

Six missed chances

How a different approach to policing people with mental health problems could have prevented James Herbert's death in custody

Foreword

At the time of his death in the custody of Avon and Somerset Constabulary (ASC) on 10 June 2010, James Herbert was only 25 years old. James had been suffering from mental illness and had recently been using legal highs. He had been in contact with the police several times during that day, the first being at around 7.30 am. The final contact was early in the evening, when police received a call about James placing himself in danger by running into the path of traffic on Bath Road in Wells, Somerset. After officers attended the incident, James was restrained and transported to Yeovil police station in a caged vehicle. On arrival, James was carried into the cells, and within minutes an ambulance was called as James had stopped breathing. He was pronounced dead shortly after 9pm.

The circumstances surrounding James' tragic death have been subject to two IPCC investigations and an inquest, when the focus was on what had happened and why. The focus of this report is on what could have happened, on the missed opportunities and unintended consequences. Its purpose is learning, by re-examining what happened to James and using it as a case study to explore alternative options for the police when they are responding to people with mental health difficulties.

Whilst it is not possible to say what **would** have happened if the missed opportunities had been taken, it is clear the outcome **could** have been very different. In common with many other bereaved parents I have met in my role, James' parents hold a fervent wish to see something positive come out of their loss. They want the knowledge that their son's suffering was not entirely in vain, and that lessons can be learnt from James' story which will reduce the chances of other vulnerable people dying in similar circumstances.

This is particularly important given the long-held concerns about the use of force and in particular restraint on those suffering from mental illness. A fifth of IPCC investigations relating to use of force involve people with known mental health issues. In our 2016 'Police Use of Force Report' Dame Anne Owers, IPCC Chair noted that people with known mental health issues *"were four times more likely to die after force had been used than those not known to be mentally ill. They were much more likely to be restrained, to experience multiple uses of force, and to be subject to force in a custody environment."*¹

This has to change – and it has to start with police culture. The welfare and safety of all those involved in an incident where someone is suffering from mental illness need to become the paramount consideration for police officers. While it is reassuring to see the significant changes Avon and Somerset Constabulary has made in its response to mental health issues in the last four years, such changes are not universal. Nor, in my view, has police culture as a whole yet fully adapted to them.

That said, though this report focuses on the police service, it must be recognised that responding to people experiencing a mental health crisis must not be seen as purely a police responsibility. Indeed, too often the involvement of the police has reflected an absence of alternative support. Nonetheless, it is crucial that whether as first respondents, or only respondents, police officers are better prepared to deal with these complex and

¹ IPCC (2016) Police Use of Force www.ipcc.gov.uk/page/use-of-force

high-risk situations.

It is an officer's fundamental duty to protect life: the statistics alone indicate that use of force and restraint when dealing with someone with mental illness is always potentially dangerous, often life-threatening and sometimes fatal. In itself, it creates a medical emergency. Guidance already states that force should only be used if it is absolutely necessary, should be kept to a minimum, and the need to use it should be continuously reassessed. This should apply equally to restraint, particularly of an individual known to have mental health issues.

The report that follows tells the story of the last day of James' life, in particular his interactions with the police. It looks at different episodes, and how the police responded – drawing on current best practice to highlight how officers should now respond to maximise the opportunity to achieve the best possible outcome and minimise the risk of harm.

There are some key aspects of this sad account that I want to draw attention to from the outset. Importantly, James' mental health issues were already known to the police. Indeed, officers with Avon and Somerset Constabulary had raised concerns over a year before – concerns that, regrettably, did not lead to James receiving any mental health support. On the day of his death, James' disturbed mental state was apparent to the police from several earlier incidents. Yet this vital knowledge did **not** inform how he was dealt with during his final contact.

In the early evening, police were called to Bath Road where James was seen to be acting in a bizarre manner. A PCSO was first on the scene, but he quickly called for assistance because, on his own, he could not prevent James from running into the road – and thus putting himself and potentially other road users at risk. James was not threatening or violent at this point. A police officer arrived and almost immediately, James was on the ground and being restrained, including by members of the public.

In quick succession, his hands were cuffed and limb restraints were applied around his knees and ankles. I cannot know how James experienced this; however, in his agitated and vulnerable state, I imagine it was terrifying, which may have been why he began to resist and struggle. It is significant that this resistance was only evident after force was used against him. Similarly, it is impossible for me to know what was in the officers' minds at this stage and whether they gave any consideration to reducing the level of restraint to see if that might calm James down. However, we do know that he remained subject to this level of heavy restraint continuously until his arrival at the custody suite.

There were, at this point, a number of vital warning signs and risk factors, but these were either missed by the police or not taken into consideration. It was a hot June day and James was wearing a heavy winter coat, which restricted his ability to move and must have led to him becoming very overheated, especially in his distressed and agitated state. Once restrained, James' physical condition deteriorated rapidly: he was out of breath, clammy with sweat and red-faced, but he was not recognised as a medical emergency. The police were given information which indicated he may have taken drugs (legal highs). He needed to go to hospital, but instead, he was carried to a police van and put into a cramped caged area. He then endured a lengthy journey of about 45 minutes, with speeds of up to 50 or 60 mph at certain points during the journey, while in limb restraints, alone

and unsecured in the back of the van.

At Yeovil police station, a 'reception committee' of officers was waiting for him – ready to help those transporting James to get him into the cells. They were not expecting or prepared for the arrival of a seriously ill young man, and they did not treat him as such. James was carried face down on a blanket to a police cell where he was left naked on a bare cement floor. He was unresponsive and remained so, but rather than call for urgent medical assistance, officers withdrew, leaving him alone. When medical help was summoned by the custody sergeant, he contacted the call centre, not 999, and the level of urgency was not made clear. Initially technicians were sent and paramedics did not arrive until 10 minutes later.

In spite of attempts to save James, he remained unresponsive and was taken by ambulance to Yeovil District Hospital. He was pronounced dead at 9.21pm. A coroner's inquest, held in 2013, concluded the cause of James' death was "*Cardiorespiratory arrest in a man intoxicated by synthetic cathinones with an accute [sic] disturbance following restraint and struggle against restraint*".

Whilst the primary purpose of this report is to consider how a different outcome might have been possible if the police had responded differently to James, I know that his parents' loss was made even more painful by what happened afterwards. Whilst James was receiving life support in the police cell, his mother was contacted by the police to secure further information, but she was told nothing of his collapse, nor of his transfer to hospital.

The next time the police contacted James' parents, it was around 1.30am to notify them he had died. By this time Avon and Somerset Constabulary had already informed its press and media department of his death and had cordoned off the part of Bath Road where James had been restrained, just around the corner from his mother's house.

We all instinctively recognise the importance of timely and sensitive communication with families when their loved one is dying or has died. Yeovil hospital staff contacted the police at around 11pm on the night James died to ask whether his family would be attending the hospital. Without consulting James' parents, the police replied that the family would not be attending and that James' body could be transferred to the mortuary.

At the end of this report, I make a number of recommendations, which I believe if implemented could reduce the chance of others suffering what happened to James and his family. They are recommendations not merely for Avon and Somerset Constabulary, but for all forces.

Rachel Cerfontyne
Deputy Chair, IPCC

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Summary of events

On 10 June 2010, James Herbert died in the custody of Avon and Somerset Constabulary (ASC). James was a 25 year old man, who had a history of mental illness and had recently been using legal highs. Shortly before 7pm, the police were called to Bath Road, Wells, Somerset, because James had been seen by members of the public running in and out of the road, into the path of oncoming traffic, with no apparent concern for his safety. It was a hot summer's day, and James was wearing a heavy overcoat.

James' initial detention

A Police Community Support Officer (PCSO) was the first to attend. This PCSO had spoken to James about half an hour earlier. He tried to talk to James again this time, and usher him off the road. James was not behaving aggressively towards the PCSO, but he was not co-operating, and thus continuing to put himself and other road users at risk by running in the road. The PCSO radioed for assistance. Members of the public came out of a nearby pub, the Britannia Inn, to try and help – initially by alerting and slowing down traffic.

Within ten minutes, a PC arrived in a police van and attempted to get James out of the road. Once James was out of the road and on the ground, the PC restrained him with the help of the PCSO and members of the public. James had not been aggressive at this point. However, the PC stated he chose to restrain him to prevent James from running back into the road.

As he was being handcuffed and held, James began to struggle and shout. The PC radioed for further police assistance, and two others came to the scene. The handcuffs were reapplied, this time with James' hands behind his back. Two sets of leg restraints were also applied. James was then carried into the police van, still shouting and struggling.

At around this time, James' mother Mrs Barbara Montgomery arrived. She spoke to James and also to officers, requesting that James receive medical attention. An officer assured her James would receive medical attention once he calmed down.

Journey to Yeovil

The first PC that had arrived on the scene, accompanied by one of the pair that arrived in response to his request for assistance, then took James in the van from Wells to Yeovil, where the nearest designated custody station was. This is a distance of approximately 27 miles, and the journey took around 45 minutes.

The only accounts of the journey come from the two officers: according to these accounts, James continued to shout and struggle, then would go quiet for a period, before shouting and banging again. During one of the quiet periods, the officers stopped the van to check on James; immediately he started shouting again. They resumed the journey. James continued to shout during most of the journey, as well as bang on the metal cage. The officers radioed for colleagues to be ready at Yeovil police station to help them take James out of the van. They arrived at Yeovil shortly after 8pm.

At Yeovil police station

On arrival, James was quiet but reportedly breathing heavily. The two PCs were helped by four other officers to carry James out of the van and into a police cell, where he was placed face down on the floor. The handcuffs and both sets of leg restraints were removed, as was James' clothing. The mattress that had been in the cell had been removed by the custody sergeant when James was still in the police yard. The officers left the cell one by one.

Initially James had been mumbling, but once he was in the cell, he was quiet. He had shown no signs of resistance since arriving at Yeovil. After the last officer had left the cell, two officers continued to monitor James. He did not react or move, so within a minute, they went back in to the cell. James still did not react. His breathing had become shallow, and he started shaking.

An ambulance was called at 8.18pm. Shortly after, James was observed to have stopped breathing and the officers attempted CPR. Ambulance technicians attended and, on being informed James was in cardiac arrest, immediately requested paramedic assistance. The ambulance crew continued to try and revive James, using a defibrillator, and when the paramedic arrived, she administered intravenous injections. However, he remained unresponsive and shortly before 9pm was taken by ambulance to Yeovil District Hospital. He was pronounced dead at 9.21pm.

A coroner's inquest, held in 2013, concluded the cause of James' death was "*Cardiorespiratory arrest in a man intoxicated by synthetic cathinones with an acute [sic] disturbance following restraint and struggle against restraint*".

Responding to James' death

There have been several investigations into these tragic events, including the coroner's inquest referred to above, which returned a narrative verdict, and two IPCC investigations – both of which identified officers as having a case to answer for misconduct.² However, James' family remain concerned that the investigations did not adequately address some of their questions, and as a result that necessary lessons have not been learned which could protect against the same thing happening again.

² The IPCC investigations looked at the circumstances of Mr Herbert's death on 10 June 2010, evidence provided by officers at the inquest, information about Mr Herbert held by the force prior to his restraint, the actions of officers earlier on the day of his death and a complaint about the conduct of Avon and Somerset Constabulary during the inquest.

In the investigator's opinion, there was a case to answer for gross misconduct for an acting inspector in respect of evidence given at the inquest. The acting inspector was cleared at a misconduct hearing in September 2017.

The investigator also found a case to answer for gross misconduct for a former custody sergeant, and misconduct for three police constables and a PCSO. Management action was agreed by the force for one of the police constables and the PCSO. No further action can be taken in respect of the former custody sergeant who retired following 30 years' service and two of the police constables, who have since died.

A changed landscape for mental health

There is no doubt that since 2010 police awareness of mental health issues has increased. In particular, it is now recognised that officers need to be better trained to identify and respond to potential mental health problems. Rules on the use of restraint have been re-examined, not only in policing but in the health and care sector.

The Policing and Crime Act 2017 has introduced new requirements for the police to consult mental health professionals, wherever practicable, before detaining someone under the Mental Health Act and also changed rules on the use of police stations as a place of safety. However, these latter changes have not yet come into force and no date has been announced for when this will occur.

Guidance too has evolved. The cross-service Mental Health Crisis Care Concordat, launched in 2014, clearly delineated the respective responsibilities of different services in the event of a mental health crisis. On 3 August 2016, the College of Policing produced a new Authorised Professional Practice (APP) guidance module on mental health – which is both far more extensive but also more practical than previous guidance.

That said, the new APP focuses extensively on best practice for officers after someone with mental health issues has been detained. In many situations where officers deal with someone with mental health issues, they will (rightly) not detain them; it is crucial that guidance to officers is understood to apply to these situations too.

As well as national change, there has been change on a local level. ASC itself has introduced important changes to its approach to mental health. Where previously, its guidance to officers responding to incidents where mental health was a factor was extremely limited, in particular with relation to how and when they should call on the services of mental health professionals, that guidance has now been extensively redeveloped. Crucially too, a more robust and practical protocol has been introduced for joint working with the local health service – replacing a protocol that was (as will be considered later in this report) not fit for purpose.

Where mental health issues may be a factor in an incident, ASC policy dictates that this is now recorded in initial incident reports. Street triage, where a mental health professional joins police officers in responding to incidents, has been successfully introduced in ASC. There have also been changes to officer training.

Nonetheless, police forces themselves – ASC included – are aware that there is much more to do. It is clear that there are still significant differences in the way processes are applied between forces and even within them, from one area to the next. Concerns remain that there is no national standard for police training around mental health, and guidance on some of the most important issues remains unclear.

The focus of this report

In the light of these concerns, I have reviewed the investigations into James' death and identified a number of key points where a different response from the police *could* have led to a different outcome. In this report, each of these points is revisited, and an alternative approach outlined – based on current best practice.

The aim of this is not to pinpoint failings of individual officers or the police force involved, but rather to provide an extended case study, based on a real incident, that helps to put the best practice now adopted into a context that police officers can understand and relate to. At the same time, this approach serves to highlight specific issues where officers may need better guidance and/or training so that they are equipped to respond differently.

Six missed chances

In my view, there were six clear junctures at which the police could have responded differently to James. Initially, these were missed chances that could have prevented James' behaviour escalating to crisis point on the evening of 10 June; later, they included missed chances to de-escalate the situation, to seek suitable professional help and ultimately to identify James was in need of urgent medical assistance.

In looking at each of them, there seems to be a recurring theme: that James was seen less as a person urgently needing assistance and more as a problem or nuisance to be managed. Clearly other people had been worried about James' behaviour throughout the day and he was undoubtedly disrupting traffic in the evening. However, officers' primary concerns did not appear to be for James' wellbeing: their first priority was to remove him from the scene, not to address his increasingly obvious medical needs.

The police have a difficult balance to strike between protecting the public and themselves and considering the needs and safety of an individual who is believed to be a potential or actual threat to others. However, it is a fundamental duty of the police to protect life; in fact, this is the first duty listed in the College of Policing's definition of the role of the police.³

³ See www.app.college.police.uk/app-content/operations/operational-planning/core-principles/#role-of-the-police (accessed 4.4.16)

1. During the day: a missed chance to avert a crisis

The summary of events set out above began at a point in the early evening, when the police responded to several calls from the public about a man behaving strangely in the road. It was the police response to this specific incident which led to James being taken into custody.

However, this was not the first time that ASC had responded to incidents involving James on 10 June 2010. Through taking witness statements from officers, and reviewing the force incident log, Airwave transmission records, the intelligence system and police notebooks, IPCC investigators compiled the following chronology of interactions with James.

- Between 7.15am and 7.30am, a PC spoke to a large, bare-chested man with singed hair near St Thomas Street in Wells. The officer enquired after the man's welfare and the man told him he was ok, that he had been taking legal highs and was "*on his way home after partying all night*". The officer did not recognise the man, but was content with the answers. He called the intelligence unit at Wells Police Station to enquire whether anything was known about him.
- At 7.35am, an incident log shows ASC received a telephone call from a woman who reported a man in St Thomas Street who "*...looked a little odd and [the caller] was concerned as the children will be going to school shortly.*" At 7.38am, according to the incident log, a different PC was dispatched.

Between 7.38am and 7.39am, an officer working in the intelligence unit in Wells Police station, made several radio transmissions in which he identified James as the person involved. Transcripts show he stated: "*James Herbert I think he's from Churchill Road or somewhere nearby but I think he is known to us possibly for mental health issues or drunkenness or something.*"

At 7.45am an intelligence report was created, and at 8.03am the second PC went to a property in Churchill Road. According to the incident log, this was to "*check on welfare*". There was no answer at this address. The officer continued to search for James until 9.15am when an entry on the incident log stated "*no trace*".

- At 10.26am, an alert was received by ASC that a panic alarm had been pressed at a convenience store / Post Office on Bath Road. Three PCs were dispatched (none of whom had been involved in previous incidents) and spoke to the shop manager.

No records exist of their conversation, but the manager told the IPCC that a man had been in the shop, and behaving strangely. She stated she asked the man to leave which he did not "*take too kindly*". She said she felt intimidated by the man and she told the other staff member to press the panic alarm. However, she opened the door and the man left the shop. The officers told her they knew who the man was and asked why she had pressed the panic alarm. At 10.33am the incident log was closed, with the note "*button pressed in error*".

According to their statements to the IPCC, at around 10.35am, two of these three officers were then flagged down in their car by a passing motorist who indicated to them that the man who had been in the post office was at the bus stop. They drove to the bus stop and one of the officers recognised James. They spoke to him for around 10 minutes. The officer described James as “*happy*”, and his behaviour as compliant and not aggressive. Both PCs noted this interaction in their pocket notebook entries on the day but did not submit intelligence reports.

- At 11.17am, the police received a call from a man who lived on Churchill Road near James. The man told the call handler James had knocked on his door and when he opened it, James said “*Six, six, six*”. When the man asked him what he meant, James laughed and ran away. He returned a few minutes later and knocked again. The man didn’t open the door this time, but spoke to him through the window and asked if he was alright. James again laughed. The man and the call handler agreed that it was not an urgent situation; the man stated that if something else were to happen he would call back.
- At 12.44pm, a call was received from a different member of staff at the same store as earlier. The caller reported a man in the shop being very abusive and refusing to leave. It was recorded on the incident log that the man was intimidating the females in the shop and “*poss drunk or drugged*”. Two officers were deployed – one that had spoken to James at the bus stop and the other who had searched for James between 8 and 9am. The former stated they reached the shop around 1.15pm. The man was no longer there but from the descriptions, the officers identified the man as James. James had not been physically aggressive towards the staff.

The two officers went the short distance to James’ home on Churchill Road, where his mother, Mrs Barbara Montgomery, invited them in. One of the officers spoke to James; the other to Mrs Montgomery.

In a statement to the IPCC, the officer who spoke to James recalled that James was in a “*state of some agitation*”. James told the officer he had been taking legal highs and waved a foil packet in front of him. Mrs Montgomery confirmed this to the IPCC, stating it was a packet of NRG-1, a stimulant drug which prior to 27 July 2010 was legal. The officer stated he told James his behaviour had intimidated the staff, and explained to him that such behaviour could lead to him being detained under section 136 of the Mental Health Act.⁴

⁴ Section 136 of the Mental Health Act states that “If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.” It is one of the key pieces of legislation – as opposed to guidance – that covers police duties around mental health. It was amended by the Policing and Crime Act 2017 (section 80) to clarify where this power could be used and allow the officer to keep the person in a place of safety if they are already in one. The new legislation is not yet in force. See

The officer that spoke to Mrs Montgomery stated to the IPCC that she told him James had not been sleeping. He suggested to Mrs Montgomery that she make an appointment with the GP and also possibly contact social services. The PC recorded this interaction in his pocket notebook. However, it is Mrs Montgomery's recollection that she asked the police officers to contact social services for her.

One of the two officers then made a radio transmission, stating the "...gentleman [was from] Churchill Road and he's in a private premises". It was further stated by an officer "I think it is mental health issues. He's been told if [inaudible] again he will be arrested even if we had to take him in for sec..." The radio transmission did not name James.

- In his pocket notebook, the officer that had spoken to James an entry timed at 3.55pm stated "*spoke to lates re Churchill Road, advised them that there had been three calls to James and told if seen in public place sec 136 MHA should be considered.*" Neither officer submitted an intelligence report in relation to their contact with James. One subsequently stated to the IPCC that he felt the fact that his colleague had informed the late shift was sufficient and there was no necessity to submit a report.

In total, five different officers directly interacted with James three separate times before 1pm that day and a sixth issued radio messages concerning him. ASC took calls from four different members of the public, again before 1pm. Officers visited James and his mother at home. All of the incidents and reported incidents took place in a small area of the city, near James' home. Some of the same officers were involved in more than one incident and some already knew James.

As far back as early 2009 – almost 18 months earlier – a different PC with ASC had identified that the force was receiving a large number of calls about James' behaviour. He approached the local mental health team, who agreed to assess James. The assessment notes, provided to the IPCC, showed that at the time of the assessment (April 2009) there was no evidence of acute mental disorder and no reason to detain him.

Returning to 10 June 2010, at 6.23pm ASC received a further call about James – this time from his mother, who was concerned James was missing from home. According to the police call log, she told the call handler that James "*really needs a mental health assessment and that officers had advised that they would contact social services*".

At 6.30pm, a PCSO spoke to James who he saw walking along Bath Road in what appeared to be a stressed state; he was hugging the St Bernard dog he had with him. James told the PCSO he was okay, and heading home; as James was not deemed to be a danger to himself or others, the PCSO left him to carry on walking. The police then called Mrs Montgomery to let her know James had been found and was okay. Mrs Montgomery drove round, picked up the dog to take home and told James she'd be back for him.

Less than half an hour later, the PCSO responded to a separate call to police to head to

Bath Road. The radio logs showed the police force had identified the incident “*appears to be about James Herbert*” and asked the PCSO to “*just go out and double check on him*”.

What should happen?

So how would, and should, a police force respond to such a series of incidents today? Drawing on established police procedure and policies, as well as best practice around mental health, which has evolved over the last seven years, some of the key aspects of an expected response are outlined below.

Information should be recorded promptly

In recent years, police forces have estimated that around 20-40% of their time is spent dealing with incidents that involved mental health issues.⁵ ASC’s own analysis has identified it receives over 1500 calls a month related in some way to mental health. This has motivated police forces to be more diligent about recording such incidents, even where no crime has been committed. Since January 2014, the ASC control room has used a “*mental health*” qualifier when recording incidents; this information is given to officers when responding to incidents but also provides a means of identifying recurrent problems.

The key to turning this from an administrative exercise into something that guides an appropriate response is the quality of information. Section B8 of the Mental Health Crisis Care Concordat⁶ sets out the ideal information that should be gathered: basic information, such as name, contact details, gender and age, all of which could help identify the individual on existing risk databases or through the knowledge of offices. In addition, the Concordat recommends recording a description of the individual’s behaviour, whether they are likely to be affected by drink or drugs and any “*presenting risk factors*” such as self-neglect or impaired judgement. Though this is specifically around those in a crisis, it provides a useful starting point to help prevent an acute mental health crisis developing.

All of this could have been recorded in James’ case, but the records made of interactions with James varied. For instance, even though it appeared officers recognised each incident on the day as involving the same person, James was not named in several of them. (Older records also show that incidents involving James were recorded under two surnames – as James Herbert and James Montgomery – meaning that there was no full picture of James’ behaviour.) Other important details, such as the legal highs that James had been taking, were recorded in a pocket notebook – so an individual record, rather than something that was made available to others.

The Concordat also highlights other useful information that could be recorded, such as whether an individual has a mental health crisis plan; officers may not be able to ascertain this immediately, but by recording the details listed above, they would be able to find out.

Information should be consolidated and shared

In section B8, the Concordat states: “*If the same person presents to police, ambulance or Emergency Departments repeatedly, all agencies should have an interest in seeking to*

⁵ See House of Commons Home Affairs Committee (2015) *Policing and mental health* pg 8 para 4

⁶ HM Government (2014) *Mental Health Crisis Care Concordat* section B8 pages 26-27

understand why this is happening, and how to support that person appropriately to secure the best outcome. This may include identifying whether the individual is already in treatment, and/or is known to services, their GP or other community-based mental health services.”

There are two important points here. Firstly, the police are expected to identify when someone presents repeatedly. Secondly, the police should take action if this happens, which we consider further below.

To identify when someone presents repeatedly, the right information must be gathered at each incident, but it must also be shared. Taken individually, each interaction with James raised concerns about his mental wellbeing; taken as a whole, they paint a picture of a man who was in significant distress, possibly delusional and deteriorating. There are several references in radio transmissions to officers being concerned about his mental health, but no specific action taken.

Even if individual officers responding to one-off incidents cannot see the pattern, someone at the centre can and should. Furthermore, if information is consolidated, officers are aware of what their colleagues may have said or done. In James' case, officers spoke to James and his mother about using section 136 of the Mental Health Act if there were further incidents involving James; regardless of whether that was appropriate, this specific information wasn't passed to colleagues. Instead, information was given verbally to the late shift; not only an informal process, but more importantly incomplete.

The second point, as indicated above, is what happens next. Many of the officers responding to incidents in Wells were aware it was James each time. By the time the PCSO was sent to “*double check*” on someone thought to be James, there had been a series of calls from the public, a call from (and back to) James' mother and a large number of incidents in the day involving this one individual. An officer at the centre observing such a sequence of events would be expected to identify that sending a single PCSO may not be appropriate. The crucial next step now would be not only to allocate more suitable police resources, but also to contact other services.

Mental health services should be contacted

One of the purposes of the Concordat was to set out clear responsibilities and expectations for all services. For the police, this in particular means alerting health and social services to a potential mental health crisis as soon as possible, so that the individual concerned can get the best possible help and support before the situation escalates. For example, the Concordat states:

“When the police make contact with health services because they have identified a person in need of emergency mental health assessment, mental health professionals take responsibility for arranging that assessment.”⁷

It is clear from reviewing the actions of the officers who interacted with James on 10 June that several were concerned about his mental health. When James' mother spoke to

⁷ Mental Health Crisis Care Concordat, section B6

officers at her home at around 1pm and again when she called the police at 6.23pm, she specifically highlighted the need for mental health assessment and support. Today, given the greater understanding of the role of police with regard to mental health, and the use of approaches such as street triage, I would hope and expect that officers attending any of these incidents would have contacted local mental health services. At each point on 10 June, that was an option to the officers responding, or to an officer noticing a pattern of incidents; in addition, intelligence records and other relevant safeguarding systems could (and arguably should) have been updated.

What might prevent best practice being followed?

Though today guidance is far clearer – not least through the new College of Policing Authorised Professional Practice (APP) guidance on mental health – it's important to consider if there are any potential barriers to these steps being followed.

One potential barrier is a reluctance to record information, simply because it 'creates' work – predominantly paperwork. However, recording and sharing the right information early could not only save lives, but also potentially reduce workload. In James' case, if a referral had been made to mental health professionals at an early stage, subsequent incidents may not have taken place.

Another potential barrier lies in local protocols around mental health. Police forces are expected to work with other relevant agencies – most obviously NHS trusts – to agree local protocols that cover mental health assessments and how section 136 of the Mental Health Act will be implemented locally. Specifically, the protocols should set out what places of safety are available and how individuals should be conveyed to them.

At the time of James' death, there was a protocol between ASC and the Somerset Partnership NHS Foundation Trust. This is understood to have been the only local guidance given to ASC officers around mental health at the time.

However, the protocol only covered what should happen once an officer determined that it was necessary to detain an individual under section 136. It did not give any guidance on when to apply section 136, or more importantly still, the availability of relevant mental health support before reaching a level where section 136 is deemed necessary.

While much has changed in the mental health landscape, this same issue is still occurring: while the APP on mental health does include guidance on engaging with people with mental health issues in general – so would be applicable before detention – the guidance appears disproportionately focused on the point of detention and what should happen thereafter. Many incidents do not lead to detention and do not even require consideration of detention; it is crucial that officers are not given the impression that their responsibilities start only at the point of detention.

As outlined above, several of the officers who interacted with James during the day had concerns about his mental health, but none contacted the local mental health team. A protocol that focused solely on what should happen after section 136 is applied might have given the impression that officers were not expected to make contact with the mental health team *unless* section 136 was applied.

The Policing and Crime Act 2017 sets out a specific duty for officers to consult, wherever practicable, a medical practitioner or mental health professional **before** applying section 136. Though not yet in force, this principle appears to be in line with the approach of the Concordat, which stated:

“Police officers responding to people in mental health crisis should expect a response from health and social care services within locally agreed timescales, so that individuals receive the care they need at the earliest opportunity.”⁸

The emphasis on the “earliest opportunity” is key here. It is worth reiterating that ASC did attempt to intervene at a much earlier opportunity – over a year before. This was based on a recognition that the force had responded to several incidents where James’ mental health was a concern. However, the resulting mental health assessment did not indicate James needed to be taken to hospital and James himself was recorded as seeming “bemused” as to why mental health professionals would want to be in contact with him.

It is possible that this previous assessment influenced the actions of officers a year later; they had raised concerns, but been assured that James’ mental health was fine. But just like physical illnesses, mental illness can develop quickly; it can also be episodic – people talk about having bouts of depression, for instance. Given this, it is crucial that officers understand that a previous mental health assessment or diagnosis does not necessarily hold true at the time they respond to an incident.

2. At the roadside: a missed chance to de-escalate

All of these prior interactions with James are being considered as one missed chance; the next took place at the roadside. The timings shown here come from STORM⁹ logs, the description of events from radio communications, officers’ statements, interviews under caution and evidence to the inquest.

When the PCSO arrived at the scene at 6.56pm, he immediately did the logical thing: he tried to get James out of the road, and keep him out of it. But PCSOs have limited powers and training, and the PCSO quickly recognised he needed assistance as James’ behaviour and demeanour had changed considerably since he had met James half an hour previously.

In his accounts to the IPCC and inquest evidence, the PCSO described James as imitating a bull, charging into the road and snorting. He endeavoured to talk to James but found him unresponsive. He tried to usher him to the side of the road, or stand in his way, but James ran round him. James was not being aggressive towards the PCSO, but was also not compliant: unable to keep James off the road, the PCSO radioed for urgent

⁸ Mental Health Crisis Care Concordat, section B6

⁹ STORM (System Tactical Operation and Resource Management) is a computer system used by a number of police forces, including ASC, to record information relating to 999 calls and the police response to them. Staff in the Force Control Room add notes to a central log for each incident. The notes typically include the initial call, which officers were dispatched and then summaries of radio messages from officers at the scene.

assistance at 7.03pm. Members of the public helped stop the traffic.

According to the STORM log, the first PC arrived at 7.06pm. Like the PCSO, he tried briefly to engage with James verbally. However, within a very short time of the PC's arrival, James was on the ground. Both when interviewed by the IPCC and when questioned at the inquest, the PC could not recall with any certainty whether this was because he took James to the ground, or James stumbled, or even sat down of his own accord. Either way, immediately James was on the ground, the PC restrained and handcuffed him, stating in his inquest evidence: *"I had concerns for his safety and with that in mind the best place for him was off the road."* A STORM log entry at 7.10pm stated that James was now handcuffed.

There are some differences in the accounts of different witnesses about the exact sequence of events. According to the PCSO, his PC colleague took hold of James and led him to the pavement, where together the officers got James onto the ground. Accounts from some members of the public indicated that the officers took James to the ground in a controlled movement. One witness suggested in evidence to the inquest that the officer even warned James he would be taken to the ground.

What they all agree on, however, is that this process happened very quickly after this first PC arrived. Furthermore, they agree that **once on the ground and restrained**, James began to struggle. He became aggressive, flailing his arms and in the PCSO's view, threatening to bite the officers. Members of the public came to help restrain James and the PC radioed for additional support. Several of these reported hearing officers speaking calmly and gently to James at this point.

In short, the situation escalated quickly from one in which James had been non-compliant, but non-threatening, to one in which he was struggling forcefully and perceived by the police to be threatening.

What should happen?

There are a number of aspects of this rapid escalation and use of force which best practice today would recommend managing differently.

Officers should attempt de-escalating communication techniques first

The APP on mental health¹⁰ describes de-escalation as *"an approach and range of tactics that may be used by the police or other professionals to calm an agitated individual to reduce or prevent the use of force or restraint"*. It advises that *"verbal de-escalation and containing a disturbed or confused and vulnerable person in a calm, ideally familiar, and closed environment may be safer and less traumatic for the individual"* [than restraint]. In layman's terms, this effectively means trying to calm someone down, keep them in one place and persuade them to co-operate. The guidance doesn't specify how long should be spent on this approach, but suggests that *"where possible, officers and professionals should maximise the time and space provided so that an individual is offered every*

¹⁰ College of Policing Authorised Professional Practice (APP) - Mental Health
www.app.college.police.uk/app-content/mental-health/mental-vulnerability-and-illness/#de-escalation

opportunity to calm down”.

Clearly, this specific guidance was not available at the time. However, it is an expansion of previous guidance which emphasised that *“officers should use de-escalating communication techniques where possible to calm and control a person.”*¹¹ Restraint should only be used if someone is being violent or aggressive.

James, initially, was neither. Yet within just four minutes of the first PC’s arrival, James was handcuffed on the ground and showing signs of resistance. Witness evidence testifies to the fact that the officers did attempt to engage with James verbally and persuade him to leave the road. In his evidence to James’ inquest, the PC stated that he began by talking to James and seeking to usher him off the road, and he felt this approach was working. Yet within a very short time period, he then restrained James with handcuffs. The timings clearly indicate that only brief attempts could have been made to de-escalate the situation before the officers decided to restrain James.

An alternative and preferable approach in such a situation is containment, which in practice might simply mean using more officers to try and stop someone running in the road: it’s easy to avoid one officer, but harder to avoid four. Traffic can be stopped – as it was on Bath Road – and a substantial risk removed. In James’ case, additional officers were called for, and arrived quickly, but only once James was restrained.

Officers should avoid using restraint on people with mental health problems if at all possible

Restraint is a use of force, and like any police use of force, must be proportionate and necessary. The APP on detention and custody advises that, when dealing with people with mental ill health, vulnerability or learning disabilities, *“safe containment may be a more appropriate response in many situations than restraint.”* The more recent APP on mental health goes further, stating: *“Officers should not use methods of restraint on people with mental ill health or vulnerabilities, however, unless absolutely necessary. They should reserve this for emergencies and circumstances in which the safety of the subject, the public, police officers and other professionals is at risk.”*

This reflects the findings of numerous investigations into deaths in police custody, including James’, which have identified that when someone is experiencing a mental health crisis, restraint is often experienced as extremely intimidating and can lead to panic. This may cause the person to struggle against it, which is counter-productive when the aim must be to help the individual to calm down.

Though this guidance was not in effect at the time, available national guidance from the National Police Improvement Agency made it clear that restraint should only be used as a last resort, and when there was no other option to prevent serious harm to the individual.¹²

Set against that, the local protocol between ASC and the NHS trust reminded officers that

¹¹ College of Policing Authorised Professional Practice (APP) – Detention and Custody www.app.college.police.uk/app-content/detention-and-custody-2/

¹² NPIA (2010) - *Guidance on Responding to People with Mental Ill Health or Learning Disabilities* See www.rcpsych.ac.uk/pdf/NPMAPracticeImprovement.pdf (accessed 07.04.16)

“common law also provides the power to restrain to end any breach of the peace, or prevent a recurrence or occurrence”, although it appears to take no account of the potential vulnerability of the individual involved. While the text of the protocol mentioned “proportional restraint”, it did not flag any of the risks associated with restraining people who are experiencing a mental health crisis. This was a further example of the inappropriateness of the local protocol, which almost appeared to suggest that officers should consider restraint as a practical step rather than use it only as a last resort.

The first PC told the IPCC that he had overheard from officers on the earlier shift that there had been incidents earlier in the day involving a male acting strangely in Wells. He appeared to connect the two: in fact, radio transmission records show that he asked *“is this about the chap from earlier with mental health problems?”* This indicates he was aware of the situation, when making his decisions.

What might prevent best practice being followed?

The priority for police officers should always be the wellbeing and safety of the individual, together with any others at risk of serious harm. The first PC’s evidence to the inquest, however, suggests one of his main priorities was to get the traffic flowing again. It’s not clear why. The police response to a person threatening to jump off a bridge onto a busy road would normally be to close the road, and officers would take as much time as needed to de-escalate, recognising the inherent risks of using force. This approach would have been equally appropriate in James’ situation.

It is not clear, however, if de-escalation is part of standard training.

In the IPCC’s 2016 report on *Police use of force*¹³, we recommended that all police forces provide training for their officers in communication techniques to help them manage and de-escalate situations without using force.

It is equally important to educate officers about the grave dangers of forcibly restraining someone who is experiencing a mental health crisis. For issues as significant as this, which have enormous potential consequences, it is not in my view sufficient simply to include instruction within guidance materials. Most officers now fully understand how positional asphyxia can occur and take considerable steps to prevent this; they need to have the same level of understanding of the potentially dangerous impact of **any** restraint on someone with mental health difficulties.

Police guidance and APPs now extend to hundreds, if not thousands of pages; it is not practical to expect officers to be familiar with every nuance. The NPIA *Guidance on Responding to People with Mental Ill Health or Learning Disabilities* was over 300 pages; it is inevitable that officers will sometimes miss elements. Much of the APP on detention and custody is, or appears to be, focused on the correct practice in a police custody suite; officers reading this could draw the conclusion that it only applies to those physically in the custody suite, rather than from the point of detention. The 2016 APP on mental health itself is substantial and provides a wealth of links to further guidance.

¹³ IPCC (2016) *Police use of force* Recommendation 19
www.ipcc.gov.uk/sites/default/files/Documents/IPCC_Use_Of_Force_Report.pdf

There is clearly a balance to strike: detailed guidance that sets out correct processes and examines different nuances is an important training and reference material. However, guidance must also be practical – a challenge for future APPs – and above all the most important issues and responses need to be incorporated through training. Responding to incidents involving people with mental ill health is one such issue.

3. Once James was restrained: a missed chance to release the pressure

The accounts of the officers are clear. Once James was restrained – being held on the ground and handcuffed – he began to resist, forcefully. Officers and members of the public described being shocked by his strength; James was reportedly kicking and thrashing his arms, and the PCSO thought he was threatening to bite those restraining him. James was also screaming “*six, six, six*”.

Even though by the first PC’s own account, the initial restraint was a matter of convenience and used for James’ safety, the response of the police to James struggling was to increase the degree of restraint. Though witnesses provided different recollections about the exact timings and sequence of events, it is accepted that James was initially handcuffed with his hands in front; because he was struggling, the handcuffs were removed and reapplied with his arms behind his back – a more restrictive position. Around the time two additional PCs arrived, two sets of leg restraints were also applied. James continued to struggle forcefully against the officers and the restraint.

The officers decided to take him into the police van, where he could be locked in a cage. The majority of witness accounts indicate that James continued to struggle while being carried. He was placed into the cage head first, and officers stated that he was initially seated upright, with his back against the rear wall of the cage. Once James was in the van and the doors were closed, members of the public described hearing sounds that indicated he was striking the cage. Given that the only part of his body that was wholly free to move was his head, these noises suggested that James was banging his head against the cage – and thus risking a head injury.

Based on the accounts of officers and members of the public, there is no evidence that at any point did officers appear to consider the possibility of reducing the restraint, to see if that would help calm James down. There is no evidence that officers, at any point, advised James that if he stopped resisting he might be released and or that the pressure being applied would or could be reduced. They told him to calm down, but did not offer the ‘incentive’ of reduced restraint.

Shortly after James was placed in the van, his mother Mrs Montgomery arrived. She attempted to speak to James and also spoke to the officers. She mentioned to them that he had been taking legal highs, and requested he be given medical assistance. She was assured that he would receive medical assistance once he had calmed down. The additional information she gave was noted down, but not passed on or acted upon.

What should happen?

Officers should consider reducing restraint if it's counterproductive

Once someone is restrained by the police, the restraint is typically only removed once the individual is deemed to have calmed down. However, the APP on detention and custody highlights that signs of aggression or anger in a person who has mental health issues may be *“a rational response by the individual to a fear that they have.”* That may include a fear of restraint.

In 2010, best practice guidance emphasised that – for anyone – restraint should be used for the shortest possible time, and with the minimum possible restraint. That guidance remains. Where an individual is struggling against restraint, officers should consider whether it is the right option, or whether they could reduce the level of restraint available. It is of course a difficult balance, with decisions being made in the heat of the moment. However, if – as in James' case – the use of restraint correlates directly with an escalation of violence, a logical and appropriate response would be to consider whether restraint was aggravating the situation rather than helping it.

According to STORM logs, by 7.26pm – shortly before the van left the scene – officers had reported that James did indeed have “a bit of a head injury” as a result of banging his head against the cage. This was later described as a v-shaped cut. Given that they then intended to transport him 27 miles within the same cage, it is hard to understand why consideration was not given to reducing restraint to reduce the risk of further injury.

Officers should record important information about anyone they are detaining

Above, I referenced section B8 of the Mental Health Crisis Care Concordat¹⁴, which sets out what information should be gathered, to enable an effective response. One part of that information is whether an individual is likely to be affected by drink or drugs. Clearly, this is important in determining how to respond to a situation – and particularly in terms of the medical response. James' mother gave the officers such information; it was noted down by individual officers, but not acted upon in any way. It was not shared with the Force Control Room or relayed to those awaiting James at Yeovil police station. Further, James' mother had already specifically requested a mental health assessment, and reiterated as he was in the van that in her view James needed urgent medical attention. Again, this information was not recorded.

It is imperative that information given to officers is recorded so it can be shared with medical professionals. It can also help officers themselves determine how they respond.

What might prevent best practice being followed?

Police officers have to make decisions in the field that reflect their understanding of an evolving situation. They are not and will never be expected to be mental health experts, and may not always recognise that they are dealing with someone with mental health difficulties. For this reason where officers have any reason at all to suspect someone may have mental health problems, they should assume that is the case until they know

¹⁴ Mental Health Crisis Care Concordat (2014) section B8 pages 26-27

otherwise – and respond accordingly.

However, in James’ situation, it’s clear that most officers felt there **was** a mental health problem. The first PC himself referred in his evidence to the need to take James to a place of safety – a key term for police in implementing the Mental Health Act.

Perhaps the more important issue therefore is to look at how officers are trained around reassessing risk and reducing levels of restraint. Restraint should be a continuum, rather than a series of increasing levels. This is not something that was explicit in the NPIA *Guidance on Responding to People with Mental Ill Health or Learning Disabilities*, nor has it been addressed in subsequent guidance. For example, existing police guidance on the use of limb restraints focuses predominantly on the correct way to apply them to avoid injury, rather than on the question of whether it is appropriate to apply them in the first place. It does not address the need for ongoing re-assessment of risk, how long it is safe to leave restraints in place, and the possibility of removing the restraints. ASC’s own training materials and guidance on the use of limb restraints did not address at any point the potential medical risks of using them, or make any reference to the increased risk of using restraints on people with mental health issues.

4. The decision to take James to a police station: a missed chance to get immediate mental health support

Under section 136 of the Mental Health Act 1983,

“If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.”¹⁵

The first PC told the inquest that he detained James under section 136. This meant that James had to be taken to either Yeovil or Bath because they were the nearest police stations that could be used as a “place of safety” under the Mental Health Act. Wells police station would have been nearer, but was only authorised to be used to hold people who

¹⁵ As noted earlier, this was revised in the Policing and Crime Act 2017 as follows:

“1. If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—

(a) remove the person to a place of safety within the meaning of section 135, or

(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.”

The earlier definition is retained in this report as this was the guidance in effect at the time.

were not violent and who had no medical needs (including mental health needs).

Yeovil is 27 miles from Wells, and the journey takes approximately 45 minutes by car or van. However, because of known traffic delays, this was deemed likely to be a faster journey than getting to Bath (which is around 20 miles from Wells).

The inquest accepted that James was detained under section 136 of the Mental Health Act 1983, a view shared by the IPCC investigator on the balance of probabilities. However, it is hard to determine this with any degree of certainty, due to the lack of clear evidence in relation to whether or not section 136 was used.

Either way, in the circumstances, the use of section 136 may well have been appropriate. James inarguably was in immediate need of care and medical attention. However, once section 136 is applied, it should trigger a process to get relevant support and treatment for the patient being detained. This process was not followed correctly for James following his detention: rather than being treated as a patient would be, he was treated as if he was a violent criminal suspect.

What should happen?

The fundamental process that should be followed when section 136 is used has not changed since 2010 (even when they come into force, the changes introduced through the Policing and Crime Act 2017 will not alter this). However, guidance has since been updated and in many cases, clarified, particularly through the Crisis Care Concordat.

A person detained under section 136 is a patient, not a prisoner. This vital distinction guides everything that should happen thereafter. Once someone is designated a patient, irrespective of local protocols, they are entitled to medical care. The NHS Constitution grants a fundamental right to access NHS services, with the further proviso: “*You will not be refused access on unreasonable grounds.*” The fact that someone is being detained under section 136 means they need medical treatment; police officers should exercise the right to access services on behalf of an individual they have deemed necessary to detain for mental health reasons.

As will be made clear below, the local protocol between ASC and the Somerset Partnership NHS Trust in effect at the time did not reflect this basic right of access to health services.

The individual should be told clearly that they are being detained under section 136 and, if possible, be given some explanation of what this means and the reasons for it

This is a simple process – much like reading someone their rights when they are arrested.

The person should be taken to a non-police place of safety

The overriding aim of taking a person to a place of safety under section 136 is for their protection – taking them out of a potentially dangerous situation, to a location where they not only are safe but feel safe. The emphasis therefore should be on taking them to a place that meets this purpose.

Though police stations *can* be used as a place of safety, the reality is that they are not a

suitable environment for vulnerable people in need of medical attention. Hospitals and other clinical settings are preferable for several reasons. Taking someone to police custody wrongly gives the individual the impression they are being arrested. Furthermore, if the individual does need urgent medical care – whether for a physical or mental health condition – they are better placed to receive it in a hospital. The Mental Health Act Code of Practice in force at the time of James’ death was clear about this, stating “*a police station should be used as a place of safety only on an exceptional basis*”¹⁶.

This was reiterated in a national protocol developed by the Association of Ambulance Chief Executives regarding the transportation of individuals detained under section 136¹⁷. Under this protocol, any police officer who detains an individual under section 136 is **required** to “*contact the Ambulance Trust through a locally agreed route*”. The Trust must send a vehicle within 30 minutes – and will prioritise urgent requests such as where there is a clinical concern arising from restraint.

Perhaps belatedly, the Policing and Crime Act 2017 has addressed this issue with a new section 136A.¹⁸ It forbids the use of police stations as a place of safety for anyone under 18 under any circumstances; for those over 18, it allows police stations to be used only under specific circumstances set out in regulations. However, as noted above it is not clear when this part of the Act will come into force nor when the regulations will be published.

Nonetheless, the guidance around the issue was clear even in 2010, so why did the officers involved not consider taking James to a hospital? They stated that, in their experience, hospitals would not have accepted James as he was violent. This explanation is lent credence by the local protocol, which at several points seemed to contradict the national guidance.

The protocol stated that a place of safety “*will usually be either a hospital or a police station*” – thus putting them on an apparently equal footing. It then stated “*the primary place of safety should be a hospital, except when the conditions detailed below (4.2) apply.*”

The conditions in question were things such as if patients were violent or might become violent, if they needed physical restraint to prevent them from leaving, or if they were suffering the effects of serious alcohol or drug abuse (which would make assessment impracticable). In any of these situations, the protocol stated the hospital was allowed to refuse to accept the patient.

¹⁶ Department of Health (2008) – *Code of Practice: Mental Health Act 1983* paragraph 10.21 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597. This was succeeded in 2015 by a revised Code of Practice, which included a similar provision:

“16.5 Proper planning should ensure that it is not necessary to use a police station as a place of safety for people removed under section 135(1), other than in the exceptional circumstances described in paragraph 16.38.” <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

¹⁷ Association of Ambulance Chief Executives (2015) – National Mental Health Act 1983 Section 136 Protocol www.crisiscareconcordat.org.uk/wp-content/uploads/2015/09/A1-National-Section-136-Protocol-complete-v2-FINAL-version-Reviewed-April-2015.pdf

¹⁸ See <http://www.legislation.gov.uk/ukpga/2017/3/part/4/chapter/4/enacted> section 6

It then referred to the option, in exceptional circumstances, of using a place of safety other than a hospital or a police station – again implying the two are interchangeable rather than following the national guidance that a police station should only be used in exceptional circumstances.

This local protocol was not compatible with national guidance – which has now been strengthened through both the APP on mental health and the national ambulance protocol. The former states: *“It is for the paramedics to decide, having assessed the individual’s health, whether the individual should go directly to the appropriate ED [emergency department] or to the place of safety (if they are different).”*

This is supported by the national ambulance protocol, which explains that if the senior ambulance clinician attending believes the patient has a medical need which requires emergency department assessment, then the place of safety must be an emergency department.

Even more specifically, it lists several “red flag” criteria; if the individual presents any of these, they should be taken to an emergency department as the first resort place of safety. If none of these red flag criteria are present, they should be taken to a defined place of safety, and only be transferred to a police station if they have committed an offence or *“become an unmanageably high risk”*.

The key point here is that the red flag criteria – of which there are many – take precedence. Any one of these is sufficient to mean the individual should be transferred to an emergency department for assessment. Of direct relevance to James’ situation, some of these red flags from the ambulance protocol include *“actively head-banging”* and *“possible excited delirium¹⁹”*, which it defines as:

“Two or more from:

- *Serious physical resistance / abnormal strength*
- *High body temperature*
- *Removal of clothing*
- *Profuse sweating or hot skin*
- *Behavioural confusion / coherence*
- *Bizarre behaviour”*

Though this protocol did not exist at the time, its meaning is clear: officers must call the local ambulance trust when they detain an individual under section 136. While the response of the ambulance trust will be determined by clinical need – and thus in the first instance, on the information the officers give to the ambulance trust – in a large number of

¹⁹ ASC has recently introduced training for its officers on recognising and responding to “excited delirium”. While the IPCC welcome training which highlights the medical emergency posed by this set of circumstances, it should be noted that the use of the term “excited delirium” remains in question and the alternative term “acute behavioural disturbance” is increasingly preferred. (ABD is the term used in the APP).

instances, the ambulance will then take the individual to an emergency department for assessment.

The police responsibility extends as far as contacting the ambulance trust and the local mental health trust – in the latter case, simply to ascertain where the individual should be taken.

It is vital therefore that police officers are aware of this protocol, and that police forces review any existing local agreements to ensure they are compatible with it.

ASC has taken a number of steps to address this issue – working with local partners to increase the availability of non-police places of safety and specifically prohibiting the use of custody as place of a safety for under 18s detained under section 136. This was introduced well before the Policing and Crime Bill (which became the Policing and Crime Act 2017) was put in front of Parliament.

At the same time, it also introduced a force-wide policy that no adults detained under section 136 should be taken into custody unless exceptional circumstances apply. In effect, this simply implements the requirements of the Mental Health Act code of practice. Nonetheless, by drawing officers' attention to this, there has been a notable impact: in six months since the policy was introduced, custody has been used just four times as a place of safety.

Even in police custody, the individual must be treated as a patient

It is worth reiterating that, even in the exceptional use of a police station as a place of safety, the very act of determining a place of safety is required means the individual should be treated as a patient whose safety is at risk. They therefore must be treated and managed accordingly, as soon as they are in police custody, for instance by being given the support of an Appropriate Adult.

A mental health assessment should be requested

Relating to speed of care, as soon as section 136 is employed, a mental health assessment should be requested by officers. This is (and was in 2010) a standard element of taking someone to a place of safety. It was reiterated in the Crisis Care Concordat:

“When a decision is made by a police officer to use their power under section 136, it is essential that the person in crisis is screened by a healthcare professional as soon as possible.”²⁰

Even if there is no other option than to take an individual to a police station as a place of safety, a medical assessment should take place as soon as they arrive. This is in line with the principles set out in the Home Affairs Select Committee report, that a mental health crisis *“should be considered primarily as a health matter”*.²¹

A simple parallel, used by Inspector Michael Brown who is respected as a leading

²⁰ Mental Health Crisis Care Concordat section B9. The changes introduced by the Policing and Crime Act 2017 will mean that, wherever practicable, the healthcare professional should be consulted **before** section 136 is used.

²¹ Home Affairs Committee (2015) *Policing and mental health* paragraph 1

authority on policing and mental health is this: if an individual was hit by a car and had a broken leg, they would be taken to hospital straight away, whether they were calm or not, and whether they had committed a crime or not. The same should apply to mental health.

ASC call records from 10 June 2010 show earlier in the evening show that at 6.23pm Mrs Montgomery specifically told police that James needed a mental health assessment. When she saw James in the van, she requested that officers take him to hospital. Her evidence is that officers told her James would be given medical help once he had calmed down.

Ambulances should be used to take someone to a place of safety

As indicated above, the national protocol developed by the Association of Ambulance Chief Executives regarding the transportation of individuals detained under section 136 makes it clear that unless the Ambulance Trust specifically advises the police they cannot send a vehicle, an ambulance will always be available to take someone to a place of safety. This has now been incorporated in the APP on mental health which states: *“When an officer detains an individual in a public place using their power under section 136 MHA 1983, they must request an ambulance. The ambulance service is required to transport all section 136 detentions.”*²²

This specific instruction actually serves only to reinforce guidance that already existed. For example, the APP on detention and custody states that ambulances should be used to take someone to a place of safety unless there are *“exceptional or life-threatening circumstances that mean other means of transport are necessary.”*²³ The Crisis Care Concordat states specifically *“caged vehicles should not be routinely used.”*²⁴

Though this guidance came into force after James’ death, the transportation of someone detained under section 136 was also addressed in 2008 ACPO guidance²⁵. The guidance gave two options for transportation:

- *First, an ambulance with police personnel present to assist the ambulance staff and any mental health staff;*
- *Second, in a police vehicle with mental health staff present to monitor and assist in communicating with the detainee.”*²⁶

Neither was used in James’ case. Instead, James was left restrained, in a caged van, in a state of considerable distress.

²² APP on Mental Health – Transfer to a health-based place of safety as a result of section 136 detention www.app.college.police.uk/app-content/mental-health/mental-health-detention/#transfer-to-a-health-based-place-of-safety-as-a-result-of-section-136-detention

²³ College of Policing Authorised Professional Practice (2015) – Detention and Custody www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/mental-ill-health-and-learning-disabilities/

²⁴ Mental Health Crisis Care Concordat section B12

²⁵ ACPO is now known as the National Police Chiefs’ Council.

²⁶ ACPO (2008) - *Guidance on the safer detention and handling of persons in police custody* section 5.6.3

What might prevent best practice being followed?

Clearly, in James' case, the local protocol was a key barrier to following best practice. Whether the individual officers were aware of the protocol wording, or just acted on their experience, is largely immaterial. It is clearly essential that local protocols follow and continue to incorporate evolving regulations, national standards and best practice.

That aside, while guidance **did** exist around transportation of individuals detained under section 136, it appears that there was perhaps a degree of confusion as to how it should be implemented.

There was also – as was historically the case in many areas – a lack of non-police places of safety available. This was recognised as a risk in the Crisis Care Concordat, which specifically stated: *“The signatories of the Concordat will work together to achieve a significant reduction in the inappropriate use of police custody suites as places of safety.”*²⁷ The Concordat also promised a change in the Mental Health Act Code of Practice, to ensure that *“People intoxicated as a result of alcohol or drug misuse who have been assessed as mentally disordered or are currently being treated by a mental health service will be accepted into the designated health based place of safety.”*²⁸

Data published by the Government in August 2015 indicated there has been progress on this aim. Since 2011/12, there has been a 55% reduction in England in the use of police cells as a place of safety for people detained under the Mental Health Act, and a 34% reduction since 2013/14.²⁹

The very clear and direct national protocol from the Association of Ambulance Chief Executives may help to achieve a further reduction in this – not least as it makes it clear to all parties that the Emergency Department should be considered the first resort place of safety in a large number of circumstances.

5. During the journey: a missed chance to check on James' wellbeing

According to the accounts of the officers in the van that transported James from Wells to Yeovil, James continued to struggle during the journey. They could hear him shouting and banging. At one point, he went quiet, so they stopped the van. This was about nine or ten miles into the journey.

The officers were both in the front of the van. According to their accounts, they got out and called to James as he had become quiet during the journey, but he did not respond. When they opened the doors, he began to shout and bang again, so they closed the doors and resumed their journey.

During the journey, the officer who wasn't driving made a radio call requesting the

²⁷ Mental Health Crisis Care Concordat section B6

²⁸ Mental Health Crisis Care Concordat action 3.14 pg 46

²⁹ See www.gov.uk/government/news/use-of-police-cells-for-those-in-mental-health-crisis-halved

presence of other officers when they arrived at Yeovil police station to help take James out of the van. He advised that James had been banging his head against the walls of the van and as an indication of the level of force the officers felt may be necessary, he included in his message the request that one be Taser-trained.

During the radio call from the PC, the communications operator heard a noise in the background and recognised it as “*a sound I have heard before when people are being violent in the van.*” However, based on their own statements, the officers did not consider further whether there was a risk that James was injuring himself.

According to this officer, there were other quiet periods in the journey, but they did not stop the van again, and after a pause, James began to shout and bang again. Just before they arrived at Yeovil, the officers radioed in again to advise them they were five minutes away. There was no banging in the background at this point, and the officers later indicated this had been another quiet period.

What should happen?

Today’s guidance makes it clear that people detained under section 136 should be transported to a place of safety by ambulance. More broadly, however, officers have a duty to focus on the wellbeing of anyone they are transporting.

Officers should be able to observe a detainee throughout a journey

ACPO guidance on transporting people in custody is clear. “*Detainees should not be left alone and unsupervised in vehicles; an officer must be able to observe and monitor the person and react to any situation which may arise.*”³⁰

In general, police vehicles are designed to enable this, with visibility into the rear of the vehicle. But, as their accounts explained, the two officers transporting James did not have such visibility: to check on James, they had to stop the van, get out and open the doors.

If a detainee is being transported in such a vehicle, guidance indicates that an officer should be in the back of the vehicle with them. However, even if they had followed this, the van was laid out in such a way that all seating areas, including those directly in front of the caged area, were forward facing. Had either officer been in the back, they would still have had some difficulty constantly monitoring James, though it is worth pointing out that the van in use did meet the national requirements which were in effect at the time.

If someone is violent, officers should stop the journey

The same ACPO guidance also states “*Where a detainee becomes violent staff should, where practicable, stop the vehicle, regain control and only then resume the journey; it may be necessary to call for assistance and to change to a more suitable vehicle.*”³¹

Clearly, this might mean multiple stops, if someone is – like James was – repeatedly banging the walls. The reason is obvious: it’s about protection of the detainee. The journey may take longer as a result; alternatively, as the ACPO guidance indicated, it might mean

³⁰ ACPO (2008) *Guidance on the safer detention and handling of persons in police custody* section 5.5

³¹ ACPO (2008) *Guidance on the safer detention and handling of persons in police custody* section 5.6.1

changing vehicle – or considering alternative options.

What might prevent best practice being followed?

The only reason for not following this best practice is a need to complete a journey in a hurry – perhaps due to a medical emergency. But even if this were the case, the right procedure would be to call for medical assistance such as an ambulance, rather than continuing with a journey which is endangering someone.

The inquest verdict in James' case was clear: in response to the coroner's question "*Were there any matters of concern that may have contributed to Mr Herbert's death?*" the jury highlighted a lack of monitoring of James throughout the journey as a factor that may have contributed to his death. They also cited the failure to "*call for medical assistance en route to, or at the latest on arrival, at the Yeovil custody suite*" as a potential contributory factor.

6. On arrival: a missed medical emergency

On arrival at Yeovil police station at 8.03pm (as recorded on CCTV), the van carrying James was met by a 'reception committee' of seven officers. They were there to help take James out of the van and into the custody suite. This was clearly something that was relatively common practice, but only when dealing with violent prisoners; the accounts of some of the officers who met the van indicated that is what they were expecting.

James, however, was a patient. He showed no signs of violence. He was reportedly slumped over, in a state of undress. He did not respond when spoken to: the only noises he made were described as grunting. According to several accounts, officers were sufficiently concerned to check James was breathing and had a pulse; once this was confirmed, they began the process of manoeuvring him out of the van.

Officers involved explained that, in their experience, previously violent detainees – especially if under the influence of drink or drugs – often fall asleep, or pretend to be asleep, at the end of a journey. They then become disruptive again when they are woken up, or when they see an opportunity such as when a door opens or some form of restraint is released. As a result of this experience, none of the officers thought James' behaviour and demeanour gave cause for concern. One told IPCC investigators: "*he seemed to be a regular drunk.*"

James was taken out of the van, and placed on the ground on his back. He was rolled onto his front, and then carried, head first, by around six officers, into a cell. This took at least two minutes, as officers were careful not to let James' head hit the walls.

Throughout, James was motionless and unresponsive, though some officers' accounts stated he was making a grumbling noise. Some accounts indicate his breathing was heavy; some that it was shallow.

Once in the cell, the officers performed a cell extraction – a standard process that allows a team of officers to leave the cell one-by-one. This is designed to protect the officers if a prisoner becomes violent. The officers placed James on the floor and his clothing was removed, along with the handcuffs and two sets of leg restraints. Still, James did not react,

though officers stated he was breathing.

After the last officer had left the cell, and James still did not respond or move, officers became concerned that he was not 'faking'. Some officers went back into the cell almost immediately to put James in the recovery position. Two of the officers who had helped carry James continued to monitor him through the cell door, and within a couple of minutes went back into the cell, where they found James was not breathing. CPR was attempted and an ambulance called.

What should happen?

Patient welfare must be the priority

In such circumstances, medical assessment and assistance must be the priority. This is not just about mental health, but also physical. A patient who has been restrained, transported for a long time, and who is known to have struggled forcefully against that restraint, clearly needs to be checked thoroughly. Additional factors such as the use of drugs (in James' case, legal highs) mean the requirement is even clearer. Such a check should be planned in advance, with medical staff on-hand when a detainee is brought in. This involves more than ascertaining that someone is still breathing, which is why it requires more than a police officer with basic medical training to conduct it.

As identified earlier, the ambulance protocol for responding to detentions under section 136 sets out a number of "red flags" which indicate the individual detained should be taken immediately to the emergency department. They include "noisy breathing" and "not rousable to verbal command" – both of which were identified as James was being taken from the van. A simple checklist like this could be a valuable asset for officers.

What might prevent best practice being followed?

The evidence gathered indicates that some officers were acting on their experience of dealing with prisoners under the influence of alcohol. The reason was simple: based on the information they had been given, that was the kind of individual they were expecting to be dealing with. This nonetheless raises some important issues.

Firstly, it underlines how crucial information flow is in incidents such as this to organise an effective and appropriate response. James was a patient, being taken in for his safety: he was not only not drunk – a description that brings with it a different set of expectations from someone under the influence of other substances – he was not a prisoner.

Secondly, it indicates a potentially dangerous preconception amongst officers: namely, that the most likely cause of someone struggling against restraint or banging against the walls of a police van is drunkenness. That then potentially leads to other risky assumptions about the best way to respond.

In reality, there are many reasons why individuals may be in custody in a disordered state, or may be resisting the police, from being under the influence of alcohol or other substances to profound distress to mental health problems. In many cases, there may be more than one factor – intoxication *and* mental health issues, for example. Officers cannot be expected to diagnose or even discern a specific cause without the right information. It is therefore essential that, rather than assuming one cause over another, they respond in

an appropriate way – seeking the input of a medical professional where necessary. The information about James' consumption of legal highs should have been passed on to those in the custody suite for precisely this reason.

The need for professional advice notwithstanding, officers are expected to respond to the situation in front of them. It is hard to see why it was not immediately apparent to those involved in carrying James that not only did he not present a threat, but more significantly was unresponsive.

Again from prior experience, some suggested that James might have been feigning sleep or even unconsciousness. This is again a high-risk assumption: in my view, the safer presumption should always be that individuals are not feigning and that unresponsiveness may be an indicator of a medical emergency. Moreover, officers are trained in techniques to test whether someone is feigning: if there is any doubt, these must be applied promptly, rather than waiting for a reaction.

Once the medical emergency was finally recognised, officers acted quickly. But this was not until James had stopped breathing. They began CPR, having called for an ambulance just a few minutes earlier, because at that very late stage they felt that James **may** need urgent medical attention. Improved training, however, may have helped them identify the signs of a medical emergency at a much earlier stage.

We will never know for certain whether action at this late stage would have been sufficient to protect James, but taking a different approach *throughout*, putting James' wellbeing first, could undoubtedly have led to a different outcome.

What can we learn?

As I stated at the start, my focus in this report is not to re-examine the actions of individual officers, but rather to try and learn from the missed chances. In particular, I have sought to identify areas where it appears police training or guidance may be unclear, or insufficient, and so there is a risk of similar events happening again.

For example, it is my view that while officers appeared to have the skills and knowledge to identify that James had mental health problems, they did not seem clear about how they should respond, or how to apply section 136 of the Mental Health Act. Whilst at ASC and some other forces, a commitment to improving training has been made, there is not yet a universal standard that addresses issues such as the use of de-escalation when dealing with a person with mental health problems. There is particular complexity around the use of section 136 when an individual has committed a crime – not relevant to James, but potentially important in other cases in the future as officers need to know whether an arrest, or a detention under section 136 should take precedence.

I am aware that while officers receive training in *how* to use limb restraints, there is a lack of detailed guidance on when they should be applied, and how long they can be continuously used without release. Similarly, though it is clear that police stations should only be used as places of safety in exceptional circumstances, there is no clear definition of what exceptional circumstances are. The Policing and Crime Act 2017 committed to the development of regulations addressing this; however, as noted above, it is not yet clear when the relevant sections of the Act will come into force and the regulations have not yet been published. Latest indications are that the Act will come into force by the end of 2017 and be supported by Home Office guidance and a “frequently asked questions” document, produced by the Royal College of Psychiatrists on the use of section 136.

Both will be welcomed, yet will only address some of the issues raised in this report. It is with these issues in mind that I make a number of recommendations.

Recommendations

1. Police officers responding to an incident involving someone with mental health problems should prioritise the welfare and safety of all those involved, including the patient.

This sounds simple and obvious, but in reality it will involve a change of culture and mindset for many officers. When someone is disruptive, behaving ‘oddly’, being intimidating or even threatening, the standard response of police officers is to get the situation under control as fast as possible. Their focus is often understandably on others – removing the disruption or potential threat to the wider public. However, the way in which they try to achieve this can often aggravate the situation and increase the risk of harm to the individual.

In the most extreme circumstances, this risks contravening the most fundamental duty of a police officer, as defined by the College of Policing: to protect life. This is reflected at the start of the new APP on mental health.

Someone suffering from a mental health crisis that requires police officers to intervene should be treated as a medical emergency and an ambulance should be called for the patient. Someone suffering from a mental health crisis and being restrained by the police is in even greater need of urgent medical support; their struggle and distress can mean the risk escalates to be genuinely life-threatening, as cases like James' underline.

There needs to be a change in the way officers respond to these situations – and it is a change not merely of process, but of culture and understanding.

To achieve this culture change requires training firstly to help officers identify where someone may have mental health needs and then to understand suitable responses that focus on patient welfare. Even the use of the word “patient” rather than “prisoner” is significant, and should be reinforced.

A simple example is ensuring that once a situation is safely under control, the next step is to get adequate mental health support for the individual – just as officers would ensure physical health care was provided to someone injured. When officers have any reason at all to suspect someone may have mental health problems, they should assume that is the case until they know otherwise – and respond accordingly.

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

This recommendation logically follows from the first recommendation. It's a practical means of embedding a focus on patient welfare; if the initial mindset of the officers responding to the incident is to de-escalate the situation, rather than to take control of it, further (and more forceful) intervention may not be necessary.

This is something some officers – like some people in many other walks of life – are naturally adept at. However, most officers would benefit from training that sets out standard techniques and best practice. Such training already exists for various professions: in my view, it's something that should be incorporated into police training programmes in England and Wales. Guidance, such as the new APP on mental health, is valuable but needs to be reinforced with practical training.

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

Again, this builds on the previous recommendations. As a minimum, forces should actively promote the guidance that restraint can often be the most dangerous response to someone experiencing a mental health crisis. If officers fully understood the inherent risks of all restraint in these circumstances, I think they would be more likely to persevere with alternatives for longer. Where restraint is used, the least restrictive techniques possible should be applied, and be for the shortest time possible.

Restraint is a use of force, and like any police use of force, it must be proportionate and necessary. To someone in a mental health crisis, any restraint is a risk, as it can make them more likely to struggle, escalating the situation. The APP on detention and custody highlights that signs of aggression or anger in a person who has mental health issues may be “*a rational response by the individual to a fear that they have.*” That may include a fear

of restraint.

There are of course times when restraint may be necessary, but often containment will be a more suitable and far safer approach in response to someone in mental health crisis. Containment tactics will depend on the situation, but James' case offers a simple example: using more officers to try to safely hold and prevent someone running in the road, and stopping the traffic to remove the risk of being hit by a car if the individual gets past the officers.

Officers are trained to use restraint only as a last resort; however, training does not typically go the extra step of considering reducing restraint if it's having a deleterious impact, or when it's no longer necessary. Too often, it seems a one-way journey: if an individual struggles against the initial restraint, then the response is to restrain more severely rather than re-assessing the approach and considering reducing restraint – even though in the case of detention under section 136, the individual is a patient, rather than a prisoner.

Again, it is worthwhile equating this with other uses of force: officers must keep considering whether the level of restraint is proportionate and necessary, rather than simply continuing to use it. In my view, this is again something that guidance alone is not sufficient for: it's an issue that can best be addressed through training.

In the context of this discussion, I would also like to draw attention to the positive progress that appeared to be made with the establishment of mental health restraint expert reference group in 2016. The IPCC was amongst the organisations represented on this multi-agency group which as well as including professionals from across policing, health and the third sector, crucially included mental health service users and representatives.

Chaired by Lord Carlile of Berriew, the group developed a memorandum of understanding covering Police Use of Restraint in Mental Health & Learning Disability Settings. The intention was that this would be followed by a second phase, looking at use of restraint in all other settings; this has however yet to commence. Given the strong support for the work to date and the very high ongoing risk of people with mental health issues being restrained by the police, I am not alone in hoping this second phase can begin soon.

4. Each local force should ensure that it has in place robust, effective and relevant local protocols that support police officers in the discharge of their duties, backed by effective working relationships with other agencies, on how to respond to incidents involving someone with mental health problems.

The Crisis Care Concordat set out clear principles to this effect. But we know from what different officers and forces have told us that the implementation of this on the ground is very different from area to area. In this report, we have highlighted the fact that the local protocol in effect in the Avon and Somerset area appeared to contradict national guidance and placed a disproportionate burden on the police. A leading authority on mental health and policing, Inspector Michael Brown, reviewed the protocol in detail and concluded that he would have advised the police force not to have signed it.

This is something for leadership teams to address with their counterparts in different agencies and services. Protocols must be clear, so that officers responding to situations

know who to contact for information about an individual they believe may have mental health problems and can have realistic expectations about services and response times. They also have to be practical, workable and above all protect the vulnerable.

The Home Affairs Select Committee report highlighted that “*as many as two-thirds of those detained by the police under s. 136 of the Mental Health Act are already in receipt of mental health care.*”³² There is clearly an opportunity here to use this information to either avoid the use of section 136 where a more suitable alternative is available, or to take more appropriate action once section 136 is applied.

Of course, protocols on paper only go so far: they need to be backed up by working relationships at all levels, so each party not only knows what they are entitled to expect from others but also how this will work in practice. That builds the trust, without which individuals in the field can be inclined to fill a gap and shoulder responsibility for situations: admirable in many ways, but also creating additional risk. It is welcome, therefore, that the new APP on mental health specifically identifies where the responsibilities of police officers stop and other agencies start.

There are a growing number of examples of innovative cross-service approaches – including several involving ASC referred to above – that help police officers respond more appropriately to incidents where mental health may be a factor, and understand how and when to engage mental health professionals. They should be the basis for others to follow.

5. Forces should develop clear processes for the recording and sharing of information about individuals who are known to, or are suspected to, have mental health problems.

Police forces gather information in a range of different ways from radio transmissions to call and incident logs to individual officer notes and reports. This is not always consolidated unless a specific incident demands it – so small details where there is no crime committed can often be overlooked. This was the case with James: the information regarding the repeated interactions with the police wasn’t formally brought together, but rather shared in an ad hoc way. Looked at as a whole, there was a clear pattern and one that may – and arguably should – have led to a different response from the police.

It is in this context that I recommend that forces develop specific protocols for recording information about people with mental health problems – or who are suspected of having them – so that there is an opportunity to intervene before a crisis point is reached. ASC’s approach of introducing a mental health qualifier on its STORM system is a useful starting point.

While individual officers responding to one-off incidents cannot be expected to see a pattern, someone at the centre can and should. Where they do so, they can then follow the protocol to identify clear “trigger points” with a related response: for instance, a call from a close family member or carer expressing specific concern that an individual is at risk of harm, or harming others, might necessitate the immediate use of section 136 to

³² Home Affairs Committee (2015) *Policing and mental health* para 3

take an individual to a place of safety. A second or third police contact with an individual in the same day might require a referral to the local mental health team.

Clearly, these trigger points rely on clear and timely information collection and recording, with effective lines of communication and information sharing with officers on the ground. By collating the information officers routinely gather and applying it effectively, the decision about how and when to intervene can be less about the judgement of an individual officer, and more about the known mental health needs of an individual.

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Rachel Cerfontyne

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