Mental health and policing

Overview of issues/concerns arising out of police deaths involving mental health

1. *Understanding the overall picture*

   An analysis of the context is important. INQUEST's experience of specialist casework is of an increase in police related deaths involving those with mental illness. The IPCC's published statistics on deaths in police custody for 2011/12 showed that nearly half (7 out 15) of those who died in or following police custody were identified as having mental health problems. Does this reflect greater numbers coming into contact with the police? Is there an increase in use of s 136? What are the reasons for the increase? For example, does this reflect any changes in mental health care or funding/service cuts?

2. *Cases for review*

   The issue is the police's response to someone in a vulnerable state of mental disturbance. This should include not only those with mental illness but also those suffering a mental disturbance e.g due to the affects of drugs or medical treatment (for example Philmore Mills and Victor Massey) both outside London cases. It is important to consider near deaths as well as deaths and INQUEST is concerned at the lack of qualitative data on the use of restraint that has resulted in serious injury/near death.

3. *Timing of collapse/death*

   All of the mental health policing cases INQUEST is working on involve similar circumstances in terms of the timing and circumstances of collapse/death.

   Either
   - collapse/semi conscious by time of arrival at station. Follows restraint/detention/transportation (Sean Rigg, Frank Ogboru). Suggests focus should be particularly on initial policing response.
   - Restraint in context of NHS setting, whether A&E (Michael Sweeney) or psychiatric unit (Olaseni Lewis)

4. *The need to properly assess and identify mental health from outset of situation*

   INQUEST's experience is that the police apply the same approach/response irrespective of any mental health feature. It is vital that mental health is identified from the outset (as soon as the police arrive) and that this informs every aspect of the policing response in terms of de-escalation, use of force,

exercise of s136, transportation, transfer to hospital etc. These are medical and not policing situations.

5. *Stereotyping and discrimination: extent to which this is informing police response*

- mental health: 'mad and bad'. Agitation/disorientation not necessarily aggression/violent
- race: disproportionate use of force against black men. Double discrimination of black men with mental illness eg Sean Rigg.

INQUEST's Casework and Monitoring show that a disproportionate number of those who die in police custody following the use of force are from black and minority ethnic communities (BAME). In 2011, BAME deaths accounted for 38% of all deaths in police custody.

6. *Section 136: hospital not custody*

- Hospital not police station
- Importance of looking at what happens at NHS end of the s 136 process.
- Note difficulties experienced by police with NHS response.
- contingency plans in the absence of sufficient NHS 'place of safety' provision what should police be using in the short-term? Alternatives? Identifiable police custody centres with mental health support/expertise?

7. *Is restraint ever safe to use where someone in mental crisis?*

It is important that this question is addressed. Medical evidence suggests that there is acute danger and risks in restraining anyone in mental crisis given the additional stress on the body. Although the dangers of positional asphyxiation from the prone position are generally recognised (at least in theory) to what extent are the additional dangers of using restraint against someone with mental illness recognised or understood. This should be feeding directly into training and policing practises. INQUEST casework and IPCC statistics indicate disproportionately high number of police deaths involving mental health and restraint.

8. *Use of force/restraint*

The requirement is for restraint to be used as a last resort and only following communication and de-escalation. There is no evidence that this is happening on the ground.

Unlike in the prison context, there is no mandatory monitoring and central reporting of the use of police restraint and therefore no overview/management/learning.

This is in comparison with prison restraint where lead officer monitors timing, physical responses etc and such interventions are recorded,monitored and subject to external scrutiny (HMIP).

Traumatising/escalating impact of restraint/use of force on someone with mental illness

9. *NHS settings: primacy of role; deferring to police* (Roger Sylvester, Seni Lewis, Michael Sweeney)

- Understanding reasons for NHS calling the police – is it ever justified?

- NICE guidance as distinct from police's guidance on use of force. NHS staff not permitted to use restraint to same degree. Would be deemed "unlawful restraint" under NICE guidance. To what extent informing NHS actions in calling police and NHS hands-off approach once police attend?

10. Interface between police and mental health services

- Structures/arrangements in place for effective communication and co-ordination between police and mental health services to anticipate and respond to mental health crises
- Since the death of Roger Sylvester INQUEST has called for multi-disciplinary emergency response teams to respond to people in mental health crisis – this is possible in context of Armed response units and should be given similar priority.
- Sectioning process: arrangements in place to ensure informed/co-ordinated urgent police response in conjunction with mental health services;
- Operation of s136
- Mental health info/flags on police computer system
- Multi-disciplinary response unit? Mental health expertise within the police in recognition of changing role in responding to MH situations.
- Examination/comparison of existing practises/protocols across the MPS areas to identify best practise

11. Training

- Recognising mental health and assessing level of threat/concerns: agitation/disorientation not necessarily aggression/violent
- Tackling discriminatory preconceptions and stereotyping
- Addressing fears around mental health: better understanding of behaviour in terms of agitation/distress and likelihood or not of aggression/violence
- Appropriate responses: de-escalation etc
- Understanding of stress levels etc and the impact of inappropriate responses

- Dangers of use of force and circumstances generating stress levels eg heavy handedness, transportation, police station
- S 136 and need for medical care
- Involvement of family/those able to calm/de-escalate
- Paperwork and practical training.
- Involvement of mental health users in training

12. Extending policing/MH review

- Mental health is the single most significant feature in all police related deaths. This is a national issue; it cannot be looked at in isolation.
- Good practice learning requires look at full national picture

13. Learning

- INQUEST remains frustrated by the failure to learn from the tragic cases of the past.
- Sustained learning; preventing repeat patterns.
- What are the structures/systems for organisational learning? (Should not just be about learning when things go wrong)
- The need to develop/implement national best practice
- Collective and individual responsibility: the critical need for individual as well as organisational accountability and for justice to be done
- Rule 43 reports and verdicts [see INQUEST report on recommendations for a new framework to ensure proper monitoring, analysis, auditing and follow up on investigation and inquest outcomes to ensure action taken to prevent further deaths. What exists at present is a serious accountability void.]

14. Cases

- Glen Howard (1999)
- Roger Sylvester (1999/s136/restrained in psychiatric setting)
- Andrew Howard (2003)
- Frank Ogboru (2006/restrained in street)
- Andrew Hammond (2008/shooting)
- Sean Rigg (2008/restraint in street/police station)
- Liu Jianping (2009/detained by police/self inflicted death after release)
- Olaseni Lewis (2010/psychiatric hospital/ inquest awaited)
- Michael Sweeney (2011/ hospital setting/inquest awaited)

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