[redacted]
Deputy Chief Constable

Force Headquarters, Woburn Road
Kempston, Bedford, MK43 9AX

[redacted]

Ms Emma Whitting
Senior Coroner for Bedfordshire

[redacted]

26th November 2021

Dear Ms Whitting,

Regulation 28 Report – Leon Briggs

I write in response to your regulation 28 report to prevent future deaths dated 4 October 2021 ('the report') addressed to the Chief Constable of Bedfordshire. This is the formal response of Bedfordshire Police.

I start by repeating the apology which I made on 12 March 2021, acknowledging that the Inquest Jury had identified a number of significant failings by police which contributed to the death of Mr Briggs in 2013 and for which we are truly sorry. The Jury recorded their specific findings in the Record of Inquest, including that Mr Briggs' death was contributed to by neglect.

The matters of concern identified in the report relate to the adequacy of the local section 136 multi-agency policy; lack of sufficient training for police officers, ambulance crew and other front-line responders; and the adequacy of monitoring of detainees, subject to restraint.

Bedfordshire Police has considered the terms of your report carefully and consulted relevant local and national stakeholders before giving the following response.

Adequacy of the local section 136 multi-agency policy

As you are aware from the evidence at the inquest, the policy which applied in 2013 had been superseded. The current policy is under a task and finish group. It was reviewed by the current National Lead for Mental Health, Deputy Chief Constable [redacted], whose team stated they thought it was comprehensive. Additionally, officers met with partners on 13 October 2021 to review, update and confirm understanding, which took place with the benefit of the concerns you have identified. A revised policy is due to be signed-off this year. I will ask my legal services department to provide you with a final copy as soon as it has been signed off.

Significant learning came out of the Briggs Inquest and resulted in the local multi-agency Mental Health Hub being even more determined to form better working practices with our partner agencies. Despite good working relationships already, there are still challenges for front-line officers including medically-supervised transport; resourcing; making sure ambulance colleagues are leading medical assessments, monitoring and taking responsibility for medical situations brought to their attention; and ensuring there are routes into emergency departments.

Chief Constable [redacted], CEO for the College of Policing, confirmed in his meeting with the Chief Constable of Bedfordshire on 29 October 2021, the current College of Policing and National Police Chiefs' Council (NPCC) Mental Health Leads are the most appropriate sources of guidance and support, and referrals to experts, and will continue to act as consultees in these respects.

Lack of sufficient training for police officers, ambulance crew and other front-line responders

The Chief Constable met with the National Lead for restraint's team, headed by Deputy Assistant Commissioner [redacted], on 29 October 2021. The national position is that officers are not mental health practitioners and that the skills officers have are not the same as those of clinicians and practitioners in mental health units. It is important to keep in mind that police officers should defer to ambulance staff and clinicians on medical matters because of their specialist training and focus.

However, Bedfordshire Police officers do receive training on section 136, mental health awareness and First Aid (see below) and the regular training provided to all officers and meets the standards set out by the College of Policing. If you would like more detail regarding the current training provision, I will ask my legal services department to provide you with all the relevant units and guidance.

The circumstances of Mr Briggs' death, which again I acknowledge the Jury found was contributed to by neglect in the particular circumstances of his case, is well known to those responsible for training and refresher training, and will have a lasting impact on their provision of training to individual officers.

Adequacy of monitoring of detainees, subject to restraint.

The College of Policing has issued updated Authorised Professional Practice (APP), and provides 'College Learn' (formerly NCALT) with regards Officer Safety Training, First Aid and Mental Health Awareness. These packages have been updated significantly since 2013 to reflect learning with regards to awareness of Acute Behavioural Disturbance (ABD) and principles of detainee monitoring.

Our policies around 'observation and risk assessment' of a detainee in custody, also provided in Use of Force training, reflect national guidance from the College of Policing, which in turn is reinforced by respective NPCC Leads.

Bedfordshire Police highlighted, in light of your report, the 'NHS Patient Safety Alert' to the National Mental Health Lead. Their view was that this document reinforced the requirement for monitoring of 'vital signs' for patients post restraint. Monitoring of vital signs, as referred to in a clinical context, is not something officers are trained or equipped to do. However, officers do receive the modern training referred to above (including First Aid) and it was felt that a separate document adapting the

NHS Patient Safety Alert may lead to duplication, or create confusion. On reflection it would be preferable to incorporate any additional guidance into existing guidance for the relevant policing areas such as Use of Force and Custody.

I make clear that all officers involved in the provision of restraint and care to a detainee are required to monitor the detainee. That did not happen appropriately in Mr Briggs' case. While we cannot guarantee a particular specialist level of additional monitoring in every case, due to the significant variety of circumstances and resourcing challenges, there is in the current training the concept of a 'Safety Officer', where possible a supervisor, who will not have a hands-on role in restraint of a detainee but will be observing them and looking for any signs of problems and can give advice to the officers performing restraint.

The National Lead for Mental Health informed Bedfordshire Police that at the NPCC National Forum in July 2021, an update was provided by Chief Superintendent [redacted] of South Yorkshire Police, who is working alongside Dr [redacted] (Medical Director for West Yorkshire Metropolitan Ambulance Service, and Consultant in Emergency Medicine and pre-hospital care at Mid Yorkshire Trust) on a national ABD policy. I understand that it is likely that, once completed, a request will be made to the NPCC and College of Policing to incorporate any recommendations from this review into APP, including recommendations being made for officers to formally declare suspected ABD cases as 'critical incidents' therefore ensuring they receive immediate management oversight.

Bedfordshire Police are grateful to the Coroner for the opportunity to address the steps which have been, and are being, taken in respect of the matters of concern outlined in the report. And, again, I will ask that you be forwarded the most up to date multi-agency policy as soon as it has been signed off.

Yours sincerely

[redacted]
Deputy Chief Constable