METROPOLITAN POLICE **TOTAL POLICING**

DIRECTORATE OF PROFESSIONALISM

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Date: 20 August 2015

Dear Ms. Hassell,

I write on behalf of the Metropolitan Police Service (MPS) in response to your Regulation 28: Prevention of Future Deaths (PFD) report dated 10th June 2015, following the inquest touching the death on 12th March 2013 of Darren Neville. This Inquest opened before Assistant Coroner Lynch on 9th May 2013, and concluded before you (sitting with a jury) on the 10th June 2015, at the St Pancras Coroner's Court.

At the conclusion of this Inquest, the jury gave a narrative determination, and you went on to find that:

> *"...Mr Neville died having taken cocaine, suffering acute behavioural disturbance and following restraint by police. His medical cause of death was:*
>
> *1a cardiac arrest encephalopathy (global cerebral ischaemic hypoxia)*
> *1b fatal dysrhythmia*
> *1c restraint and struggling in association with acute behavioural disturbance, in an individual with evidence of cocaine use (acute and chronic.)"*

The jury set out part of their narrative that:

> *"...Police did not give sufficient consideration to the risks associated with prolonged restraint to a person suffering from acute behavioural disturbance; more specifically, the risk of death following prolonged restraint. It is unclear the extent to which this single factor caused Darren's death."*

You may recall a previous response which the MPS provided in another case (that of Michael Sweeney who died April 2011, response delivered in November 2013) that the MPS has in recent years invested in considerable training for officers in recognising the

medical emergency occasioned by 'Acute Behavioural Disorder' (ABD). This has been coupled with the development of more effective joint working practices with our colleagues in the London Ambulance Service (LAS) and the National Health Service (NHS) when responding to such incidents.

The MPS has continued to refine and develop its response to the challenges posed by ABD since the response provided to you in in November 2013. The MPS recognises that dealing with ABD poses particular difficulties for officers who must balance the need to protect an individual who be suffering from ABD from harming themselves and the need to protect the public, against the risks inherent in restraining an individual who may be in a state of ABD. This may of course be all the more difficult in the fast moving and dynamic circumstances that officers are likely to encounter individuals exhibiting ABD.

I have set out below: (a) a summary of actions taken by the MPS since the conclusion of the Sweeney inquest, (covered in greater detail in our report to you on that case); together with (b) additional developments since the death of Mr Neville. It will be noted that some actions set in train immediately after the verdict in Mr Sweeney's inquest, for example, developing the Memorandum of Understanding (MOU) between the MPS and the LAS were still 'works in progress' at the time of Mr Neville's death. This work has now been completed as regards the joint response to any similar incidents which may occur in the future. I should make clear that the work which I have set out below has been carried out in consultation with subject experts in the relevant areas of police operations and policy.

Summary of work resulting from the earlier case

One of the first improvements in the response by police and other agencies to cases of possible ABD was the adoption of this phrase as a common terminology across first-responding agencies to describe the behaviours which might be exhibited in individuals with ABD. There were a number of implications for training, business processes and practice for all parties which flowed from this.

Parts of this new approach which could be introduced rapidly were expedited. For example, on the 3rd December 2013 (a little more than a fortnight after the verdict in the Michael Sweeney inquest) an instruction to all officers was delivered (via the MPS intranet system), advising that from the following day, our partners in the LAS would treat all 'ABD' and/or ongoing restraint calls as medical emergencies, with a target response time of 8 minutes or less, a so-called 'Red' response.

Meanwhile, the MPS contribution, our intranet circulation went on to state, would be as follows: *"If a patient is being actively restrained, believed to be suffering from excited delirium, acute behavioural disorder or cocaine toxicity, officers must ensure this information is sent on a new CAD message to the LAS and they will upgrade to a Red response."*

The other significant development, post the Michael Sweeney case was the publication in January 2014 of the aforementioned MOU between the MPS and LAS to provide guidance on joint working including use of CAD Link and Joint Response Units'. This document sets out in detail how the respective agencies communicate about and respond to joint incidents. It put on a formal footing the earlier 'fast time' agreement (referred to above) between both agencies regarding response to 'ABD' and/or ongoing restraint incidents. Governance arrangements, mechanisms for managing

disagreements over deployments, expectations of service, and so on were also captured, and placed on a formal footing for the first time in this document.

Section 11 of the MOU, states under the heading 'Patients being restrained or suffering other condition':

> *11.1 Physically restraining patients presents a serious risk of positional/restraint asphyxia and death. Restraining patients with other vulnerabilities (e.g. Acute Behavioural Disorder, under the influence of alcohol or drugs, obesity) presents an increased risk.*
>
> *11.2 MPS CAD Operators must create a new CAD and EXP/LAS clearly stating a "patient is being restrained" in the remarks field and send this to the LAS.*
>
> *11.3 The LAS will upgrade all calls where a patient is being restrained to a RESP1 (8 minutes). This is the equivalent response code to a cardiac arrest. Therefore the number of clinical upgrades will be closely monitored by the LAS."*

The MOU is supported by regular review meetings between the MPS and the LAS, which were also instituted since the Michael Sweeney case and which provide an ongoing forum for both parties to resolve any operational difficulties arising in the course of daily business. The MOU itself meanwhile is a 'living document' jointly owned and developed by both agencies through this forum, and provides a means of developing policy on all aspects of day to day joint working. For example, at time of writing, policy guiding the approach to the management of 'concerns for safety' calls (formerly known as 'welfare checks') dealt with by both agencies is being developed for capture in the next edition of the MOU.

Further developments since Mr Neville's death

As well as the adoption of the common terminology, it was recognised that further attention needed to be given in training and operational practice to the need for first responders from all agencies to rapidly *recognise* signs and symptoms suggestive of ABD and to then treat this as a medical emergency.

Given the size of the MPS first-responder workforce, this training had to be delivered incrementally through the established training structure, such as the bi-annual Officer Safety Training (OST) refresher courses, which every operational police officer up to the rank of Superintendent is obliged to attend.

Two complementary strategies are relevant here. The first was the introduction, in September 2013 (by the MPS Mental Health Team under the direction of Commander Christine Jones), of the Vulnerability Assessment Framework (VAF), and it's associated 'ABCDE' risk-assessment tool.

The second was the practical integration of that tool into the mandatory bi-annual OST cycle. Developed in conjunction with researchers from the University of Central Lancashire, the VAF is intended to move officers away from earlier 'diagnostic' condition-specific training regimes. The VAF acknowledges that even trained mental health professionals often find it difficult to pinpoint the precise reason why a person may be acting in a distressed or disordered way; and that such 'diagnosis' is of little direct relevance to the range of options a police officer, as opposed to a mental health professional, may need to consider.

The VAF provides a different approach. It encourages officers to recognise when they are dealing with a person who is in a 'vulnerable' state of mind by focussing on objectively observable behaviours and circumstances and then to adopt an incident management style appropriate to this circumstance. 'Vulnerability' is defined in the following terms in the VAF:

> *'[it] may result from an environmental or individual's circumstance or behaviour indicating there may be a risk to that person or another. Those who come to notice of police as vulnerable will require an appropriate protective safeguarding response. Additional factors to vulnerability may include mental health, disability, age or illness and should include appropriate multi agency intervention especially in cases of repeat victimisation.'*
>
> [Commander Jones' Vulnerability Assessment Framework briefing note v.2, 02/11/13]

The VAF is thus a holistic approach to assessing vulnerability and is to be utilised in all interactions the police have with the public, regardless of whether someone is a victim, witness or suspect. The rationale for this is that, properly used, this will pick up on *any* potential vulnerability which might otherwise hamper normal communication between the individual and attending officers, regardless of whether the difficulty is temporary of permanent, the result of substance abuse, mental illness, or physical or mental disability. It also offers through the use of reports into the MPS 'Merlin' database, a means of developing an accessible 'corporate memory' over time of dealings with any individual where 'vulnerability' is detected. This record may include not only a history of previous incidents but also, where appropriate, contacts for friends, family, or mental health professionals engaged with them, and so on.

The primary tool to aid the officer in identifying 'vulnerability' is the mnemonic 'ABCDE', which directs the officer to consider objectively observable characteristics of the person they are engaging with: a persons' **A**ppearance and **B**ehaviour, their **C**apacity/Communication, any **D**anger their actions may cause themselves or others; and any indications from their **E**nvironment of risk, their history of self-care, and so on.

An officer may create an 'Adult Coming to Notice' Merlin report for 'vulnerability' if any of these elements are engaged. Where three or more elements are detected, an entry on the database is mandatory.

Training for first responders in this new model began in January 2014, and the underlying policy was announced formally (via the MPS intranet) on the 13th August 2014. Guidance on the approach has also been provided via 'Policy Pages' the 24/7 intranet 'one stop shop', accessible to all MPS employees. This replaces the MPS previous approach (based upon a collection of 'Standard Operating Procedures') with a series of succinct guidance documents, checklists, and Frequently Asked Questions.

Within the 'Vulnerability and Protection of Adults at Risk Toolkit' the relevant documents are:

- Vulnerability and Protection of Adults at Risk Toolkit - Vulnerability Assessment Framework (VAF) and Quick Guide Tool
- Vulnerability and Protection of Adults at Risk Toolkit - Primary Investigation - Checklist

- Vulnerability and Protection of Adults at Risk Toolkit - Primary Investigation - Supervisor - Checklist
- Vulnerability and Protection of Adults at Risk Toolkit - Secondary Investigation - Checklist
- Vulnerability and Protection of Adults at Risk Toolkit - Secondary Investigation - Supervisor - Checklist

This resource sits alongside a continuing emphasis on de-escalation tactics in the OST sessions. The classroom element of the current cycle of the mandatory training includes a section called 'Mental Health - Safety In Mind', a DVD and tutor led interactive session. This has been developed in conjunction with South London & Maudsley Hospital (SLAM) and the LAS and is aimed at improving the management of a situation involving a person identified as vulnerable. This package discusses the importance of the VAF and ABCDE models; and offers practical guidance on de-escalation tactics using the 'CARES' model (see below.)

On receipt of your PFD report, [redacted] an MPS expert on OST related issues, has provided the following account:

> *"Restraint issues including ABD and Positional Asphyxia remain central tenets of Officer Safety Training (OST), which is mandatory for all officers below the rank of superintendent. This training is pass/fail insofar as officers must demonstrate 'competency' in each module of OST in order to carry out their operational duties. Restraint issues have formed part of this training for nearly 20 years and are, therefore, firmly embedded with continuous corporate review from local, national and international sources. These processes, coupled with an established in-house national secretariat and policing lead for OST, help to ensure the MPS's commitment to the latest developments in training. These include advancement in tactics and technologies in addition to legal, medical and ethical developments. The current mandatory OST programme includes the following objectives:*
>
> - *State the signs & symptoms of a person in crisis using the 'Vulnerability Assessment Framework' (ABCDE)*
> - *State the main causes of Acute Behavioural Disorder (ABD) and police response*
> - *Discuss the 'CARES' approach to mental illness -*
>
> ***C**ontain the situation - rather than restrain.*
> ***A**pproach within view of person. Avoid approaching from behind.*
> ***R**educe distractions - helmet off, turn radio down, one officer talking.*
> ***E**xplain what you are doing (simple language) and listen to the person.*
> ***S**low down your actions and give the person more space. Seek the help of a relative or Carer.*
> *REMINDER: ABD = A&E*
>
> - *Where restraint is nevertheless unavoidable:*
> - *State the role of the 'Safety Officer' -*
>
> ***Control** by restraining the person.*
> ***Care** by monitoring the person and being aware of the dangers of the prone position.*
> ***Communicate** with the person e.g. 'you are under arrest', 'Stop resisting'. 'We are here to help you'. Communicate also includes talking to colleagues. If any person has any concern regarding the person's medical condition, it is important that they say something: 'Speak Up/Speak Out'. If*

possible have a second 'Safety Officer' to stand back and observe/evidence the restraint. This can be useful as those restraining are more likely to be affected by stress (tunnel vision etc).

- *Discuss the purpose of the side control/restraint position -*

  To assist with breathing, monitor the person and reduce the dangers of the positional asphyxia. This should be done ASAP. Where possible the person should be brought to a sitting, kneeling then standing position. Explain that in general, people are handcuffed behind their back, as it restricts the movement of the hands. If handcuffs are applied to the front, a person is able to move their arms around, use their elbows and grab with their hands. However, also note/explain the comments of medical expert [redacted] *with regard to handcuffing behind the back and breathing.*

Additional aspects of the current OST syllabus also include the 'Safer Restraint' and 'Medical Implications of Restraint' DVDs. These are MPS/NHS joint training tools designed in partnership to help promote a unified response to restraint crisis management and an enhanced understanding of each organisation's roles and responsibilities.

The MPS is also promoting the newly formed National Mental Health Restraint Expert Reference Group, which is independently chaired by Lord Carlisle. This group of leading experts from partnership groups and organisations has been convened to help ensure a unified response to best practice across the UK. The OST learning outcomes from such groups will continue to be fast-tracked into corporate training as an on-going process of development, in line with College of Policing principles. For these reasons, work is 'on-going' from an OST perspective."

Steps have also been taken at a national level to help officers structure their decision making, in recognition of the fact that they are often obliged to make dynamic risk assessments in fast moving situations, frequently on the basis of partial or misleading information. This is often the position in the many emergency situations which first-responding officers attend.

Risk taking involves judgement and balance, and harm can never be totally prevented. Risk decisions should, therefore, be judged by the quality of the decision making, not by the outcome. To help everyone in policing make these decisions and to provide a framework in which the decisions can be examined and challenged, both at the time and afterwards, the police service has adopted a single, National Decision Model (NDM), comprised of six key elements:

- Code of Ethics – Principles and standards of professional behaviour
- Information – Gather information and intelligence
- Assessment – Assess threat and risk and develop a working strategy
- Powers and policy – Consider powers and policy
- Options – Identify options and contingencies
- Action and review – Take action and review what happened.

[Source: College of Policing Authorised Professional Practice website, 'National Decision Model 15/10/14': https://www.app.college.police.uk/app-content/national-decision-model/]

The model has at its centre the Code of Ethics, as the touchstone for all decision making. Using the model in advance of a pre-planned activity or in review after a spontaneous incident encourages officers and staff to act in accordance with the Code, to use their discretion where appropriate, and to evidence the thought processes behind the actions they have taken. It also reduces risk aversion, and helps weigh the balance of resourcing against demand, threat and risk. Police managers have undertaken to support decision makers in instances where it can be shown that their decisions were assessed and managed reasonably in the circumstances existing at the time *even where harm results from those decisions and actions* (my emphasis). The NDM therefore offers a way of structuring the necessary evidence to enlist that support.

Conclusion

I have not had sight of transcripts of the inquest proceedings, and make no reference here to the particular actions of the officers involved in this incident. I have noted however the findings of the IPCC investigation that this was *"...a fast-moving, dynamic situation" in which the first officers on scene were confronted by Mr Neville in a public street "...dressed in only his boxer shorts and his socks... a recycling box over his head, and he was covered in blood. When the officers went to approach...he displayed violent behaviour towards them..."* [para 290, IPCC report], with the result that the officers moved promptly to restrain him. I understand that Mr Neville had thrown himself through the glass window of a door and had injured himself and that this may have added to the complexity of this situation.

The nature of behaviours associated with ABD - bizarre, often violent and erratic action, great strength etc - frequently presents immediate risks to the person concerned, members of the public, and to the attending first responders. ABD of itself may present a propensity to catastrophic physiological collapse. This presents officers with an acute difficulty because it remains the case that officers will, on occasion, be confronted by a need to act spontaneously, and to take decisive action immediately, *even if* they are fully aware of the risks involved in doing so. In short, the very factors that may indicate that an individual is in a state of ABD may require that the individual is restrained (so as, for example, to ensure they receive medical attention or to protect the public). Equally the state of ABD may put the individual at significant physiological risk of collapse. Dealing with these complexities in the sort of environment that they are likely occur has required the MPS to refine its training (and the emphasis in that training) over the course of the past two decades.

The MPS recognises its responsibility to furnish its officers with the equipment, tactics, training, and cognitive tools so as to enable them to approach such fast moving, frightening situations with confidence, and the ability to protect themselves and the public they serve (beginning with the person before them in the incident).

I trust you will consider that the efforts we make to learn from each such regrettable circumstance, exemplified here both by the measures introduced since 2013, and those in response to Mr Neville's tragic death, are evidence of our continuing commitment to this aim.

Yours sincerely

Fiona Taylor
Deputy Assistant Commissioner