BRITISH TRANSPORT POLICE

29 August 2024

Dear HMC Hassell,

Inquest into the death of Mohammed Akramuzzaman – PFD Response

This is a response prepared by British Transport Police ('BTP') following a Regulation 28: Prevention of Future Deaths Report issued in the inquest of Mohammed Akramuzzaman.

The Prevention of Future Death report identified 5 areas of concern for BTP as outlined below.

1. *The officers left Mr Akramuzzaman after he had simply nodded that he was alright and shaken his head that he did not want medical treatment. They never actually heard him speak. They did not attempt to stand him up to see if he was able to support himself. I appreciate that if Mr Akramuzzaman had mental capacity then he could not be forced to go to hospital, but it is difficult to see how he could have been assessed properly following just a nod and a shake of the head.*
2. *The three station officers (one PC and two PCSOs) who attended Mr Akramuzzaman told me that they had placed great reliance on hearing a BTP response officer (one of three who had arrived just moments before the station officers) give an opinion over the radio that Mr Akramuzzaman was "coming round" after having taken drugs or alcohol. However, the station officers were themselves very experienced, and should have formed their own view.*
3. *The officers also eventually accepted at inquest that it was impossible to decide so quickly that this was a drug comedown.*
4. *It must have been a very cold night (it was minus 4ºC when he was found in the morning), but nobody went back to check on Mr Akramuzzaman later. I appreciate that a decision had to be made about what action to take there and then. But when I asked, BTP witnesses agreed that it would have been an easy matter for an officer on patrol later to check on a person in that situation. No consideration was given to that*

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by either of the PCSOs, by the PC, or by the sergeant who then took the decision to cancel the ambulance called earlier.

5. *I was told that the BTP officers had reflected a lot about this incident in the time since, and had learnt a lot. However, when giving their evidence they struck me as defensive, and they were unable to point to any specific learning or any changes in their procedures following Mr Akramuzzaman's death. Whilst I readily accepted that the officers had talked about Mr Akramuzzaman since his death, I did not gain the impression of a culture of learning. The sergeant told me that before the inquest, he had not known about the existence of ketoacidosis. The officers reminded me that they are not healthcare professionals. However, as I explained in court, I was not suggesting that they should have a particular understanding of ketoacidosis. Mr Akramuzzaman could have been suffering from any number of medical conditions. He could have sustained a subtle head injury. He could have had diabetes (which, as it happens, can also result in ketoacidosis). He could have had epilepsy. The list goes on. Mr Akramuzzaman did not need the BTP officers to be doctors in order to survive this episode, but he was probably already confused when officers dealt with him, and he needed them to make an appropriate assessment and to take appropriate action as BTP officers. The sergeant told me that he thought learning should be undertaken by BTP at an organisational level.*

Following the death of Mr Akramuzzaman, BTP referred themselves to the IOPC. A decision was made that the IOPC would investigate the actions of the officers and the officers were still under investigation when the inquest was taking place. This may have been a factor in why the officers appeared to be defensive when giving evidence before you.

The IOPC report provided the following recommendations for BTP.

The IOPC recommends that the British Transport Police (BTP) should explore opportunities to raise awareness of the Vulnerability Assessment Framework (VAF), outside of the Public Protection and Vulnerability training programme, to ensure that officers are made aware, and

regularly reminded, of how and when this should be used in respect of safeguarding vulnerable individuals.

In response to the IOPC recommendations, a force wide bulletin was circulated on 19 July 2024 to highlight the learnings identified as a result of this incident. This bulletin is exhibited to this response **[EXHBIT 1].**

The safeguarding of the vulnerable is a key objective for BTP and we have opted out of the national programme 'Right Care, right person' due to the increased vulnerability of people on the rail network. We are currently promoting our own 'Mental Health Crisis to Care' programme in force and have eleven regional single points of contact pulling this activity together. A force wide update was circulated on 7 August 2024 to provide an update on Mental Health Crisis to Care. This update is exhibited to this response **[EXHIBIT 2].**

Reflective practice has been provided to the officers involved in the incident. The officers have reviewed their understanding of BTP's safeguarding policy and legal powers under the Mental Capacity Act and Mental Health Act, and they have reflected on the comments made by the Coroner around making further checks on the male's welfare, which in hindsight would have required the ControlWorks log to have been left open. They have also reflected on their use of BWV and the importance of capturing everything. They have commented that they would look to be more persuasive in convincing subjects to get medical attention in future incidents.

The reflective practice was also provided to the IOPC who gave feedback as follows.

I would just like to feedback that the RPRP process here appears to have been very positive, with both individuals demonstrating genuine reflection and positive steps to develop their understanding of issues that were relevant in this case, as well as things that would be done differently if faced with a similar situation to help prevent another tragic outcome.

BTP trusts that this addresses the concerns of the coroner but if there is anything further that can assist, please do not hesitate to let us know.

Yours sincerely,

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[redacted]

INNER NORTH LONDON CORONER COURT
INQUEST OF MOHAMMED AKRAMUZZAMAN

BTP PFD RESPONSE – EXHIBIT 1

Mind the Gap: 19th July 2024

Following the death of a man in January 2024, it was concluded at the coroner's inquest that there was learning to be taken for BTP and we were issued with a Prevention of Future Deaths Regulation 28 notice.

What happened

The man had sadly passed away at a railway station from an alcohol related condition and hypothermia. He went into cardiac arrest having been outside all night in extremely cold conditions. Concern had been raised by a member of the public the previous evening and officers attended, but the man refused medical treatment and officers did not return. Medical care and a warmer environment could have saved his life.

Learn from experience

Officers should **always seek medical assistance** from an approved medical professional as soon as reasonably practicable. **Officers should not cancel any ambulance called unless the need for medical assistance has been rescinded** or a duty of care has been relinquished to someone else, for example a family member or friend meets the individual and arranges hospital transfer.

If a delay is anticipated in the ambulance response and you're advised by Ambulance Control that immediate transport to hospital is more appropriate, Police may use police vehicles to transport a person to hospital but only when authorised by the Force Incident Manager (FIM) and when the Control Works log has been endorsed.

If there's a suspected mental health related concern, officers should consult with the appropriate mental health pathway regarding options, one of which could be detention under section 136 of the Mental Health Act 1983 (England and Wales) or Section 297 of the Mental Health (Care and Treatment) Act 2003 (Scotland). For internal advice, contact our Vulnerability Unit.

For further guidance on how to look beyond the obvious in relation to someone's mental health, please take a look at the safe and well checks for police response by the College of Policing.

INNER NORTH LONDON CORONER COURT
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BTP PFD RESPONSE – EXHIBIT 2

We’re progressing with our Mental Health Crisis to Care project

The Mental Health Crisis to Care MHC2C project was formed to review our current vulnerability operating model and assess our response in attending mental health incidents.

You’ve routinely told us that you spend long hours in emergency departments and places of safety, you receive mixed support when requiring tactical advice and that you’d benefit from additional training. Now the appropriate approvals are in place we’ll delivering a two year programme of change and investment to ensure we can support you more when dealing with mental health incidents, whilst maintaining our duty to protect those in crisis and minimising disruption to the railway.

Over the next year you’ll start to see a difference in our Force Control rooms with the addition of Clinical Mental Health professionals within the Psychiatric Liaison Team (PLT) to enable specific patient advice, guidance and escalation assistance. The missing person portfolio will move from Public Protection to Public Contact with a revised policy and reduced to two categories (high or low risk). We’ll be adopting new technology to help aid Section 136 and Section 297 detentions which will improve the service for those in distress and will reduce the administrative burden for our officers by creating an improved handover mechanism, allowing for quicker handover times. To help develop you, look out for our new mental health and wellbeing training which will consist of new e-learning packages, a virtual hydra course, face to face inputs woven into our yearly first aid and personal safety training refreshers and webinars with the PLT.

We’ll be reviewing the activity over the first year and with the assistance from our Analysis and Insight colleagues, we’ll assess our demand data to ensure there’s been an impact before then looking to progress even further, starting off with an interactive map of available Mental Health services. Based on the data we’ll look to expand triage vehicles of a Band 6 mental health practitioner and an officer to locations reporting the most demand. We’ll also lower the Harm Reduction (HaRT) criteria from four presentations to three in eight weeks to bolster prevention work and incorporate both clinical supervision and police staff with mental health expertise within HaRT. There’ll be more focus on training with hydra training made available for frontline rail colleagues and additional guidance for those attending Coroners court and ensuring they can access a network of SPOCs across England and Wales.

Following the national launch of the Right Care Right Person model, the project team will continue to liaise with the National Police Chiefs' Council and College of Policing as well as our Home Office colleagues to build on our effective partnership working, contribute to the national agenda and raise awareness of our national jurisdiction.

To effectively monitor our ongoing response to mental health incidents, the below SPOCs are now in place across the force. You can contact your local SPOC by email with any operational queries, good news stories, or new ways of working