public) and a survey launched jointly by the Home Office and Department of Health on the operation of police powers under the Mental Health Act 1983. INQUEST has also been invited to be on the expert group of the recently established HMIC review of the treatment of vulnerable people in police custody.

41) Examples of other recent initiatives include:

- placing mental health nurses in police stations: a £25 million national pilot scheme was announced to run in ten areas to help divert people with mental health problems away from the criminal justice system;
- Triage car schemes staffed by officers and mental health nurses: a joint NHS/Police scheme being piloted in various areas including in Leicestershire and Cheshire. Further pilots were announced in 2013 in North Yorkshire, Devon and Cornwall, Sussex and Derbyshire.

42) INQUEST welcomes attempts to increase mental health specialist expertise within police settings. As well are providing important sources of specialist advice, the presence of mental health staff is likely to impact on the understanding and approach of police in those settings.

43) However, while many of the initiatives represent examples of good practice, INQUEST's main concern is that they amount to a piecemeal, disconnected reaction to a problem that is not fully understood and fail to address many of the issues that are giving rise to the deaths INQUEST is working on. Not least the police's failure to recognise and/or respond safely to someone in mental health crisis, the failures to access urgent medical care, the life threatening dangers of restraint for someone in this situation, and the entrenched cultural attitudes of some parts of the police including that, despite the big increase of people with mental health problems coming into contact with the police, "mental health isn't our job".

[18] For details of our submission and the critical May 2013 report please see: www.inquest.org.uk/media/pr/inquest-and-sean-riggs-family-respond-to-findings

44) INQUEST believes a coherent overview of the issues is needed together with a mapping out of all initiatives, reviews and action already underway. This is essential to ensuring a joined up approach and the best and most effective use of resources. As the body with oversight of this area, the Ministerial Board on Deaths in Custody should be notified of all initiatives and work underway to ensure an understanding of the evolving national picture and to aid the process of accountability.

45) **Concluding remarks**

INQUEST is only involved in cases where deaths have resulted and cannot therefore comment on the cases where good police practice may have resulted in lives saved and urgent medical treatment secured. It also fully recognises that this is a challenging issue for the police, who may be having to address the consequences of cutbacks to front line mental health services.

However, it is clear that this emerging picture of policing need is not improving and that in all likelihood the numbers of people with mental health issues coming into contact with the police will continue to rise. Urgent learning is not happening and further unnecessary deaths are occurring. The fact that deaths are continuing to occur in near identical circumstances is exposing a dangerous failure by the police to understand or properly address the dangers and needs involved in responding to vulnerable people suffering a mental health crisis.

46) Without clear strategic oversight of developments at a national level there is a danger that good practice is not recognised, disseminated, implemented and properly resourced.

47) Key to any changes must be:

- The development of policing systems, responses and training which recognise and responds to the fact that a significant proportion of policing work now involves and will continue to involve those with serious mental health issues;
- Commitment and understanding at leadership levels for practical and cultural change;
- Consistency of policing action and approach nationally;
- The development of systems and arrangements for effective joint working between the police and other agencies involved

48) INQUEST remains concerned that whilst shocking, contentious cases generate an immediate response and commitment to change and learning, that learning is not sustained, does not become embedded in approach and practise, with the risk that the same cycles and patterns repeat. The high number of deaths involving mental health and restraint, including the use of prone restraint, are reminiscent of cases INQUEST was working on many years ago. The shocking death of Roger Sylvester in 1999 prompted a wide look at policing and mental health and lead to the development of policing policies. Nearly fifteen years later it is profoundly disturbing to see the same problems and issues presenting across so many cases.

49) Essential to any change must be mechanisms in place for ensuring sustained, organisational wide learning. Systems are needed for effective monitoring, including a national wide auditing of learning and recommendations coming out of previous deaths for dissemination and action across the policing system.

50) INQUEST believes only a national strategy on policing and mental health can provide the co-ordinated and dynamic reform urgently needed.