1263/14 JD/RED Inq

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20 APR 2016

18th April 2016

David Hinchliff
Senior Coroner
Coroners Office and Court
71 Northgate
Wakefield
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Dear Mr Hinchliff

Inquest touching the death of Adam RICE 8th February – 16th February 2016
Response to announcement pursuant to Regulation 28 of the Coroners (Investigations) Rules 2013.

I am writing in response to the matters you raise in Annex A paragraph 5B of the Regulation 28 report directed towards West Yorkshire Police.

First of all I wish to take this opportunity to express my sincere condolences to the family of Adam. I can appreciate how distressing the loss of a family member would be, particularly in these tragic circumstances. I would like to apologise for the distress that the death of Adam has caused for all those who knew him and assure you and Adam's family, that lessons have been learnt. Please could I stress that West Yorkshire Police has not waited until the conclusion of your inquest to learn lessons, but has actively been putting measures in place to reduce the risk of a similar situation arising again. We are committed to ensuring that those persons who come into contact with the Police who are vulnerable, receive the best possible care.

In your report to prevent future deaths Annex A paragraph 5B you identified 4 matters of concern which I shall reply to in turn.

1. To ensure that Custody Staff (Police Officers of all ranks, Civilian Detention Officers and Nursing Staff) have a full and comprehensive knowledge of the Police and Criminal Evidence Act (PACE), the relevant Codes of Practice and the relevant provisions of the College of Policing 'Authorised Professional Practice' (APP) in respect of Detention and Custody and Custody Management Planning.

All Custody Staff employed by West Yorkshire Police undergo a full training programme in line with the College of Policing requirements prior to working in a live custody suite. During this initial course, Custody Officers, Detention Officers and PC Gaolers all receive training on the Police and Criminal Evidence Act (Code C) and Authorised Professional Practice (APP).

Each year, all permanent and 'ad hoc' Custody Staff attend refresher training which is currently of 4 days duration. Both PACE and APP are covered on these refresher courses.

APP and PACE are both available electronically to all staff for reference should the need arise on a day to day basis and all custody suites have hard copies of Code C available should staff need to remind themselves of its content. In addition, Custody Services and Custody Training are available centrally to provide guidance and clarity on more complex matters should the need arise.

On promotion, all Inspectors attend a professional development and leadership course which contains a custody module. This ensures that all Inspectors have knowledge and awareness of the key issues relating to custody. In addition each custody suite has at least one dedicated Custody Inspector to oversee the daily running, provide advice and support and to ensure standards are maintained.

Healthcare in custody is provided by Leeds Community Healthcare Trust (LCHT). All Healthcare Staff attend a week long training programme prior to commencing a shadowing period in a live custody suite. This programme was devised in conjunction with West Yorkshire Police and PACE is included and delivered by a suitably qualified police officer. There is a knowledge test on PACE for health care professionals at the end of the week. Key elements of APP (including levels of observation) are also included in the training plan.

2. That West Yorkshire Police only recruit Custody Staff of the highest calibre to carry out this vital role, as it involves some of the most vulnerable members of society.

Staff are only able to train as a Custody Sergeant or PC Gaoler once they are substantive in role and have received authorisation from their line manager to apply. This ensures suitability of the staff.

Detention Officers are non-warranted and do not conduct any other roles, if they are employed as Detention Officers. The application process currently entails an application form and interview by our Human Resources (HR) Team. We are currently progressing and developing proposals to involve Custody Services (led by Inspector [redacted] to have involvement in the selection of future Detention Officers, which will further ensure suitability for role at time of selection.

Should Custody Staff not perform to the highest of standards, there are recognised practices available to deal with them. This ranges from training and developmental support, to the Unsatisfactory Police Performance Process and Police Misconduct Regulations for Officers and capability procedures and code of conduct for Police staff. All Custody Staff, like all West Yorkshire Police employees, are subject to an annual staff appraisal by their line manager, called a Personal Development Review (PDR).

3a. To ensure that there are adequate staffing levels of all ranks and grades to fulfil this vital role particularly during periods of high demand when it is known that Custody facilities will be extremely busy and in particular Fridays, Saturdays and Sundays.

West Yorkshire Police currently has 7 Inspectors, 55 Custody Sergeants and 147 detention Officers working across the five custody suites. A new Police shift pattern was introduced in February 2016 which contains periods of overlap across the busy times and the shift templates have been adjusted to meet the needs of each district. ACC [redacted] has also reviewed the staffing levels at the five custody suites in February 2016, the result being that an extra five Detention Officers (one per shift) are being recruited to work at Leeds. This will result in reducing the need to bring in 'ad-hoc' PC gaolers at the Detention Officers meal times. Furthermore, at a recent Custody Partnership Board, [redacted] tasked the healthcare provider (Leeds Community Healthcare Trust) to review their nurse coverage at both the Bradford and Leeds custody suites and suggested options for them to move nurses from a less busy custody suite, which has low medical demand, to ensure there are no 'medical queues' at the busier custody suites of Bradford and Leeds.

The additional benefit of this change in Police shift pattern is that the Neighbourhood Patrol Teams are aligned to the same pattern as the Custody Staff making it easier to draft in 'ad hoc' staff when necessary.

3b. To ensure that they have a bank of staff which might ordinarily be engaged in other duties but who are trained and have experience in Custody work who can be drafted in at short notice during such periods of high demand when it becomes obvious that the existing staff cannot cope with the demands being placed upon them.

West Yorkshire Police have staff who work permanently in our custody suites, but also have a bank of 'ad hoc' staff who are fully trained. 'Ad hoc' staff are used to cover periods of abstraction of the permanent staff (such as annual leave) or when demand is such that additional resources are required during a busy shift. These 'ad-hoc' staff receive exactly the same level of training as permanent staff, including the annual refresher training. Whilst this is a very costly training requirement for staff that will only be used on an 'ad-hoc' basis, it is absolutely necessary to have all staff who may work in a custody suite, trained to the highest standards.

There are currently 61 'ad hoc' Custody Sergeants and 146 PC Gaolers who are distributed across the 5 Districts of the Force, but can be called upon to work in any suite if required. Of note, these 'ad hoc' trained staff now work the same shift pattern as the permanent Custody Staff and have done since the new Police shift pattern commenced in February 2016, thus making cover much easier to plan and much speedier to put into action, in peaks of high demand. These figures are monitored quarterly by Force Training School to ensure sufficient staff are available to provide additional capacity when necessary.

I do hope that the information provided above allays your concerns which you expressed in your letter dated 3rd March 2016. I also hope that this provides the family and any interested parties with assurance that West Yorkshire Police are committed to ensuring that those persons who come into contact with the Police who are vulnerable will receive the best possible care.

Yours sincerely

Dee Collins
Temporary Chief Constable
West Yorkshire Police

The Leeds Teaching Hospitals NHS
NHS Trust

Date: 27th April 2016
Our Ref: YO/JA
Your Ref: DH/JS/1263/14

RD 6516.

Private & Confidential
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Dear Mr Hinchliff

RE: INQUEST TOUCHING THE DEATH OF ADAM RICE (Deceased)

I refer to your correspondence of 3rd March 2016, received on 7th March 2016, regarding the inquest touching the death of Adam Rice and the Regulation 28 Report to Prevent Future Deaths in respect of this case.

I can confirm that the contents of your Regulation 28 Report have been shared with the relevant clinical staff and our risk management team to enable us to provide you with a comprehensive response.

In your report at paragraph 5 you highlight your concerns as:

1. *When a patient self-discharges against medical advice and it is known or it is highly likely that the Police will immediately thereafter become involved and it can be foreseen that the patient will be taken into Custody.*
2. *Then the Clinician(s) involved should inform the Police that the person has self-discharged against advice and should give brief details of any desired and outstanding investigations or treatment (e.g. reference to a possible head injury would suffice and the desire to carry out a CT head scan). This I suggest would not breach confidentiality.*

In your narrative conclusion you make reference to the following:

a) Adam Rice was taken to Leeds General Infirmary on 11th May 2014 at 15.09 after being found under a skate ramp in Hyde Park, intoxicated and with a possible head injury.
b) In hospital he refused a CT head scan.
c) He discharged himself against medical advice, which was not communicated to the Police.
d) Due to an outstanding arrest warrant, Mr Rice was immediately arrested and taken to Elland Road Custody Suite.
e) He was placed in cell 19 where he later exhibited features consistent with alcohol withdrawal.
f) At 06.37 on 12th May 2014, Mr Rice suffered a seizure.

g) At 07.04 Mr Rice was found unresponsive in his cell and CPR was commenced.
h) Adam Rice was pronounced dead by paramedics at 07.43 on 12th May 2014 at Elland Road Custody Suite.
i) Adam Rice's death was coincidental and not as a consequence of his detention within the Elland Road Custody Suite

I note that the pathologist concluded that the most likely cause of Mr Rice's death was a fatal cardiac arrhythmia caused by an acute dissection of the aortic root. No evidence of a head injury was found at post mortem examination.

The clinical team advised me that Mr Rice was a 46 year old gentleman who was brought to Leeds General Infirmary on 11th May 2014 at 15.09. Mr Rice, who was known to the Department, appeared intoxicated and had sustained a nasal wound. He was generally uncooperative but his observations were satisfactory. After a fall in the Emergency Department, Mr Rice was examined by a CT1 doctor who was unable to find any new or lateralising signs to suggest that a CT head scan was urgently required. [redacted] an experienced ED registrar, also reviewed Mr Rice and concluded that he was uncooperative and intoxicated. She arranged for Mr Rice to be transferred to the Clinical Decisions Unit (CDU) for observations and a CT head scan in due course.

At approximately 22.00 Mr Rice was demanding to leave hospital. At this point he was independently mobile, coherent and did not appear to be impaired by alcohol. Mr Rice was informed that the medical staff wished for him to have a precautionary CT head scan. He was clearly told of the risks of taking his own discharge against medical advice. Some considerable time was spent attempting to persuade Mr Rice to remain in hospital. However, he was clear that he wished to leave. [redacted] eventually concluded that Mr Rice had the necessary capacity for this specific decision in that he understood the information being given to him, was able to retain and weigh up the information, and then communicate that information back to [redacted] Mr Rice stated that he intended to go to St George's crypt (adjacent to the LGI) and was advised of the importance of seeking shelter and warmth indoors.

Although Police officers had accompanied Mr Rice to hospital, the Emergency Department staff were unaware that the Police were considering arresting Mr Rice immediately after discharge.

No subsequent request for information was received by the LGI emergency department from the Elland Road Custody Suite staff.

My staff have provided me with detailed comments following your Regulation 28 Report, which I hope you will find helpful.

a) [redacted] is clear that Mr Rice had the necessary capacity to make a decision about taking his own discharge, however unwise that decision.
b) There was no conventional 'safety net' of family or regular GP that could be informed of the recent admission and features that should trigger re-attendance, but Mr Rice's intention which was clearly expressed, to attend St George's crypt, provided some

reassurance that he would be in an environment following discharge where any concerns could be acted upon.

c) In your Regulation 28 Report you suggest at Section 5 A(2) that it could have been foreseen that Mr Rice would be taken into Custody and that clinicians should have informed the Police about any desired or outstanding investigations. You suggested that this would not constitute a breach of patient confidentiality. In response to this point, the staff have made the following comments:

i) The General Medical Council set out in their 2009 guidance ("Confidentiality") at Paragraph 36 the circumstances where a disclosure without patient consent can be made in the public interest. Essentially this is confined to a situation where there is a need to protect individuals from serious harm, such as serious communicable diseases or serious crime. As you know, the GMC takes the view that there is a clear public good from having a confidential medical service and quite rightly doctors who break patient confidentiality put themselves at risk of serious censure. After extensive multi-disciplinary discussion on this matter, we have been unable to identify either an indication for disclosing information about Mr Rice's medical assessment or a justification in this case for such disclosure without the necessary permissions.

ii) The staff were unaware that the Police were considering arresting Mr Rice following discharge. Indeed, this decision appears to have been formalised by PCSO [redacted] and PC [redacted] once Mr Rice had left the building. No subsequent request for information was received from the Elland Road Custody Suite.

iii) Our Emergency Department staff would like to reassure you that there are already arrangements in place for a handover of relevant medical information when patients are discharged from the Emergency Department. When a patient leaves the department for their own home, their GP will receive a discharge summary and the patient will normally be given advice in the presence of their next of kin as to features which warrant re-attendance. Similarly, when a patient is transferred to another hospital, relevant details will accompany the patient to the new healthcare provider and a formal handover of care will take place. The same principle applies where a patient is being transferred to a facility, such as a Police Custody Suite that is recognised to have trained medical or nursing staff. In this case a direct transfer was not being facilitated and the decision to arrest Mr Rice was made by PCSO [redacted] and [redacted] once Mr Rice had left the care of Leeds Teaching Hospitals NHS Trust and without liaison with the responsible medical team. Had the decision been made to arrest Mr Rice in the Emergency Department and take him directly into custody, an appropriate medical discharge note would have been provided as is the normal practice together with a verbal handover of care.

iv) The reality of a current day Emergency Department is that many patients take their own discharge every week. Many such patients will be known to the Police. We do not believe it feasible or reasonable to expect a healthcare practitioner to make a judgement as to whether that patient is likely to be arrested soon after discharge against medical advice. We believe that routinely contacting the Police in these circumstances would take a significant amount of

time and in most cases would be associated with an unjustified breach of patient confidentiality. This category of patient would be unlikely to attend, or to stay for conventional investigations or observations, if they were aware that healthcare practitioners would be liaising with the police as to their potential arrest for incidents that fall beyond those which warrant urgent disclosure. This scenario would be likely to have a detrimental impact on overall healthcare provision to this class of patient, which would represent an unintended adverse consequence of a course of action intended to prevent future deaths of a similar nature.

I can reassure you that all the staff involved in Mr Rice's care were saddened to learn of his untimely death. However, they are confident following reflection that they acted appropriately and professionally at all times, despite the challenges presented by such patients, with nothing to suggest any discrimination or shortfalls in anticipated care standards. Sadly it would seem Mr Rice suffered a sudden and unexpected death that could not have been predicted during his assessment at Leeds General Infirmary and was seemingly not in any way contributed to by his subsequent detention at Elland Road Custody Suite.

In conclusion, I can reassure you that there are appropriate mechanisms already in place to share patients' medical information with other healthcare providers. However, doctors must act within the confines of their professional regulator and only share information with third parties with appropriate consent or where there is clear public interest to disclose information without consent. If however, the scenario arises where a patient is to be arrested within the ED either because no further medical management is required or because this has been capacitously refused, the staff would predictably provide a summary of the relevant healthcare issues to the arresting officers to ensure that that process was informed. That expectation would exist before these events and before your Regulation 28 letter.

The Trust is receptive to a need to review practice following any adverse incident or outcome as hopefully demonstrated by this response and we would be happy to have further dialogue if any element of our review and response is unclear or causes concerns. We would always wish to cooperate fully with any initiative that reduces future deaths and as such are very much aligned to your responsibilities as coroner.

Thank you for bringing these matters to my attention.

Yours sincerely

[redacted]
Chief Medical Officer
Leeds Teaching Hospitals NHS Trust