GREATER MANCHESTER
POLICE

Ian Hopkins QPM, MBA
Chief Constable

Ms Joanne Kearsley
HM Senior Coroner
HM Coroner's Court
The Phoenix Centre, L/Cpl Stephen Shaw MC Way
Heywood
OL19 1LR

28 February 2019

Dear Ms Kearsley

Re: Regulation 28 Report following the Inquest touching upon the death of Gregory Rewkowski

Thank you for your report sent by email dated 3 January 2019 in respect of Gregory Rewkowski (deceased) and pursuant to Regulations 28 and 29 of The Coroners (Investigations) Regulations 2013 and paragraph 7, Schedule 5 of the Coroners and Justice Act 2009.

Having carefully considered your report and the matters therein, I reply to the concerns raised as follows:

Extract from Regulation 28, point 1:
There is a lack of acknowledgement of the role of the police when dealing with people who are taken on a Section 136 from their own home. The Court did not explore the numbers of Section 136 patients who are taken to a place of safety from their home address. The Court heard how Mr Rewkowski had been taken from his own home on the 17th September. Other agencies are clearly familiar with this process and how GMP facilitate this. However this was also used as an explanation as to why GMP may have been restricted in what they could do on the 27th and 28th October i.e. "...there is nothing we can do if we attend at his own home. We have no powers." There appears to be a significant difference between the legal position and the practical reality of how police deal with such matters if they are called to a home address. This inconsistency is causing confusion amongst other agencies.

Response: Had Mr Rewkowski been taken to hospital under s.136 of the Mental Health Act 1983 (MHA) from his home address on 17 September 2017, this would have been unlawful as the exercise of powers under s.136 requires that the person who is the subject of detention is not in their own home (s.136(1A)). When police attended on 17 September, Mr Rewkowski was, in actual fact, found to be in the street and so was lawfully detained pursuant to the police's s.136 powers as he was not in a private dwelling. This is confirmed within police documentation disclosed in the Inquest proceedings:

> **FWIN 170917/2257 and PPI/K003033680** (pages 47-55 of the disclosure bundle):
> *"Suicidal Male O/s Number 55. Male Violent And Aggressive. Rang In By A Passer By – [DPA]569 Male Has Tried To Hang Himself"* (FWIN page 1 at 22:18hrs when the incident was created).
> *"Ppa -Inft Stating Male Has Recently Been Released From Hospital - Male In Crisis Team. Currently Outside Number 42. Stating He Will Hang Himself But Has No Rope On*

Him. Inf Stating Male Did Attempt To Hang Himself 30 Mins Ago At Number 62" (FWIN page 3 at 22:27hrs).
"Tel [DPA]596 - Friend Of Grzegorz. 4. A Call Was Recived Regarding A Suicidal Male Who Was being Aggressive. When Police Arrived Grzegorz Was Aggressive And Obstructive. He Was Being Restrained By his Friend To Prevent Him Walking Off. He Was Placed In Handcuffs For His Own Safety And The Safety Of Others. His Friend Said That He Had Been At A Bbq With him And Said That He Wanted To End It All. He Left His Laptop At His Friends House And When His Friend Returned It He Was Making Preparations To Commit Suicide By Making A Noose With A Bedsheet And He Also Had A Kitchen Knife In His Hand, He Did Not Make Any Threat With The Knife. He Then Went Out Into The Street..." (FWIN page 5 at 04:03hrs).

It is accepted that there may be a requirement to improve the understanding amongst partner agencies about police powers in responding to concerns for welfare where the person in question is in a private dwelling. However, the police officers who gave evidence as part of inquest proceedings demonstrated that they had an accurate understanding of their powers – and the limitations thereon – under s.136. Where a concern for welfare is received in relation to an individual who is within a private dwelling, there is an option under s.135 of the same Act to require the attendance of qualified mental health practitioners to undertake a formal mental health assessment, following which it will be possible for officers to convey an individual found to require detention under the Act to a health-based place of safety. Again, the evidence would suggest these powers are broadly understood by the agencies who must apply and rely upon them. Notwithstanding this, GMP will give further consideration to how information as to its powers, obligations and restrictions may be better disseminated to other agencies as part of its joint working initiatives, so as to minimise the opportunities for confusion in future.

Extracts from Regulation 28, points 2, 3 and 4:

- *In this case GMP did not call NWAS and asked the nurses to contact NWAS. The Court heard evidence from the Deputy Sector manager for NWAS as to how GMP will contact them to attend concerns for welfare. This was not a process that PCT staff were familiar with. This also led to a delay in the call being made.*
- *Evidence was heard from the Inpatient Services Manager of PCT of their understanding, that the Police are the organisation to call in relation to concerns for welfare (regarding risk to life). The Court heard PCT are still advised the police are the contact. In addition this is the advice within the acute trusts.*
- *It was clear to the Court from all Senior Managers that there was a distinct lack of understanding across all three agencies of each agencies' roles/responsibilities, systems of working and current practices in relation to concerns for welfare involving risk to life (not immediate i.e. someone in the process of harming themselves). The evidence to the Court was of a confused picture across Greater Manchester with no clear guidance as to how to deal with such matters.*

Extract from Regulation 28, point 5:

The Court heard evidence there is no Mental Health Community Response team available to deal with mental health issues out of hours. The only out of hours service is in A&E which would necessitate someone attending there. Evidence was given as to the substantial increase in such issues being reported to GMP. The Court heard how there is now a mental health professional within the GMP control room to assist with the calls received. However the main issues are in attending to conduct face to face assessments. The police are the service who have a power to enter property, unlike other services. Therefore whilst they may not be best placed in respect of the assessment they are often called. Given the issue in respect of

resources heard throughout this Inquest the Court would question the lack of this Mental Health provision.

Response: The demands on public services to respond to the needs of people with mental ill-health are increasing. The rationale for advising the PCT to contact NWAS directly was explored in some detail as part of the Inquest. The reality, recognised by all agencies, is that increased demand for services means finding more appropriate and timely solutions to incidents, particularly if there are pressures on resources which are preventing one agency from providing a swift first response. However, GMP would accept that this requires the police to work more closely with other agencies to align services and ensure those on the frontline understand that services may need to respond in different ways in future, if we are to better meet the needs of vulnerable people who require support and assistance.

Unfortunately, it is not always clear-cut as to which agency will be best-placed in any given event to take the lead as this will depend on the facts of the situation. For example, the police may have powers to force entry to a property to protect life and limb, but that does not mean that it will be appropriate to call them in every instance, or that they are the best first port of call. It is recognised therefore that a substantial focus of joint working needs to be on ensuring that frontline staff across the board understand each other's roles and responsibilities and, importantly, how to access the most appropriate resource in a given scenario.

To that end, considerable work has gone into developing a more responsive and joined-up 'front end' to services, so that the caller requiring assistance gets the right help right away.

Control Room Triage

In 2017 North West Boroughs Healthcare NHS Foundation Trust were commissioned to deliver a pilot control room triage (CRT) service in partnership with Greater Manchester Mental Health, Pennine Care NHS Foundation Trust and GMP. This followed a successful business case for an initial 18-month pilot during which two mental health professionals would work alongside GMP staff within the Operational Communications Branch (OCB) 24/7, supporting the police and existing frontline services' response to mental health demand within GMP calls.

The service is jointly funded by 10 Clinical Commissioning Groups (CCGs) and the police and crime commissioner, with an inbuilt independent evaluation designed to review the effectiveness of the enhanced response and inform any future business case. The evaluation is being led by the Greater Manchester Combined Authority (GMCA).

The agreed service is provided by a team of 14 mental health professionals, including registered psychiatric nurses and psychiatric social workers. Team members are based in the vulnerability support unit (VSU) at Clayton Brook Operational Communications Room alongside GMP staff dealing with the 101 or 999 calls made to the police. The mental health practitioners have direct access to patient records held on each of the three mental health trusts electronic systems, summary care records and to information held on the GMP incident system.

The daytime CRT offer was launched on 22nd August 2018 and has been running 24/7 since 1st September 2018. Call handers and radio operators send incident records that contain a mental health element to VSU staff. The VSU staff assess the incidents and refer the call to the CRT staff in the following circumstances:

- Where the circumstances of the incident or attending officers suggest use of powers under s.136 MHA 1983 or voluntary attendance at A&E or a s.136 suite by the person in need of help;

- Incidents involving high risk missing persons where mental health is relevant to the circumstances in which the person went missing; and
- Any incidents where mental health is a dominant factor (with or without any associated crime report), which captures relevant incidents categorized as concern for welfare.

In addition, the CRT staff will advise on incidents where the provisions of the Mental Capacity Act 2005 (MCA) may be engaged.

The purpose of the CRT service is to support police officers by providing relevant mental health advice and adding relevant mental health information to the police log to support more informed decision making. The staff are able to provide real-time clinical advice to police officers. The staff can also re-contact callers to provide clinical advice, telephone support and onward referral where appropriate.

The CRT staff work closely with local services to transfer care at the earliest opportunity to the local care provider. The CRT staff communicate with existing care providers and GPs to ensure jointly agreed care plans and improve information sharing. The service will also contribute to approaches to address the challenges of repeated 'High Volume' users of emergency services, where mental ill-health is a factor.

The CRT staff provide a written summary of all contacts to the individual, their GP, and any health or social care services actively involved in their care.

However, it must be recognised that the most significant limitation on the service is the availability of CRT resources. The volume of incidents where a relevant person has mental health needs exceeds CRT capacity and this burden requires the VSU to act as a filter focusing CRT staff time to providing the commissioned service.

Communications

All partners in this vital service will have their own internal mechanisms for advising colleagues of the process and procedures for accessing the CRT resource. As far as GMP is concerned, this has involved a wide-ranging communication plan to ensure officers and staff are aware of the CRT team, their role and how to contact them, including:

- Placing an item on the weekly Chief Constable's Orders (CCOs), which all staff are required to read;
- Holding a joint CRT workshop with police mental health SPOCs from districts and front-line health professionals;
- Providing an electronic briefing pack to all front-line teams on districts, delivered on briefings via the electronic briefing system (EBS);
- Distributing guidance booklets across districts;
- Sending a text message to each frontline officer's mobile device with the dedicated CRT telephone number;
- Placing a feature item on the Force intranet at soft launch in August 2018;
- Publicising the official launch and placing further items and updates on the intranet;
- Posting a video about the CRT service on the Force intranet; and
- Sending emails to senior leaders on each district to cascade.

Monitoring and oversight

The GM CRT operational monitoring group is responsible for ensuring the effective implementation of the service. It has members from each of the stakeholders, who met weekly in the first weeks after the service went live and now meet monthly. In addition, rather than

waiting for the interim evaluation due in the Summer 2019, an internal review of the CRT has been conducted by GMP's external relations and performance branch (ERPB). This review focused specifically on incidents reported in January 2019 relating to s.136 MHA 1983. During this period there were 87 incidents coded as s.136 MHA; the CRT team were the leading NHS service on 56 of the incidents, with local RAID teams and NWAS involved in the other incidents.

This review has highlighted that there is still work required to optimise the use of the CRT service and this is informing a further series of communications and the current mental health training programme for frontline officers. This training, jointly delivered by partners and service users, is being rolled out as part of our CPD programme. By the end of summer 2019, over 2000 officers will have taken part in this training.

Given the high level of staff turnover our workforce development team has also commissioned a review of student officer training in relation to mental health and a revised content will be developed to reflect the CRT service and the material provided by the NHS in the frontline officer training described above.

The CRT service was not in place at the time of Mr Rewkowski's death. In similar circumstances now, for example where the subject of the concern has recently been detained by the police under s.136 MHA, the incident will be referred to the CRT team for assessment. The team members are able to access mental health records on recent admission, discharge and community care planning and on this basis co-ordinate services to ensure an appropriate response in terms of expertise and timeliness.

Further changes within GMP

The leadership of the OCB has also considered the Regulation 28 report and has identified areas where internal practice can be improved. Actions will be taken in the next three months to:

- Promote the work of the VSU and CRT in OCB and on districts;
- Review which staff have received up to date risk assessment training and address any gaps;
- Dip sample to ensure concern for welfare incidents where mental ill health is a factor are being properly assessed by call takers and referred to VSU; and
- Review incidents referred to the VSU to ensure the appropriate incidents are being sent to the CRT team.

Strategic Joint Working

More broadly, GMP plays an integral role in the Health and Justice Board and the various task groups that sit underneath the strategic forum. GMP officers met with representatives of the other agencies named in the Regulation 28 report and reached a common understanding on the areas of work that are required to address the concerns:

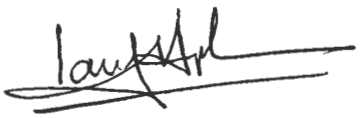
- A common understanding of the duties, powers and training of staff in the respective agencies in their response to demands for service from people with mental ill-health
- Improved information sharing processes through the development of the multi-agency 'Mental Health Control Room Triage' pilot service, jointly funded by NHS commissioners and district level multi-agency safeguarding hubs
- An agreed risk assessment framework, which takes account of increasing demand from reports of social media content and is applied by all agencies. It should address inconsistencies in the categorisation of incidents reported as concern for welfare and/or life at risk

- Agreed service levels for the assessed risk. In the short term through existing blue light services but in the medium term through increasing the capacity of first responders with mental health specialism – towards parity of response with physical harm
- Escalation procedures where agencies differ in their assessment of risk, or where they are otherwise unable to deliver the agreed service
- Access to adequate community mental health 'Crisis and Home Treatment Team' capacity for follow-up and discharge support out-of-hours (rather than inpatient staff) – especially for existing service users at higher-risk of repeated suicide attempts
- Effective communication with middle managers and front-line staff to ensure consistent service delivery and in particular that relevant front-line staff are clear about their responsibility to share information at the point of crisis and feel confident in doing so
- Enhanced inter-agency communications to ensure accurate reporting and evaluation of all assessments and actions undertaken by blue-light partner agencies – in response to calls about concerns for welfare or life at risk.

Greater Manchester Police will take a full part in the task and finish group that is being established to take this work forward. The Force is also is represented at senior level on the GM Health and Justice Operational Delivery Group and the Greater Manchester Health and Justice Board which will oversee progress on the joint work set out above.

I hope that this response is helpful in outlining the actions that we are taking to address the issues that you raised and in demonstrating our total commitment to learning lessons from tragic events such as those which led to the death of Mr Rewkowski, so that we can do our utmost to prevent such incidents from occurring in future.

Yours sincerely



Ian Hopkins
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