

**Restraint & Mental Health Report**  
**September 2004 (DRAFT)**



**METROPOLITAN  
POLICE**

*Working for a safer London*

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## RESTRAINT REPORT

### 1. Background

On the evening of 11<sup>th</sup> January 1999 Mr. Roger SYLVESTER suffered a cardiac arrest under police restraint at St. Ann's Psychiatric Hospital. He was detained under Section 136 Mental Health Act 1983. Attempts to resuscitate Mr Sylvester failed and he died at the Whittington Hospital on the 18th January 1999. He was aged 30. On 3 October 2004 the inquest jury returned a verdict that Roger Sylvester had been unlawfully killed. This verdict is subject to a Judicial Review scheduled to be heard on 3-5 November 2004.

#### 1.1 MPS Restraint Review

Following the jury's verdict the Deputy Commissioner ordered a review to be carried out with the following terms of reference:

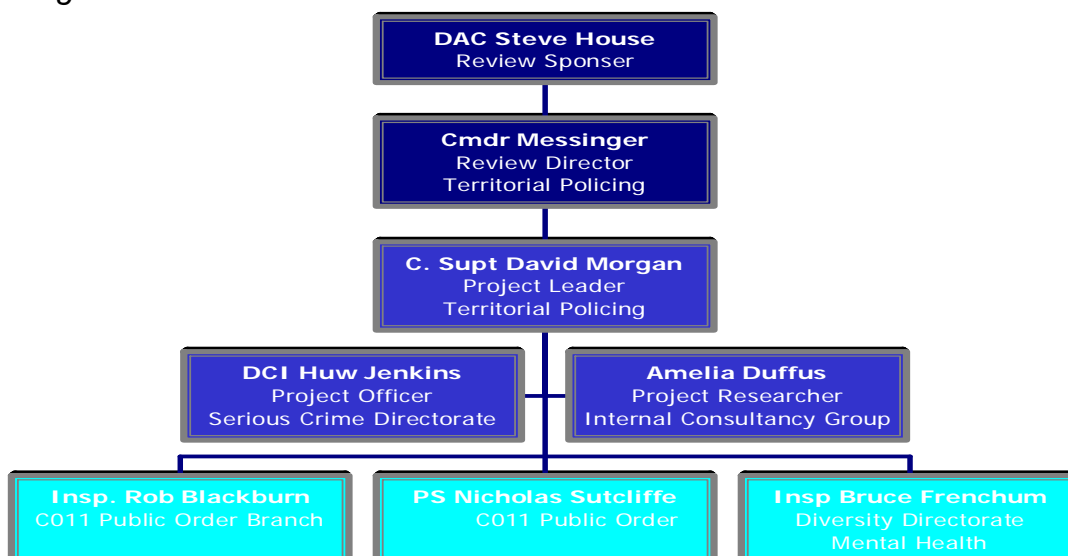
'In light of the issues emerging from the inquest into the death of Roger Sylvester to conduct a Review of

- (a) current officer safety training within the MPS in relation to techniques of restraint.
- (b) police procedures for dealing with people suffering from mental illness. and to report on its appropriateness.

Consideration was also to be given to any other issues/recommendations that have emerged from inquests into deaths in custody within the MPD since the date of Mr Sylvester's death in 1999. The Review was also charged with examining any alternative restraint procedures or equipment that may be available.

The Review team structure is outlined below:

*Fig i - Review Structure*



## 1.2 Oversight Group

To assist in directing this consultation the Review convened an advisory body, the Restraint Review Oversight Group comprising the following individuals:

**Table i - Restraint Review Oversight Group**

Oversight Group Member	Organisation
Commander Mick Messinger	Metropolitan Police Service
Elaine Rassabye	(Former Police Complaints Authority)
Richard Sumray	Metropolitan Police Authority
Sgt Dave Judd	MPS Federation
Mr Peter Horne	London Development Centre for Mental Health
Mr Jim Elliott	MPS Independent Advisory Group
CI Leroy Logan	MPS Black Police Association
Mr Paul Corry	Rethink
Chief Supt Mike McAndrew	MPS Superintendents' Association
Claire Gillham	Independent Police Complaints Commission

## 2. Consultation

### 2.1 External Consultation

Representatives of statutory and voluntary agencies, including providers and users of mental health services, attended focus groups. Non government organisations consulted include the MPS Gypsy and Travellers Advisory Group, Lambeth Community Police Consultative Group, the Confederation of Indian Organisations, the National Assembly against Racism, TASHA Foundation, Barnet Carers Centre, the 1990 Trust and Ealing User Involvement Project. One to one interviews were also held with forensic pathologists, the Police Complaints Authority, INQUEST and the solicitor who represented the family of Roger Sylvester.

The major issues raised during external consultation were:

- The need for all officers to be trained in dealing with people suffering from mental illness including de-escalation techniques
- The need for better joined-up working with the NHS particularly Accident and Emergency Departments
- The absence of a threshold for restraint

### 2.2 Internal Consultation

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Internally the MPS intranet was used to canvass the view of staff. This prompted approximately forty responses. Respondents were then invited to attend focus groups.

Major issues raised during internal consultation were:

- The need for more communication and specialist mental health training.
- The need for training that addresses the real situations faced by officers e.g. dealing with violent individuals.
- The support that officers receive from other agencies.

### 3. Medical

Between April 1998 and March 2003 there were four (Home Office Category 3)<sup>1</sup> deaths in police custody where excited delirium was given as the cause of death.

Between April 1998 and March 2003 there were five Home Office Category 3 deaths in police custody where positional asphyxia was given as the cause of death.

Expert opinion is polarised between those who believe in “excited delirium” and “sudden death in restraint” or “positional asphyxia” and those who do not. Front line officers are asked to recognise, from the gamut of human conditions, a syndrome whose very existence is in dispute among medical experts and whose name and definition is unclear. Advice to officers in Police Notices and during training makes clear that their response should be based on the symptoms that they perceive rather than on any street corner diagnosis.

### 4. HM Coroner’s Recommendations

On 11 March 2004 the MPS received Doctor Reid’s recommendations under Rule 43 of the Coroner’s Rules 1984. The report is divided into seven sections and is 59 pages long. It contains seven “*Matters for Immediate or Specific Action*” – “*to prevent similar fatalities in the short term*” and three “*Matters for further consideration*”. -that will in the opinion of Dr Reid, *prevent similar fatalities in the longer term, subject to further consultation, research,*

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<sup>1</sup> Category 3. Deaths in police custody

This definition covers the deaths of persons who have been arrested or otherwise detained by the police. It also includes deaths occurring whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

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*review and phased implementation.*” The Review has thus been informed by HM Coroner’s recommendations.

#### 4.1 Coroner’s Recommendation No.1

*Sudden death during restraint (SDR) should be recognised as a multi-factorial concept. Recognition of the multi-factorial patho-physiology of this condition will serve to reduce fatalities by focusing training, education, protocols and procedures on the dynamic aspects of the problem rather than particular elements in isolation.*

MPS Police Notice 12/1999, issued after the death of Roger Sylvester, defines positional asphyxia and emphasises that this can occur extremely rapidly listing eight factors that can contribute towards a death through positional asphyxia:

- *The body position of a person results in partial or complete airway obstruction and the subject is unable to escape from that position;*
- *Pressure is applied to the back of a person held in the face down prone position;*
- *Pressure is applied restricting the shoulder girdle or accessory muscles of respiration whilst laid down in any position;*
- *The person is intoxicated through drink or drugs;*
- *The person is left in the face down, prone position;*
- *The person is obese (particularly those with large ‘beer bellies’);*
- *Where the person has heightened levels of stress; and*
- *Where the person may be suffering respiratory muscle failure, related to prior violent muscular activity (such as after a struggle).*

Police Notice 12/99 sets out multiple factors that increase the risk of positional asphyxia. It therefore correlates with the Coroner’s recommendation that sudden death during restraint (SDR) should be recognised as a multi-factorial concept. Training and operational protocols must focus holistically on dynamically assessing the risks associated with any restraint as these will vary probably even with the same individual depending on a variety of factors.

#### 4.2 Coroner’s Recommendation No.2

*The terms “positional asphyxia” and “excited delirium” should be abandoned in all documentation, protocols and guidance. Abandoning these terms would be a consequence of taking the action recommended in paragraph 1 above. Current documentation which emphasises these terms fails to prevent similar fatalities because it encourages failure to recognise the multi-factorial patho-*





physiology. Their inclusion in documentation has the tendency to prevent lessons from being learned following adverse incidents related to restraint. The terms tend to be used in an inculpatory and exculpatory context.

In 2002 the former Police Complaints Authority published guidance on 'Policing Acute Behavioural Disorder'. ABD is a more acceptable and less controversial term. It is also the term used by the former Police Complaints Authority. The Review suggests that the term 'excited delirium' could be pejorative and agrees that it should be removed from MPS documentation.

The Review does not, however, consider that it is appropriate or necessary for the term 'positional asphyxia' to be removed from documentation. Moreover it is suggested that the term is now well understood in the police service and its removal at this stage could potentially lead to confusion. The Review therefore does not recommend removing the term from MPS documentation.

The Review asked leading medical specialists to review Police Notice 12/99.<sup>2</sup> The responses received are listed in Table ii (below).

**Table ii** - Proposed changes to Police Notice 12/99 from medical professionals.

Medical Specialist	Suggested changes to Police Notice 12/99
Dr Stephen L. Winbery, MD, PhD Specialty: Emergency Medicine Memphis Medical Center USA	<p><b>Paragraph 2.4 Reducing the risk</b>                      Under the risk of positional asphyxia can be reduced by:                      Add bullet "avoid placed direct pressure on back of neck, torso or abdomen for prisoners in prone position"</p> <p><b>Paragraph 3.3 Symptoms</b>                      Add bullet "hypervigilance, staring, paranoia"</p> <p><b>Paragraph 3.6 Causes of death</b>                      Omit first sentence, replace positional asphyxia with "complications from physical restraint"</p>
Dr R.T.Shepherd, BSc, MB, BS, FRCPath, DMJ, Senior Lecturer in Forensic Medicine, Consultant Forensic Pathologist, Home Office Pathologist	<p>In general terms the instructions contained in the Notice are fine. There are no major mistakes in the description of the problems or of their management.</p> <p>I think that the English is at times difficult to understand and some aspects could be expressed more</p>

<sup>2</sup> See notice 12-99 at Appendix II



	<p>simply to make these complex topics easier to understand by Police Officers.</p>
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**Recommendation 1** - The Review recommends that Police Notice 12/99 is revised in accordance with medical advice and that the term 'excited delirium' should be removed to be replaced by 'acute behavioural disorder' in all MPS documentation.

**4.3 Coroner's Recommendation No.3**

*3 The London Development Centre for Mental Health, the National Institute for Clinical Excellence (NICE) and the National Public Safety Agency (NPSA) must continue to take action to review and improve local implementation of policies, protocols, procedures and training.*

*3a Amendments to the existing documentation should reflect how to identify risk factors for sudden death during restraint and avoid elevating any of the risk factors to a distinct psychiatric or pathological entity.*

*3b A list of risk factors should be incorporated into police and health service forms, documentation and medical records to identify and communicate them as an integral part of the medical prioritisation/triage process when a patient has been detained under Section 136 of the Mental Health Act transfers from police custody to health care.*

Following a positive response from the NHS Executive and a subsequent agreement in principle from ACPO, guidance<sup>3</sup> has recently been produced to outline the general principles, which should inform local protocols between the police, health authorities and other related agencies, particularly in those situations involving potentially violent individuals. This guidance has taken account of the lessons emerging from recent high-profile cases involving deaths in police custody (for example, Roger Sylvester and Glenn Howard) and other cases where agencies have failed to work together effectively (such as Victoria Climbié).

The London Development Centre for Mental Health and the MPS have recently agreed protocols in relation to the Mental Health Act – Section 18 return of missing patients to hospitals; Section 135 assessments on private premises and Section 136 taking people to a place of safety for assessments.

The Review agrees with the Coroner that the MPS should continue to develop closer working with the London Development Centre for Mental Health and the National Public Safety Agency in relation to risk factors and in particular

<sup>3</sup> General principles to inform local protocols between the police and health services on handling potentially violent individuals. Home Office publication

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how these can be identified by police officers often operating in far from ideal conditions e.g. darkness and poor weather.

#### 4.4 Coroner's Recommendation No.5

*The time of distinct separate periods of restraint and the total aggregate of restraint should be communicated and recorded.*

Monitoring the time of restraint is essential to enable health care professionals to conduct a thorough assessment. The Restraint Review recognises the need for supervisory officers to be involved in incidents where a violent person is being restrained, in particular for a prolonged period (Recommendation 4 below). Supervisors have a key role in managing the incidents and recording events. The Restraint Review therefore suggests that supervisors (or where one has not attended the officer who took charge of the incident) should be responsible for ensuring that details of restraints are documented and passed to health care professionals as soon as a detainee arrives at a place of safety. Officers should also record the time and date when this information was passed to medical staff.

**Recommendation 2** -The Review recommends that officers are required to inform LAS/hospital medical staff whenever a detainee has been restrained so that they can be medically triaged as a matter of utmost priority.

Form 435 is completed by police officers when a person is detained under Section 136 of the Mental Health Act. The Review suggests that this form should be amended to include details about any restraint employed in line with the Coroner's recommendation 3b (above).

**Recommendation 3** - The Review recommends that Form 435 that is completed when a person is detained under Section 136 of the Mental Health Act should be revised to include information about risk factors, any restraint employed and its timings.

## 5. Training and Restraint

The Review considered the "appropriateness" of MPS Officer Safety Training techniques by comparing them with those used by:

- Her Majesty's Prison Service
- National Health Service Special Hospitals
- Other police services in the UK

Fundamental differences exist between the circumstances and environments when restraint is employed by the police service compared to health and prison authorities. Policing incidents take place in streets or other environments that are much less secure than a ward or cell. As an emergency or gatekeeper service police are often called when an individual is already in crisis and there is less chance of averting confrontation.








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After comparison, the Review found that, restraint techniques employed by the Metropolitan Police Service are appropriate to the environment in which they are practiced. There are no substantial differences between the Police, Prison and Health services when the specific types of holds are analysed.

The Review believes, however, that lessons can be learned from the Prison Service where team leaders are employed to direct restraint teams. The role of the supervisor is to take immediate charge of the incident, monitor the health of the person being restrained and actively control the restraints being applied.



**Table iii** - Comparison of the main holds and techniques across 3 different services

Procedure/Techniques Used							
	Verbal De-escalation*	Chemical Sedation	Ordinary Hold	Shoulder Locks	Wrist Locks	Thumb Locks	Prone Position
							
Service							
Metropolitan Police Service	✓	x	✓	✓	✓	x	✓
Centrex	✓	x	✓	✓	✓	x	✓
HM Prison Service	✓	x	✓	✓	✓	x	✓
NHS Special Hospitals	✓	✓	✓	✓	✓	✓	✓

Incidents involving prolonged restraint should be intrusively supervised. In spontaneous incidents, e.g. arrests made after a fight in the street, this may not always be practicable – often the person is controlled quickly in any case. However, the nature of the call to an incident often by itself, e.g. person behaving strangely in the street, indicates that a supervisor should attend.

The current shortage of Sergeants may mean that a supervisor is not able to attend a restraint whilst it is on-going. But fundamentally the issue of control and monitoring is one of role rather than rank. The Review therefore believes that, in any event, one of the officers involved should take the role of Safety Officer. The Safety Officer will ensure the safety of the person being restrained, the police officers involved and the public. The role of the Safety Officer is to take charge of the incident, monitor the health of the person being restrained and actively control the restraints being applied. This will involve assessment of risk factors on a case by case basis. The Review believes that this should be adopted as the model for restraint in the MPS and reinforced during refresher Officer Safety Training.

**Recommendation 4** - The Review recommends that whenever practicable a supervisory officer should be directed to attend all incidents where a person is being restrained and that, in any event, an officer should take the role of Safety Officer taking charge of the incident, monitoring the health of the person being restrained and actively controlling the restraints being applied.

Every restraint must be justifiable by police. The MPS Officer Safety Manual and training should emphasise the duty of all officers including the Safety Officer to continuously assess the health of the person being restrained and the legality, proportionality and necessity of the restraint itself.

**Recommendation 5** – the Review recommends that the MPS Officer Safety Manual and training should emphasise the duty of all officers involved in restraints to continuously assess the health of the person being restrained and be able to justify that

- a) The restraint is proportionate (i.e. that the safety of the individual is being balanced against the safety of the officers and the public) and the force used is the minimum necessary in the circumstances;
- b) The restraint is lawful (i.e. that the officers have lawful power to restrain the person and are employing approved techniques);
- c) And that continued restraint is necessary (i.e. there is an overriding reason why the restraint cannot be released or changed) and that there are no other less intrusive practicable alternatives.

### 5.1 Competency

Doctor Reid distinguishes between the case of a competent but non-compliant person and a non-competent non-compliant person. Doctor Reid suggests that officers should consider giving a verbal warning to competent but non-compliant individuals.

The Review was concerned about this approach. Police officers are not qualified to assess a person's capacity to understand. Only a medical Doctor is properly able to assess competence. The Review does not agree with the notion of a warning on either practical grounds or legal efficacy.

## 5.2 Time limits on restraint in the prone (face down) position

In his report Doctor Reid states, *“Currently, no specific techniques have been identified for restraining a person with acute behavioural disturbance, temporarily lacking capacity who continues to struggle against restraint. Training advocates repositioning but in practice repositioning is really only available when officers are restraining a compliant person. In the case of a non-compliant person with acute behavioural disturbance, it seems to be the policy that restraint on the ground is the safest option available to police in terms of safety of the restrained person, the officers’ safety and the safety of the public.”*

Doctor Nat Cary, a Consultant Home Office accredited forensic pathologist, giving evidence at the David Bennett<sup>4</sup> Inquiry stated, *“You should never restrain to exhaustion.”* He was not against using face down restraint in order to gain initial control in what otherwise might be a dangerous situation, but it was not satisfactory where the only obvious escape from face-down restraint was when the person either became limp or was unable to go on struggling.

The PCA in its report ‘Policing Acute Behavioural Disturbance’ cited Doctor Cary’s view that, *“The prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised.”*

Another consultant forensic pathologist, Doctor Richard Shepherd, also gave evidence to the David Bennett Inquiry. He said that the safest way of dealing with violence was a rapid initial restraint by people who have had proper training. He hoped control could be gained within seconds.

Current MPS advice states that that a person should be moved into, *“a seated, kneeling or standing position, as soon as possible once control has been achieved, either by handcuffing or other means (handcuffing to the front is ideally suited to escorting non-violent/compliant people).”*

The Review considered whether to recommend a time limit for restraint in the prone position. Particular regard was paid to community concerns expressed during consultation about the deaths that have occurred following prolonged restraints. At first sight the notion of a time limit would appear to be a reasonable proposition. However, this ignores the very real practical difficulty of what officers should do with a person who continues to be violent once the time limit has expired.

<sup>4</sup> An enquiry into the death of David ‘Rocky’ Bennett under restraint, whilst a patient in a psychiatric unit in Norfolk which reported early in 2004



Furthermore any time limit would be entirely arbitrary. The Bennett Report quotes Dr Sheppard as stating that, "One could construct a timetable of two or three minutes for a patient to be face down but any time limit was entirely arbitrary. While they were face down it was a very difficult and dangerous phase for the patient. There was no risk free option."

The National Health Service has rejected a 3-minute limit on the prone position recommended by the David Bennett Inquiry. The NHS Advisory Group (The Management of Violence Project) has been unable to find anyone willing to give evidence in court as to the safety or otherwise of a three minute rule.

The Review therefore concludes that it is neither safe nor practicable to set a time limit for the restraint of a person in the prone position. It believes that the prone position should be used for the minimum time necessary to achieve control and that the person should then be turned into another position preferably kneeling or standing as soon as possible. Training should therefore focus on achieving control and re-positioning the individual as quickly as possible. It should stress that the use of the prone position is only a mid-point in the restraint of a violent person. This would help to reduce the risks linked to the use of the prone position.

**Recommendation 6** - The Review recommends that officer safety training should stress that restraining a person in the prone position is potentially dangerous and include appropriate techniques to re-position violent persons from the prone position as quickly as possible.

### 5.3 Coroner's matters for further consideration

#### 5.3.1 Restraint Equipment

Restraint equipment could assist officers to achieve and maintain control of a violent non-compliant person.

Doctor Reid's report states "*consideration will need to be given to restraint equipment such as the use of "Emergency Restraint Belts" or "restraint systems", the use of which was suggested in evidence to avoid adverse impairment upon the mechanics of breathing.*"

The Review agrees with HM Coroner and suggests that relevant forms of mechanical restraint (e.g. emergency restraint belts and VIPERS) should be evaluated in an operational context. Velcro leg restraints are already being tested and the Review hopes that these will enable officers to gain faster and more effective control over lower limbs. After they have been applied it may be possible to re-position a person from the prone (face down) position thereby reducing the risks of sudden death in restraint.

Active community engagement may help to inform the trials in order to assess the balance to be achieved between Articles 2 and 3 of ECHR. It would also



demonstrate that the MPS is actively learning lessons and taking action to prevent further deaths in restraint.

**Recommendation 7** - The Review recommends that in order to minimise the use of the prone position the MPS should undertake trials of equipment (including Emergency Restraint Belts, VIPERS and others) and adopts those that facilitate the safe re-positioning of a non-compliant person.

### 5.3.2 Further Research into restraint issues

Doctor Reid although not in favour of the term ‘excited delirium’ states “*Much work still needs to be done to determine where there is a condition specific to cocaine, cannabis or other drug abuse or whether it can be precipitated by other factors and can be demonstrated organically, in microscopic or biochemical markers in specific parts of the brain. Such research may ultimately suggest an explanation for the clinical features described in cases to which this label has been applied.*” The Review suggests that clinical research should result in guidance that improves the care of individuals suffering from acute behavioural disturbance. Such individuals, police officers and health care professionals would benefit from research geared to a tangible practical outcome.

Currently ACPO does not have the benefit of definitive medical advice in relation to restraint techniques and equipment. The Police Scientific and Development Branch (PSDB) provide such advice on ballistic protection, firearms and less than lethal options. However, it does not advise on restraint techniques. The Review believes that ACPO would benefit from independent advice from medical specialists about restraint techniques. The availability of such medical guidance is a precursor to achieving definitive guidance for operational officers about what restraints are safer and which have a higher risk.

**Recommendation 8** - The Review recommends that the Department of Health and Home Office should be requested to:

- a) Commission research with the aim of producing practical guidance for operational police officers and health professionals in order to improve the care of people suffering from Acute Behavioural Disturbance;
- b) Establish an independent group of medical advisors on restraint techniques and equipment to perform a similar advisory function to PSDB.

### 5.3.3 Tasers

HM Coroner, Dr Reid, raised concerns in his report over the potential use of the Taser electrical incapacitation device in the mental health environment. The development of less lethal options to the police use of firearms is on going and the Home Office was at the time of writing this report still evaluating the use of the Taser at a number of firearms incidents as a less lethal option.







The Review is aware of the concerns of a voluntary organisation representing people suffering from mental illness about the use of the Taser as those who take anti-psychotic medicines are prone to long-term side effects on the heart. The organisation suggests that the interaction of CS spray and now Tasers with people using these medicines has not been fully explored.

Any physical engagement between people creates risks and can lead to minor, serious or fatal injuries. The Review suggests that research should be commissioned to identify methods of remotely achieving the safe restraint of a very violent individual thus obviating the need for police officers to put 'hands on' a person to achieve control.

**Recommendation 9** - The Review recommends that the MPS should investigate methods of safely achieving control of a violent person from a distance.

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**Table iv-** Restraint Equipment

	Equipment								
									
	Handcuffs	Baton	CS Spray	Taser	The Net <sup>5</sup>	The ERB <sup>6</sup>	The Hugger	The Hugger (Leg Restraint)	Leg Restraints <sup>7</sup>
Service									
Metropolitan Police Service	✓	✓	✓	T	T	X	X	X	T
Centrex	✓	✓	✓	✓	?	✓	X	X	?
HM Prison Service	X	X	X	X	T	X	X	X	X
NHS (Special hospitals)	X	X	X	X	X	✓	T	T	X

T = Under Trial  
X = Not Used  
✓ = Use

<sup>5</sup> Leg Restraints -This trial, which is being conducted by KF, MD and the TSG, is 5 weeks' old. At this time there are no reported deployments.  
<sup>6</sup> The ERB has been in use in the UK since March of 2000. There have been over 1000 uses in the UK .  
<sup>7</sup> Taser - This trial, which is being conducted by SO and TP units, is about 6 months' old. CO11 are collating the results.

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## 6. Mental Health

Mental health issues place considerable demands on the MPS. They encompass a myriad of incidents from responding to a request for police presence at a Mental Health Act assessment to dealing with a shoplifter suffering from mental illness.

But at present the demands generated by mental health issues are not quantified. Statistics are only available on some boroughs due to the interest of particular staff. However, the picture across London is unclear.

Without a detailed study there is no clear picture or understanding of the demand. It is therefore difficult to develop a strategic response shaped around the need. The forthcoming joint NHS/MPS Review provides a timely opportunity to holistically assess the demands on both services.

**Recommendation 10** - The Review recommends that the MPS engage with the forthcoming joint NHS/MPA Mental Health Review to undertake a detailed review of the demands mental health issues place on the MPS.

A survey of BOCUs commissioned by the Review found:

In half the boroughs the Accident and Emergency facility did not agree that ABD should be treated as a medical emergency or their stance on this was not known.

64% of boroughs experienced problems with staff at the place of safety refusing to accept detainees who smelt of drink.

Nearly a third of the boroughs responding said that police are routinely called to assist with quelling disturbances on psychiatric wards.

None of the Mental Health protocols examined by the Review address any of these issues.

Much excellent work is being done at local levels by Mental Health Liaison Officers who are often of Inspector rank. But progress is dependent upon the commitment of the individuals and how much time they are able to devote to this aspect of their work. Local liaison is tactical and not strategic.

There is no overall MPS strategic lead for mental issues. Responsibilities are divided between various directorates. The Strategic Disability Unit within the Diversity Directorate has responsibility for mental health protocols and TPHQ has responsibility for mentally disordered offenders. Coordination is improving but there is no overarching champion or strategic lead at a level that can draw the strands together. Individuals have also changed and greater consistency may help to lever greater benefits from existing partnerships.

**Recommendation 11** - The Review recommends that there should be an overarching ACPO champion for mental health issues in the MPS at DAC level.

## 6.1 Coroner's Recommendations on Mental Health

Doctor Reid's Rule 43 report states, "NHS bodies need to recognise the acute medical complications presented by SDR (sudden death in restraint) especially in the non-compliant person with AMI (Apparent Mental Illness) or ADB (sic) (Acute Behavioural Disorder). Where NHS bodies or other health care professionals, including FME's are faced with the situation there should be triage processes and/or algorithms for clinical decision making so that a person's care transfers from police custody to NHS or other clinical care as a matter of utmost priority with time of the essence."

Protocols for custody and/or restraint of a non-compliant person with ABD should distinguish the needs of these people in terms of a maximum continuous period of prone restraint and the maximum time that they should remain in police custody under Section 136 of the Mental Health Act 1983 pending medical assessment at a place of safety.

## 6.2 Coroner's recommendation No.4

There must be an emphasis on rapid communication and assessment of the risk factors pertaining to a specific patient detained under Section 136 of the Mental Health Act and to their specific circumstances. There is scope for joint NHS and police training.

## 6.3 Coroner's recommendation No.6

Local implementation procedures and protocols must recognise and emphasise paragraph 10.13 of the Mental Health Act Codes of Practice 1999 so that assessment can be given as soon as possible after the arrival of the individual at the place of safety.

## 6.4 Coroners Recommendation No.7

The implementation policy should set target times for the commencement of the assessment and be subject to clinical audit by the Primary Care Trust and Strategic Health Authority to review local practice against these targets.

Currently boroughs and NHS Trusts are adopting new mental health protocols. However, there are considerable variations with some protocols requiring police officers to remain with the detainee at a hospital for an hour, others do not specify times. They are silent about circumstances when the detainee is violent and by implication this could result in police officers having to restrain a person for an unspecified period before the person is assessed.

This is clearly unacceptable. Doctor Reid states that a protocol that fails to distinguish between a compliant and a non-compliant individual with ABD, "is grossly unfair to officers obliged to restrain a person in their custody until care

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*can be handed over. NHS bodies should therefore provide for the priority triage of patients with ABD who are being restrained by police.”*

The availability of restraint equipment (Restraint Review Recommendation 6) will help. But the hand over of a detained person from police to hospital is a key area of tension between the police officers and health professionals that needs to be resolved. The Review believes that officers should be able to release a detained person into the care of health professionals and resume patrol as quickly as possible.

**Recommendation 12** - The Review recommends that the MPS and the NHS in London should work together to agree minimum standards for the time taken to assess and admit people taken to a place of safety under Section 136 of the Mental Health Act.

**7. Memphis Approach**

Crisis Intervention Teams (CIT) were formed within the Memphis Police Department after an incident in 1987 where police officers on patrol in Memphis were called to a mentally ill person who was stabbing himself with a knife. The situation escalated and ended with the officers fatally shooting the subject.

**7.1 CIT and Associated Training**

CIT teams comprise officers who have had 5 full days training in dealing with mental health. This includes de-escalation training with external role players; a wider understanding of the various mental illnesses and their effects; some knowledge of prescribed drugs, which illnesses they are associated with and their effects. A day is spent with mentally ill people (in the USA referred to as ‘consumers’) either in the community or in institutional settings. CIT trained officers also patrol and deal with ‘ordinary’ calls.

Of its 2000 patrol officers about 200 Memphis Police officers are CIT trained. CIT officers are paid a small additional stipend to their basic wages. Patrolling CIT officers are identifiable by a small badge pinned to their uniform.

In order to ensure that CIT officers are dispatched to the correct calls two days training for communications staff is provided on mental health issues including an input on talking to the mentally ill over the telephone.

Officers exercising the UK equivalent of a section 136 Mental Health Act power take the detainee to the Regional Medical Centre (The Med). Officers also take individuals who are mentally ill and have committed minor crimes (if the victim agrees) to ‘The Med’.

**7.1.1 The Medical Response in Memphis**

The Med is a full general hospital on a single site with an Accident and Emergency facility. There are three areas where medical and police staff interface:



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### 7.1.2 Psychiatric Triage

This is a 24 hours a day, 7 days a week facility. Psychiatric Triage cannot refuse to accept an individual brought in by a CIT officer. The officer completes a simple form and hands over the patient. The turn-a-round time, witnessed by the Review officers, is about 15 minutes. Consumers are referred to either community resources or psychiatric facilities. The triage staff have substantial contacts with community and outreach facilities this allows knowledge of which community initiative is most suitable for a particular patient.

### 7.1.3 De-toxification Suite

This is a unit equipped with 10 robust plastic coated lounge beds. It is staffed by medical personnel and has video monitoring.

### 7.1.4 Evaluation

Memphis police receive about 10,000 mental health related calls per year. This results in about 5,000 referrals by CIT to the Med - 2,000 are diverted to community resources and a further 3,000 receive hospital admission however short.

Consumers say, and studies substantiate, that CIT improves consumer prognosis irrespective of whether they receive or take up further referrals, i.e. the act of professional crisis intervention is an aid to treatment. All the medical front-line facilities had few concerns in receiving consumers who had been 'de-escalated' by trained CIT officers.

The Memphis approach brings significant benefits not least great dignity for both the consumer and the professional. It has been sustained over a number of years and adopted by several other US cities.

The Review suggests that the Memphis approach offers a potential opportunity. However, this needs to be evaluated in the context of London. Significant commitment of resources would be required to develop a Memphis based solution that meets the needs of the capital. The Review recognises the complexities involved and the need for agencies to properly scope what would be involved.

**Recommendation 13** - The Review recommends that the MPS, NHS and Association of London Government examine the potential benefits of the Memphis initiative with a view to improving the effectiveness and efficiency of the health, police and social services response to incidents involving people suffering from mental illness.



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## 7.2 Strategic Response To Incidents Involving People Suffering From Mental Illness

On occasions incidents involving people suffering from mental illness result in the individual being restrained by police officers. Restraint negatively impacts on the individual's dignity and increases the risk of injury to the person and officers involved. The Review considers that there is potential to improve the quality of MPS response in relation to:

1. Preventing incidents
2. Pre planned events
3. Spontaneous incidents

### 7.2.1 Preventing incidents

The Review believes that there is scope to legitimately reduce the number of incidents in which the police are involved thereby reducing the chances of restraint being applied.

### 7.2.2 Case Conferences

Studies, anecdotal evidence and experience have shown that affected individuals have a raised profile prior to a crisis. An earlier intervention could prevent the crisis that may end with the person being restrained by police. The key to successful prevention is information sharing between agencies about individuals at risk through mental illness. The Review appreciates that this raises obvious questions about privacy – particularly in relation to health and police information. However, there are parallels in the management of child protection and sex offenders where information is shared. Clear definition is required in terms of the cases that should be raised and the Review believes that these should be based on the risks posed by the individual to themselves and the public.

This will involve issues of confidentiality and may engage European Convention on Human Rights (ECHR) Article 8 (right to respect for private & family life, home & correspondence), and needs to be undertaken carefully. Generally, it should be possible to justify controlled disclosure, which is relevant, proportionate and necessary in the public interest, to specific individuals for this specific purpose.

The Review envisages conferences on similar lines to those in respect of potentially dangerous offenders where actions to address concerns about the risks posed by particular individuals suffering from mental illness are discussed. The conferences will provide an opportunity for multi agency working where police concerns can be passed on to assertive outreach teams and Approved Social Workers. It is an opportunity for the police to contribute to combating the social exclusion of the mentally ill and to reduce the risks of spontaneous incidents.

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**Recommendation 14** - The Review recommends that multi-agency case conferences regarding vulnerable people suffering from mental illness should be piloted in one area of London with the aim of reducing the risks associated with spontaneous incidents.

### 7.2.3 Pre-planned events

Pre-planned events include the exercise of powers under Section 135 and Section 18 MHA 1983. Police responses and the extent of pre-planning, briefing and the use of specialist teams varies greatly across boroughs. Some boroughs, for example Haringey and Camden, have specialist teams to assist with pre-planned events.

The advantages of such teams are: -

- The officers are physically fit and trained for the work.
- Joint training and working builds mutual trust.
- Teams are properly equipped with authorised restraint equipment.
- They are confident of their knowledge and powers in respect of mental health and other legislation.
- Requests that were an inappropriate use of police resources could be challenged and therefore be less likely to be made in future.

Level 2 public order officers, already trained to a higher level, are available on every BOCU. These officers should be the first called for a pre-planned incident and through regular use would become familiar with Social Services personnel and procedures. Furthermore there are opportunities for boroughs to engage these officers in joint training with mental health professionals as both can learn from each other notwithstanding the difference in work.

**Recommendation 15** -The Review recommends that each BOCU should be required to use Level 2 public order trained officers to support joint operations with mental health partners in respect of pre-planned events involving people suffering from mental illness.

### 7.2.4 Section 135 Warrants To Enter A Private Premises

This power permits an Approved Social Worker (ASW) to apply for a warrant to enter premises where there are reasonable grounds to anticipate that admission may be refused. Difficulties can arise when a person refuses entry to a private premises or when professionals are asked to leave. Some MPS units require a warrant to be obtained before they will participate in a joint operation while others do not.

There is no consistent policy across London. This does not help partners faced with a variety of police policies or police units such as the TSG who are called to assist in different boroughs.

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**Recommendation 16** -The Review recommends that the MPS and mental health partners should develop joint policy on the requirement for warrants under Sections 17 and 135 of the Mental Health Act 1983.

**7.2.5 Officers Called To Assist In The Administration Of Medicines Within Mental Health Units**

The Review found that MPS officers are regularly called to restrain psychiatric patients to enable medical staff to administer sedation. The Mental Health Commission opposes this practice and the Review suggests that MPS policy should reflect this stance. Fundamentally there is a clear need for the NHS to train staff working in mental health units in the use of restraint so that they are able to deal with incidents without needing to call the police service.

**Recommendation 17** - The Review recommends that the MPS should seek to encourage NHS authorities to train their staff in methods of restraining patients thereby minimising the need to employ police officers for this purpose.

**7.2.6 Video Recording**

The MPS and its officers sometimes find themselves criticised following a prolonged restraint for excessive use of force. Oral and written evidence often does not properly portray the situation. Both relatives and police are left dissatisfied that the truth has come out. Video recording protects the individual and staff involved. It also helps to develop good practice through use in training. It may be claimed that video recording interferes with ECHR Art 8 (right to respect for private & family life, home & correspondence), but this can be justified when it can be shown to be necessary in the interests of public safety, for the prevention of disorder or crime, for the protection of health, or for the protection of the rights or freedoms of others.

**Recommendation 18** - The Review recommends that when a risk assessment indicates that a substantial level of violence may be anticipated that the incident should be video recorded and the justification for the decision fully documented.

**7.2.7 Spontaneous incidents**

It is inevitable that officers will have to respond to spontaneous incidents involving people suffering from mental illness. These incidents pose the greatest risk in terms of restraint as the officers may have limited knowledge of the individual who may himself or herself be in crisis. Presently MPS officers receive very limited training in relation to dealing with people suffering from mental illness and are therefore not well equipped to 'get it right first time'. The Review therefore makes proposals that collectively could reduce the risks involved when responding to spontaneous incidents.

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### 7.2.8 De-Escalation Training

Improving communication between police and the mentally ill was a key issue raised during consultation. The term de-escalation occurred time and time again. The evidence from Memphis particularly impressed the Review. Health professionals there were consistently confident that ‘consumers’ or in the UK ‘service users’ who had been successfully de-escalated posed a very small risk in terms of the recurrence of violence. De-escalation is a tactic taught to many health professionals and there is potential to adapt and adopt relevant parts of this training. The Review believes that all officers would benefit to a greater or lesser degree from training of this kind. Potential exists for the training package to be jointly developed with mental health professionals and others with relevant experience e.g. police negotiators. One mental health charity highlighted the benefits of involving people with direct experience of severe mental illness – service users and carers – in planning and delivering training.

**Recommendation 19** - The Review recommends that all recruits and officers undergoing Officer Safety refresher training should receive specific training in de-escalation techniques with the aim of reducing the number of occasions when physical restraint is required.

### 7.2.9 Dealing with violent individuals suffering from Mental Illness

Half the boroughs in the MPD said that their A & E did not accept that excited delirium existed or were unable to answer the question. But mentally ill individuals who are violent are regularly detained by police officers in London - probably daily.

The NHS has almost no Accident and Emergency facilities in London for violent people who are mentally ill. The Review found one secure hospital room within an A&E Department in London but at the time of the visit it was being used for trolley storage.

At least one mental health inpatient unit refuses to accept violent individuals detained under Section 136 of the Mental Health Act. As a result some people suffering from mental illness are taken to police cells.

There is huge pressure on A&E doctors when such a person is brought into them to do nothing. From a doctor’s perspective:

Without knowledge of or belief in excited delirium they are likely to question why the police are bringing a violent individual to hospital and not the police station. They question how a psychiatric assessment can be carried out if drugs affecting behaviour have been administered. If those in the psychiatric discipline refuse or are unable to assess the patient in these circumstances A&E staff are stuck with an unpleasant problem. The police have the patient and will not let the individual go if they believe that staff could be harmed.

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Police cells are not the appropriate place in which to hold people suffering from mental illness. The Review believes that the MPS and the Department of Health should undertake joint work to develop practical solutions to a shared problem.

**Recommendation 20** -The Review recommends that the MPS and Department of Health should work together with the aim of enabling Accident and Emergency Departments to deal more effectively with violent mentally ill patients.

**8. Learning Lessons From Deaths In Police Restraint**

The Review identified two cases within the relevant time frame (from Jan 1999 to date). The first is that of Glen Howard and the second is that of Oliver Scott.

In the case of Glen Howard the Police Complaints Authority made the following recommendations:

- 1) That the Metropolitan Police Service (MPS) urgently review advice and training with particular regard to vulnerable persons.
- 2) That the MPS review existing protocols with Health Trusts in relation to Mental Health Act patients.

In the case of Oliver Scott the Senior Investigating Officer (SIO) made a number of recommendations, inter alia:

- 1) That officers be aware that the extended use of CS spray on a suspect heavily dosed on cocaine can have the effect of rendering himself or herself ineffective.
- 2) That in similar circumstances supervisory officers consider taking detainees directly to hospital, and or providing immediate access to medical staff and that if they do not they log their decisions for not doing so.

It was difficult to trace the outcomes of the recommendations through the MPS and it was clear that there is no systematic process to ensure that action is taken.

**Recommendation 21** - The Review therefore recommends that that HM Coroners' and other recommendations relating to deaths in police custody and restraint are recorded on a corporate database and that there is an audit trail of the actions taken in response.

**8.1 Use of Force Database**

Use of force databases provides evidence about the frequency and circumstances when officers apply force to individuals. The 1997 HMIC report "Minimising the Risk of Violence" recommended that use of force information



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should be gathered. The MPS does not have such a database and therefore it is not in a position to demonstrate whether its use of force is appropriate, proportional and necessary.

The benefits of use of force monitoring include: -

- The identification and improvement of personal protective equipment
- The provision of additional personal protective equipment
- The review of training needs
- The highlighting of operational risk areas for front line officers

A trial is being conducted on three central London boroughs to test the concept of data collection and subsequent retrieval. The data would form the basis of an enhanced IT version that could be accessed via officers' AWARE workstations. Unfortunately pressures of work elsewhere have meant that there are no resources available to analyse the data collected and it has not been reviewed for sometime.

**Recommendation 22** - The Review recommends that the MPS should develop an IT based Use of Force Database to inform training needs and facilitate the effective monitoring of restraint techniques by the MPS.

**8.2 Successful Interventions**

The Review suggests that lessons need to be learned from successful interventions as well as tragic cases that result in death. Officers need to be encouraged to report these incidents. However, officers are concerned that filing a near miss report could make them liable to a criminal or misconduct inquiry.

Consultation with the NHS, where a process has been instigated, indicates that staff will only report near misses anonymously. This is a very difficult area particularly given legislative constraints such as disclosure and the possibility of civil action. The Review has not had the opportunity to fully explore the issue and suggests that it is worthy of further research in conjunction with the Independent Police Complaints Commission (IPCC) who are supportive of the notion.

**Recommendation 23** - The Review recommends that the MPS should, in conjunction with the IPCC, examine reporting schemes used by the aviation industry and the National Health Service with the aim of enhancing the learning captured from incidents

**8.3 Educating Partners and the Public**

There is a thirst for more information about why and how the MPS carry out restraint. Many people view restraint as a clinical exercise where officers move smoothly and efficiently from one defined position to another. There is little knowledge or appreciation of what occurs in the reality of a violent restraint. In this artificial clinical atmosphere it is only to be expected that

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community opinion formers and judicial forums have impossible expectations of officers' abilities to carry out authorised holds and to record their actions. New recruits to the police service also have limited awareness.

The Review believes that a video would help to explain why and how officers restrain people. It is very difficult to effectively simulate restraints and therefore consideration should be given to using video recordings from real incidents (Recommendation 18) provided that the individual's identity can be protected.

**Recommendation 24** - The Review recommends that the MPS produce a video about restraint to inform external and internal audiences about the reasons for its use and the techniques employed.

**9. MPS Officer Safety Training**

**9.1 Comparison Of MPS Officer Safety Training With That Provided By Other Police Services**

The Review commissioned Centrex, the National Police Training Organisation for England and Wales to conduct an independent comparison of MPS Officer Safety Training with that provided by other police services.

The Centrex Report states:

*The current Metropolitan Police Service Officer Safety Training Manual is out of date.*

*The manual lacks detail and information in several areas compared with the current ACPO Personal Safety Manual.*

*There is no reference to certain important areas, such as Human Rights, in the current Metropolitan manual.*

*It may be worth the Metropolitan Police Service considering adopting the ACPO Personal Safety Manual of Guidance, and benefiting from the extensive research that has already taken place, and will continue to occur through the annual review process. This would also assist in promoting national consistency in officer safety.*

The Review identified a very minor difference between the Centrex sponsored Conflict Management model and the MPS Officers Safety Model. It has not proposed changing from the Officer Safety Model to the Conflict Management Model. The reasons for this are: it is fit for purpose - it has been tried and tested in civil and criminal proceedings; the differences between the two Models are little more than cosmetic; the MPS Officer Safety model complements that currently used by the MPS Public Order and Firearms Departments within the MPS.



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The MPS plays a pivotal role in the development of officer safety training on behalf of ACPO. Informed by the Centrex report, the Review identified that in the pursuance of the national guidelines the current MPS Manual has fallen behind the re-issued ACPO Manual. The MPS manual needs to be updated to encompass all the supporting material and be readily accessible to operational staff through the intranet.

**Recommendation 25** - The Review recommends that the new MPS Officer Safety Training Manual should draw together disparate documents reflecting as far as possible the officer safety training techniques currently in the ACPO Manual specifically including sections on Human Rights and medical implications.

The Centrex report also stated that:

*The current cascade structure of the delivery of officer safety training within the Metropolitan Police Service is extremely difficult to manage due to the high number of trainers involved. With so many trainers involved, mostly on a part time basis, it is very difficult to ensure consistency of delivery.*

CO11 oversees the Officer Safety Refresher Training delivered locally.

The advantages of locally delivered training are:

- It is workable having a proven track record.
- It is accountable in that CO11 sets mandatory elements of the syllabus and local records show who has received that input.
- It has credibility in that officers serving on that borough deliver it.

The disadvantages of the system are that:

- It is difficult to assure the consistency and quality of training.
- The standards of premises are extremely variable.
- Central units use the Officer Safety Trainers network to tag on to local training opportunities.
- There may be 6 or 7 OST trainers for a unit but it is usually a significantly smaller number who are regularly abstracted to conduct the training.

The Review considered proposals for a system of “cluster” training developed during the MPS Best Value Review of Training. However, on balance the Review does not believe that this option is viable.

The Centrex report also states “*The officer safety training for the initial recruit training falls a good deal short of the training received by the probationers of all other forces.*”

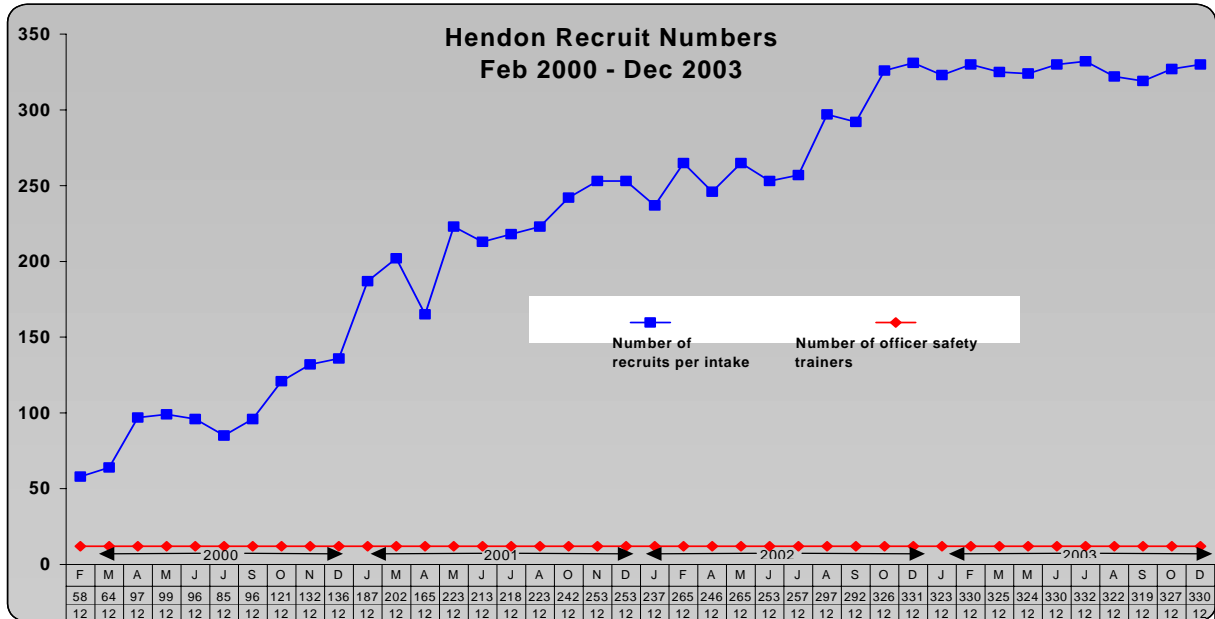
The Centrex Review suggested that police recruits in other forces receive three more days Officer Safety Training than MPS recruits. However analysis reveals that there appears to be no significant differences between the lengths of training inputs of Centrex and the MPS.

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Centrex state that “Due to the current high demand on the staff of CO11 Department to meet training delivery requirements they are unable to allocate sufficient time to monitoring the training delivered at OCU level”.

The MPS has undergone a period of unprecedented growth. A record number of recruits have required initial Officer Safety Training at Hendon. The strength of the CO11 unit responsible for providing Officer Safety training was not increased to meet the growth in recruiting.

Fig ii - Hendon Recruit Numbers



Commitments to recruit training have therefore had a significantly adverse impact on CO11’s ability to discharge their other responsibilities including quality assuring locally based refresher training.

**Recommendation 26** - The Review recommends that in view of the current and envisaged work that the resources of the CO11 Officer Safety Unit are reviewed to ensure that it is able to discharge its organisational responsibilities.

*Due to the current lack of monitoring and the resulting lack of feedback and information concerning the existing training CO11 are not in a position to assess the value of the training or to develop the training as a direct reaction to current needs.*

The Review considered the matter of monitoring of OST delivery to be urgent and drew it to the attention of CO11 management. Plans to recruit an appropriate number of staff are now in hand. This coupled with Recommendation 26 (above) will ensure that the Officer Safety Branch is able to monitor the effectiveness of training across the MPS and develop future programmes identified through the Use of Force Database (Recommendation 22) and other feedback mechanisms.

## 10. ACKNOWLEDGEMENTS

The Review Team would like to thank everyone who has been involved with this Review. Police officers and staff from the MPS, as well as those from other police forces and law enforcement agencies in the UK and overseas, members of the public and non-police organisations have all contributed to the findings of this Review. Without their input, this Review would not have been possible.

The Review team would like to give a special acknowledgement to Major Sam Cochran and other members of the Memphis Police Department.

## 11. APPENDIX

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### *APPENDIX I List of Recommendations*

**Recommendation 1** - The Review recommends that Police Notice 12/99 is revised in accordance with medical advice and that the term 'excited delirium' should be removed to be replaced by 'acute behavioural disorder' in all MPS documentation.

**Recommendation 2** -The Review recommends that officers are required to inform LAS/hospital medical staff whenever a detainee has been restrained so that they can be medically triaged as a matter of utmost priority.

**Recommendation 3** - The Review recommends that Form 435 that is completed when a person is detained under Section 136 of the Mental Health Act should be revised to include information about risk factors, any restraint employed and its timings.

**Recommendation 4** - The Review recommends that whenever practicable a supervisory officer should be directed to attend all incidents where a person is being restrained and that, in any event, an officer should take the role of Safety Officer taking charge of the incident, monitoring the health of the person being restrained and actively controlling the restraints being applied.

**Recommendation 5** – the Review recommends that the MPS Officer Safety Manual and training should emphasise the duty of all officers involved in restraints to continuously assess the health of the person being restrained and be able to justify that;

**a)** The restraint is proportionate (i.e. that the safety of the individual is being balanced against the safety of the officers and the public); and the force used is the minimum necessary in the circumstances.

**b)** The restraint is lawful (i.e. that the officers have lawful power to restrain the person and are employing approved techniques); and

**c)** Continued restraint is necessary (i.e. there is an overriding reason why the restraint cannot be released or changed) and that there are no other less intrusive practicable alternatives.

**Recommendation 6** - The Review recommends that officer safety training should stress that restraining a person in the prone position is potentially dangerous and include appropriate techniques to re-position violent persons from the prone position as quickly as possible.

**Recommendation 7** - The Review recommends that in order to minimise the use of the prone position the MPS should undertake trials of equipment (including Emergency Restraint Belts, VIPERS and others) and adopts those that facilitate the safe re-positioning of a non-compliant person.

**Recommendation 8** - The Review recommends that the Department of Health and Home Office should be requested to:

- a) Commission research with the aim of producing practical guidance for operational police officers and health professionals in order to improve the care of people suffering from Acute Behavioural Disturbance;
- b) Establish an independent group of medical advisors on restraint techniques and equipment to perform a similar advisory function to PSDB.

**Recommendation 9** - The Review recommends that the MPS should investigate methods of safely achieving control of a violent person from a distance.

**Recommendation 10** - The Review recommends that the MPS engage with the forthcoming joint NHS/MPA Mental Health Review to undertake a detailed review of the demands mental health issues place on the MPS.

**Recommendation 11** - The Review recommends that there should be an overarching ACPO champion for mental health issues in the MPS at DAC level.

**Recommendation 12** - The Review recommends that the MPS and the NHS in London should work together to agree minimum standards for the time taken to assess and admit people taken to a place of safety under Section 136 of the Mental Health Act.

**Recommendation 13** - The Review recommends that the MPS, NHS and Association of London Government examine the potential benefits of the Memphis initiative with a view to improving the effectiveness and efficiency of the health, police and social services response to incidents involving people suffering from mental illness.

**Recommendation 14** - The Review recommends that multi-agency case conferences regarding vulnerable people suffering from mental illness should be piloted in one area of London with the aim of reducing the risks associated with spontaneous incidents.

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**Recommendation 18** - The Review recommends that when a risk assessment indicates that a substantial level of violence may be anticipated that the incident should be video recorded and the justification for the decision fully documented.

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**Recommendation 20** -The Review recommends that the MPS and Department of Health should work together with the aim of enabling Accident and Emergency Departments to deal more effectively with violent mentally ill patients.

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**Recommendation 25** - The Review recommends that the new MPS Officer Safety Training Manual should draw together disparate documents reflecting as far as possible the officer safety training techniques currently in the ACPO Manual specifically including sections on Human Rights and medical implications.

**Recommendation 26** - The Review recommends that in view of the current and envisaged work that the resources of the CO11 Officer Safety Unit are reviewed to ensure that it is able to discharge its organisational responsibilities.



## APPENDIX II: Glossary of terms and abbreviations used in this report

Word/Term	Definition
A&E	Accident & Emergency
ABD	Acute Behavioural Disorder
ACPO	Association of Chief Police Officers
AMI	Apparent Mental Illness
AMI	Apparent Mental Illness
ASW	Approved Social worker
BOCU	Borough Operational Command Unit
CAD	Command & Dispatch
CIT	Crisis Intervention teams
Consumers	Term used in Memphis to describe individuals suffering from a mentally illness
DAC	Deputy Assistant Commissioner
Excited Delirium	When a person exhibits violent behaviour in a bizarre and manic way rather than just being simply violent.
FME	Forensic Medical Examiner
HMIC	Her Majesty's Inspectorate of Constabulary
IPCC	Independent Police Complaints Commission
LAS	London Ambulance Service
MHA	Mental Health Act
MPD	Metropolitan Police District
NAMI	National Alliance of the Mentally Ill
NICE	National /Institute for Clinical Excellence
NPSA	National Patient Safety Agency
OST	Officer Safety Training
PCA	Police Complaints Authority
Positional Asphyxia	"the position of the body interferes with breathing, resulting in asphyxia".
Prone position	Face down
PSDB	Police Scientific & development Branch
SDR	Sudden Death during Restraint



Word/Term	Definition
Service users	Term used in the UK to describe individuals suffering from a mental illness
SIO	Senior Investigating Officer
TPHQ	Territorial Policing Headquarters
TSG	Territorial Support Group
VIPER	Violent Persons Restraint

### APPENDIX III - MPS Notice 12/99

Dealing with violent mentally ill people and/or those exhibiting drug induced violent behaviour (Assistant Commissioner, 1 Area)

#### 1 Introduction

1.1 Dealing with violent people in circumstances where the violence is induced by mental illness and/or drugs is placing increasing pressures upon the Metropolitan Police Service (MPS). In recognition of this, an examination is being conducted of our response to these types of incidents. We are also currently liaising with our medical partners to develop strategies that will ensure officers are given skilled medical support at the scene of such incidents.

#### 1.2 This Notice deals with:

the potential for deaths to occur through 'positional asphyxia';  
 the dangers associated with 'excited delirium';  
 transportation of vulnerable people;  
 local arrangements relating to the care of mentally ill people;  
 supervision of incidents; and  
 the immediate steps to be taken by operational command unit (OCU) commanders.

#### 2 Positional asphyxia

##### 2.1 Definition

Positional asphyxia is defined as occurring when "the position of the body interferes with breathing, resulting in asphyxia". It is likely to occur when a person is in a position that interferes with inhalation and/or exhalation and cannot escape that position.

It must be noted that positional asphyxia can occur extremely rapidly.

##### 2.2 Risk factors

The following factors can contribute to death through positional asphyxia:  
 the body position of a person results in partial or complete airway obstruction and the subject is unable to escape from that position;  
 pressure is applied to the back of a person held in the face down prone position;

pressure is applied restricting the shoulder girdle or accessory muscles of respiration whilst laid down in any position;

the person is intoxicated through alcohol or drugs;

the person is left in the face down, prone position;

the person is obese (particularly those with large 'beer bellies');

where the person has heightened levels of stress; and

where the person may be suffering respiratory muscle fatigue, related to prior violent muscular activity (such as after a struggle).

### 2.3 Signs and symptoms

Officers must be aware of the following signs and symptoms and take immediate remedial action to relieve the symptoms and apply first aid:

gurgling/gasping sounds;

an active person suddenly changes to being passive (that is, loud/violent to quiet/tranquil);

the subject appears to be panicking;

verbal complaints of being unable to breathe, probably associated with an increased effort to struggle; and

cyanosis (blue coloration in facial skin). Cyanosis is very difficult to detect in some individuals (for example, those with dark skin, whose complexion may instead display a purplish/blue tinge around the lips or nail beds) or in poor lighting conditions.

### 2.4 Reducing the risk

The risk of positional asphyxia can be reduced by:

if at all possible avoiding placing a person in the prone (face down) position;

if it is impossible to avoid placing a resistive subject in a prone position to achieve control, placing the person into a *seated, kneeling or standing position*, as soon as possible once control has been achieved, either by handcuffing or other means (*handcuffing to the front is ideally suited to escorting non violent/compliant people*);

unless wholly unavoidable, not transporting a detained person in the prone, face down position. In exceptional circumstances where this is necessary, constant attention should be paid to the condition of the prisoner and immediate steps taken to alleviate any breathing difficulties. A detained

person's condition and life signs should be monitored before, during and after transportation. The rapidity of the onset of problems, especially if multiple factors are present, for example, large, obese individuals who have consumed alcohol and have been stressed by physical struggle, can be very fast, seconds *not* minutes. Vigilance is of the utmost importance.

If there is any doubt about the medical well being of a prisoner, first aid must be given and medical assistance obtained immediately.

### 3 Excited delirium

3.1 In simple terms, this is when a person exhibits violent behaviour in a bizarre and manic way rather than just being simply violent.

#### 3.2 Definition

Excited delirium, or delirious mania, is a rare form of severe mania sometimes considered part of the spectrum of manic-depressive psychosis and chronic schizophrenia. It is also known as agitated delirium, cocaine induced psychosis and acute exhaustive mania and can be caused by psychiatric illness, drugs (of which cocaine is the best known cause), alcohol or a combination of them.

#### 3.3 Symptoms

The following symptoms are not normally seen in people who are simply violent and will be of assistance in recognising excited delirium;

bizarre and/or aggressive behaviour;

impaired thinking;

disorientation;

hallucinations;

acute onset of paranoia;

unexpected physical strength;

sweating, fever and heat intolerance;

sudden tranquillity after frenzied activity; and

significant diminished sense of pain.

A person in an excited delirium state is of particular concern because they can die suddenly during or shortly after, a violent struggle, whilst at hospital or in custody.

### 3.4 Causes of death

Death is most likely to occur in two ways:

The state of excited delirium causes the suspect to have a cardiac arrest.

The efforts to avoid being restrained by police officers make an 'excited delirium' suspect at greater risk from positional asphyxia.

3.5 It is important to recognise the difference between excited delirium and a violent outburst. Once identified there then lies the problem of how a person in an excited delirium state should be handled without endangering the public, the police officer, medical staff as well as the affected person.

3.6 Officers will probably have to place them face down on the ground to handcuff them safely. The risk of positional asphyxia affecting a person who is in an excited delirium state is far greater than for a normal violent person.

3.7 They will continue to struggle beyond their point of exhaustion and it will be very difficult to prevent this regardless of whether or not they are handcuffed.

3.8 Once they are handcuffed avoid holding them face down. They should be moved onto their side or into a sitting, kneeling or standing position as soon as it is safe to do so. They may continue to kick out. However, officers must get them off their stomach in some way or other as soon as they can.

3.9 Once controlled they may continue to be extremely violent in spite of the use of handcuffs, sprays or batons. Such bizarre, exhaustive and persistent violent resistance is a classic indication of an excited delirium case. In the event of collapse attempts to resuscitate them usually fail.

3.10 The likelihood of police officers encountering people in such a violent delirium state is rare but is on the increase.

3.11 If a person exhibits symptoms of excited delirium, or when any doubt exists, they should be treated as a medical emergency and should be medically examined immediately at a hospital regardless of any subsequent behaviour or apparent recovery. Examination at a police station is not appropriate because equipment for heart resuscitation is not available to the level that may be required.

## 4 Transportation of vulnerable persons

4.1 Special Notice 37/97 of 28 November 1997 deals in detail with the medical care of prisoners – persons ill or injured. The following extract reminds officers of the policy of conveying persons who require urgent medical attention to hospital:

"When an officer considers that a person should be conveyed to hospital an ambulance must be called. Only in exceptional circumstances should police transport be used to convey a person to hospital. For example, where the ambulance control have informed police of a significant delay in the ambulance's arrival, or where there are life threatening circumstances justifying the urgent removal of a person to hospital by police transport. (Any person exhibiting symptoms of excited delirium should be medically examined immediately at a hospital.) In these cases the decision must rest with the officer at the scene and no further authority is necessary."

4.2 Special Notice 37/97 also states that where it is decided to convey a person by ambulance, police will accompany the ambulance:

where a person has been charged with crime or is in police custody; or  
if it is decided that an apparently violent, potentially violent or mentally ill patient needs an additional escort.

## 5 Local arrangements relating to the care of mentally ill people

5.1 On occasions when a mentally ill person is violent, they must be removed to a hospital that is able to provide the necessary immediate medical treatment and at many OCUs local arrangements exist for the transfer of mentally ill people direct to psychiatric units.

5.2 Such local arrangements must involve hospital facilities that are adequately staffed and equipped to deal with a medical emergency. In some instances this may not be available at a psychiatric unit and local procedures should dictate that identified accident and emergency departments must therefore be used in the first instance.

All officers need to be aware of their limitations in recognising the complex differences between drug induced behaviour, excited delirium and mental illness. Where any doubt exists as to the cause of violent behaviour the



person should be taken to an accident and emergency unit for a proper medical evaluation.

## 6 Supervision

6.1 Incidents involving violent people who may be suffering from mental illness, excited delirium, the effects of drugs or where prolonged prone restraint has been necessary must be reported immediately to a supervisor. Every effort should be made for a supervisor to attend the incident, to ensure that it is properly managed in accordance with current directions.

It should be remembered that the potential for death exists in these circumstances. Officers must ensure that a full record is made of the incident. This places clear responsibility on the Computer Aided Despatch controller and other relevant supervisors to ensure that times, actions and decisions are accurately recorded for future reference.

## 7 Immediate steps to be taken by operational command unit commanders

7.1 OCU commanders will take the following immediate steps:

ensure that all officer safety training sessions during 1999 include information on the contents of this Notice. In addition a 'Medical Implications' video package has been prepared by CO11 Officer Safety Unit and will be circulated for viewing in the near future. This must be shown to all officers during their officer safety training programme by the end of 1999. A local record of those officers who have viewed the video should be kept to ensure compliance with this direction. Such records will be kept at the OCU for at least six years; and where local arrangements, as described in Paragraph 5.1, are not in place OCU commanders will meet with the relevant agencies and develop immediate protocols on this important issue. Such protocols must include the facilities described at Paragraph 5.2.

## APPENDIX IV – Implementation Plan

No	Recommendations	Responsibility	Action Required	Target Date
1	<b>Recommendation 1</b> The Review recommends that Police Notice 12/99 is revised in accordance with medical advice and that the term 'excited delirium' should be removed to be replaced by 'acute behavioural disorder' in all MPS documentation.	CO11 Officer Safety Unit	Amend Police Notice 12/99 and issue consolidated update. Update draft MPS Officer Safety Manual.	31 Dec 04
2	<b>Recommendation 2</b> The Review recommends that officers are required to inform LAS/hospital medical staff whenever a detainee has been restrained so that they can be medically triaged as a matter of utmost priority	Implementation Manager	In conjunction with CO11 Officer Safety Unit draft policy and publish within consolidated Police Notice. Requirement to be included in recruit and refresher OST.	31 Dec 04
3	<b>Recommendation 3</b> The Review recommends that Form 435 that is completed when a person is detained under Section 136 of the Mental Health Act should be revised to include information about risk factors, any restraint employed and its timings.	Implementation Manager	In conjunction with TPHQ and CO11 Officer Safety Unit revise Form 435, publish new policy and consolidated Police Notice.	31 Dec 04
4	<b>Recommendation 4</b> The Review recommends that whenever practicable a supervisory officer should be directed to attend all incidents where a person is being restrained and that, in any event, an officer should take the role of Safety Officer taking charge of the incident, monitoring the health of the person being restrained and actively controlling the restraints being applied.	Implementation Manager	Liaison with Operation Diamond (Modernising Operations) to link with development of Supervision Model. Liaison with CO11 Officer Safety Unit to include in training and MPS Officer Safety Manual.	31 Mar 05

No	Recommendations	Responsibility	Action Required	Target Date
5	<p><b>Recommendation 5</b> - The Review recommends that the MPS Officer Safety Manual and training should emphasise the duty of all officers involved in restraints to continuously assess the health of the person being restrained and be able to justify that;</p> <p><b>a)</b> restraint is proportionate (i.e. that the safety of the individual is being balanced against the safety of the officers and the public) and the force used is the minimum necessary in the circumstances;</p> <p><b>b)</b> That the restraint is lawful (i.e. the officers have lawful power to restrain the person and are employing approved techniques);</p> <p><b>c)</b> continued restraint is necessary (i.e. there is an overriding reason why the restraint cannot be released or changed) and that there are no other less intrusive practicable alternatives.</p>	CO11 Officer Safety Unit	Draft MPS Officer Safety Manual to be updated. Recruit and refresher Officer Safety Training to include human rights and safety issues.	31 Dec 04
6	<p><b>Recommendation 6</b> - The Review recommends that officer safety training should stress that restraining a person in the prone position is potentially dangerous and include appropriate techniques to re-position violent persons from the prone position as quickly as possible.</p>	CO11 Officer Safety Unit	Trainers to develop safe method of re-positioning. Method to be cascaded through recruit and refresher training. MPS Officer Safety Manual to be updated.	31 Mar 05
7	<p><b>Recommendation 7</b> - The Review recommends that in order to minimise the use of the prone position the MPS should undertake trials of equipment (including Emergency Restraint Belts, VIPERS and others) and adopts those that facilitate the safe re-positioning of a non-compliant person.</p>	CO11 Officer Safety Unit	Restraint equipment i.e. Emergency Restraint Belt and VIPER to be tested and evaluated in MPS. Other restraint equipment to be identified and tested to re-position persons from the prone position.	30 Jun 05

No	Recommendations	Responsibility	Action Required	Target Date
8	<p><b>Recommendation 8</b> - The Review recommends that the Department of Health and Home Office should be requested to:</p> <p><b>a)</b> Commission research with the aim of producing practical guidance for operational police officers and health professionals in order to improve the care of people suffering from Acute Behavioural Disturbance;</p> <p><b>b)</b> Establish an independent group of medical advisors on restraint techniques and equipment to perform a similar advisory function to PSDB.</p>	Implementation Manager	Liaison with Department of Health and Home Office.	31 Mar 05
9	<p><b>Recommendation 9</b> - The Review recommends that the MPS should investigate methods of safely achieving control of a violent person from a distance.</p>	CO11 Officer Safety Unit	Identify methods. Consult IAGs, users and providers of mental health services. Relevant methods to be recommended for trial.	31 Mar 05
10	<p><b>Recommendation 10</b> - The Review recommends that the MPS engage with the forthcoming joint NHS/MPA Mental Health Review to undertake a detailed review of the demands mental health issues place on the MPS</p>	Joint NHS/MPA Mental Health Review	Referral to Review. Obtain findings from Review.	31 Mar 05
11	<p><b>Recommendation 11</b> - The Review recommends that there should be an overarching ACPO champion for mental health issues in the MPS at DAC level.</p>	Management Board	Designation of DAC.	30 Sep 04
12	<p><b>Recommendation 12</b> - The Review recommends that the MPS and the NHS in London should work together to agree minimum standards for the time taken to assess and admit people taken to a place of safety under Section 136 of the Mental Health Act.</p>	Implementation Manager	Negotiations with NHS and London Development Centre for Mental Health.	31 Mar 05

No	Recommendations	Responsibility	Action Required	Target Date
13	<b>Recommendation 13</b> - The Review recommends that the MPS, NHS and Association of London Government examine the potential benefits of the Memphis initiative with a view to improving the effectiveness and efficiency of the health, police and social services response to incidents involving people suffering from mental illness.	Implementation Manager	Liaison with NHS and ALG to identify applicability of Memphis initiative. Consideration of trial based on Memphis initiative in limited area of London.	31 Mar 05
14	<b>Recommendation 14</b> - The Review recommends that multi-agency case conferences regarding vulnerable people suffering from mental illness should be piloted in one area of London with the aim of reducing the risks associated with spontaneous incidents.	Implementation Manager	Negotiation with ALG and NHS to establish framework and information sharing protocols for case conference. Six-month trial in one area of London.	30 Sep 05
15	<b>Recommendation 15</b> - The Review recommends that each BOCU should be required to use Level 2 public order trained officers to support joint operations with mental health partners in respect of pre-planned events involving people suffering from mental illness.	DCC4 Strategic Disability Unit	Consult practitioners on MPS Mental Health Group regarding operating protocol. Draft and publish policy.	31 Mar 05
16	<b>Recommendation 16</b> -The Review recommends that the MPS and mental health partners should develop joint policy on the requirement for warrants under Sections 17 and 135 of the Mental Health Act 1983	DCC4 Strategic Disability Unit	Negotiations with mental health partners and London Development Centre. Develop, publish and implement policy.	31 Mar 05
17	<b>Recommendation 17</b> - The Review recommends that the MPS should seek to encourage NHS authorities to train their staff in methods of restraining patients thereby minimising the need to employ police officers for this purpose	Implementation Manager	In conjunction with DAC strategic lead negotiate with ACPO, Home Office and NHS.	31 Mar 06

No	Recommendations	Responsibility	Action Required	Target Date
18	<b>Recommendation 18</b> - The Review recommends that when a risk assessment indicates that a substantial level of violence may be anticipated that the incident should be video recorded and the justification for the decision fully documented.	DCC4 Strategic Disability Unit	Liaison with DLS and TPHQ. Develop and implement policy.	31 Dec 04
19	<b>Recommendation 19</b> - The Review recommends that all recruits and officers undergoing Officer Safety refresher training should receive specific training in de-escalation techniques with the aim of reducing the number of occasions when physical restraint is required.	CO11 Officer Safety Unit	Develop training package in conjunction with Training Directorate using learning from hostage negotiators, NHS, mental health service users and Memphis University. Implement package in recruit and refresher training.	30 Jun 05
20	<b>Recommendation 20</b> -The Review recommends that the MPS and Department of Health should work together with the aim of enabling Accident and Emergency Departments to deal more effectively with violent mentally ill patients.	Implementation Manager	In conjunction with DAC (appointed as strategic lead) negotiate with the Department of Health to determine the needs of Accident and Emergency Departments.	30 Jun 05
21	<b>Recommendation 21</b> - The Review therefore recommends that that HM Coroners' and other recommendations relating to deaths in police custody and restraint are recorded on a corporate database and that there is an audit trail of the actions taken in response.	Directorate of Organisational Learning	Development of corporate database of recommendations and governance structure to track the MPS response.	31 Mar 05
22	<b>Recommendation 22</b> - The Review recommends that the MPS should develop an IT based Use of Force Database to inform training needs and facilitate the effective monitoring of restraint techniques by the MPS.	Implementation Manager	In conjunction with DOI and CO11 identify appropriate IT package, plan and progress implementation.	30 Jun 05



No	Recommendations	Responsibility	Action Required	Target Date
23	<b>Recommendation 23</b> - The Review recommends that the MPS should, in conjunction with the IPCC, examine reporting schemes used by the aviation industry and the National Health Service with the aim of enhancing the learning captured from incidents.	Directorate of Organisational Learning	In conjunction with Health and Safety Branch and Metropolitan Police Federation evaluate the applicability of reporting systems used in other sectors. Identify potential solution to meet MPS requirements and seek Management Board approval.	30 Jun 05
24	<b>Recommendation 24</b> - The Review recommends that the MPS produce a video about restraint to inform external and internal audiences about the reasons for its use and the techniques employed.	Implementation Manager	In conjunction with CO11 and DPA commission video. Arrange for video to be shown to external (e.g. CPCG's) and internal audiences (e.g. recruits).	31 Mar 05
25	<b>Recommendation 25</b> - The Review recommends that the new MPS Officer Safety Training Manual should draw together disparate documents reflecting as far as possible the officer safety training techniques currently in the ACPO Manual specifically including sections on Human Rights and medical implications.	CO11 Officer Safety Unit	Revise and publish draft MPS Officer Safety Manual.	31 Dec 04
26	<b>Recommendation 26</b> - The Review recommends that in view of the current and envisaged work that the resources of the CO11 Officer Safety Unit are reviewed to ensure that it is able to discharge its organisational responsibilities.	CO11 SMT	CO11 review resources of CO11 Officer Safety Unit.	31 Dec 04