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His Majesty's Area Coroner Joanne Andrews
West Sussex, Brighton & Hove

By email: [redacted]

30/09/2024

Dear HMAC Karen Henderson,

Re: Inquest into the death of Miles Hurley

I write in response to the Regulation 28 report dated 9th August, issued after the conclusion of the inquest touching upon the death of Miles Hurley.

We are grateful to you for providing us with the the opportunity to respond to the concerns that relate to Sussex Police, and hope this response provides you, and Mile's family, with the information and reassurance that when concerns are highlighted, they are carefully considered and actioned as appropriate.

I address each of the Sussex Police related concerns below in turn (numbering follows those within the Regulation report):

1. Lack of effective communication between Police Officers

This concern arose when it appeared that there was no formal written handover of Miles' care whilst in custody.

Sussex Police adopts, and follows, the College of Policing Professional Practice guidance in relation to handover procedures. We have included this guidance to assist:

'It is essential that enough time is allowed for a full and effective briefing and debriefing between custody officers and staff when handing over responsibility for detainees, particularly at shift change over. This ensures that all relevant information is passed on and understood by the person taking over responsibility. If handover has to take place in or around the booking-in desks, the custody suite should be cleared of other personnel. Custody officers and other custody staff should carry out the handover together.

Officers and staff should communicate information verbally. Where CCTV exists in the custody area, handover should take place in sight and sound of an appropriate camera and microphone. If CCTV is not available, there should be written acknowledgement that all custody officers and staff have been fully briefed on the risks and needs on each detainee's custody record.

The information entered should include the risks, disabilities, medical needs, vulnerabilities, emerging issues, control strategies and welfare needs of each detainee.

It should also cover the status of each investigation, including the actions required to achieve effective and lawful resolution of the matter for which the person has been detained. The incoming shift of custody officers and staff must ensure that they are aware of all of this information.

Custody officers should ensure that rousing checks are completed on all detainees during, or as soon as practicable after, handover.

Where multiple custody officers are on duty, each must be aware of their individual duties and responsibilities and ensure that this information is recorded and kept up to date. Local force policy may provide clarity about who is acting as the designated custody officer for each detainee at any given time.

Current Sussex Police handover procedures

The Principal Sergeant within Custody is responsible for managing the custody centre, and has oversight of the safety, welfare and dignity of detainees in their care.

This is a responsibility that is taken very seriously and is carried out by an experienced and trained Principal Sergeant who is guided by the HMICFRS direction that *'it is incumbent on all police officers and police staff to ensure that information relating to threat, harm and risk is passed on to the appropriate officers and other persons responsible for the care and wellbeing of the detainee'.*

At the point of handover, the Principal Sergeant will refer to a handover document *(a copy of which is supplied at **Appendix 1**)* from which they will brief the oncoming team verbally. All members of the current duty team and the oncoming team will be present. They are each given a copy of the handover document which they can refer to during the briefing. The briefing is delivered by the Principal Custody Sergeant in person and is recorded on CCTV which is accessible at any time.

The handover document is a live document which is updated by the Principal Sergeant throughout their shift. The document contains a summary of each detainee, highlights risks and mitigating actions, including engagement with Health Care Professionals, and Liaison and Diversion (LDS) Nurses in Custody.

The document is saved in a shared drawer on Sharepoint and is accessible to all custody staff on duty. Following handover briefing a new document is started by the oncoming shift to ensure that there is an audit trail.

New Custody Officers are familiarised with the process during their initial training/ mentoring. The quality of the handover document is peer reviewed at the point of handover to ensure it captures the necessary information. The verbal briefing provides the opportunity for any questions to be asked, or clarification to be sought, by the oncoming shift in addition to what is recorded on the handover document to ensure a full understanding of the risks and background of each detainee.

2. Lack of relevant Documentation by the Police

During Miles' custody, his family raised their worries about his deteriorating mental health with officers and other partners. The inquest found that although this was generally passed on and known about by the custody staff, there was no formal record of these concerns. We hope the information provided below assists with understanding how such concerns are now recorded.

Sussex Police follows guidance contained within the College of Policing APP 'Detention and Custody Risk Assessments.'

A Custody Officer (Sergeant or Detention Officer) will complete an Initial Risk Assessment of the detainee on arrival and a Pre-Release Risk Assessment on their release from Custody. In every case a Care Plan is created to mitigate identified risk(s).

The Risk Assessment and Care Plan form part of the Custody Record and are accessed via NICHE (our central recording system). NICHE is set up to automatically create a new Care Plan whenever a review of the detainee's welfare takes place. Regular reviews are completed throughout a person's detention to ensure that new information or a change to their physical or mental health is recorded and responded to. Information received from families (such as in Miles' case) will now be added to this care plan to ensure a record is kept.

Detention Officers will carry out regular welfare checks in accordance with the Care Plan and note the outcome of those checks on the Custody Record. They verbally update a Custody Sergeant regarding a change in risk, in addition to noting that change on the custody record.

Liaison and Diversion Nurses (LDS) work in Custody between the hours of 08:00hrs and 20:00hrs. They have access to NICHE and their own portal and will proactively triage detainees in Custody. They will provide advice and guidance to the Custody Sergeant regarding the risks associated with an individual in Custody.

Health Care Professionals (HCP) work in Custody and are available 24/7. They will contribute to a detainee's Risk Assessment and Care Plan on request. They will provide advice to Sussex Police Custody Officers regarding the risks associated with an individual in Custody, their Care Plan and their Release Risk Assessment.

LDS Nurses and HCPs have access to NICHE, enabling them to both review existing information and add additional notes. They update the Custody Record directly and will record the relevant points around risk and their recommendations on the Custody Record.

A standard Pre-Release Risk Assessment is used to identify risks that may be presented to an individual upon their release from custody. The template is on NICHE *(See Pre-Release Risk Assessment,* ***Appendix 2****).*

If we consider their release to present a risk to their wellbeing, then we will ask the HCP to complete a Fit to Release Risk Assessment. The request is made where the physical or mental health of a detainee has changed. MITIE Healthcare are contracted to complete the Fit to Release Risk Assessment. In that risk assessment detention under S136 Mental Health Act 1983 may be considered.

A Child to Notice form will be completed by the Investigating Officer in all cases where a child or young person has been detained in Custody and shared with the local authority.

In the case of a Vulnerable Adult a Vulnerable Adult Referral will be completed by the Investigating Officer and shared with the local authority.

3. Lack of effective documentation and communication between the Liaison Diversion Service (LDS) and the police within the custody suite.

The Liaison and Diversion Service is provided by Midlands Partnership Foundation NHS Trust. At the time of this incident the service was provided by Sussex Partnership Foundation NHS Trust.

Health Care Professionals are employed by MITIE Health Care.

LDS Staff and HCPs are co-located with Police Custody Officers in each Custody Centre.

LDS Nurses will proactively triage detainees listed on the Custody White Board between 08:00hrs and 20:00hrs. This is a virtual white board accessed via NICHE which LDS nurses can independently access at any time. It contains details of all detainees in each Custody Centre. A Professional Discussion will be held between the LDS Nurse and Principal Sergeants to identify assessments that may need to be prioritised.

During LDS operating hours Custody Sergeants will verbally flag risks or concerns to them around the physical and/ or mental health of a detainee as soon as reasonably practicable, but generally at the time of booking in. LDS will also consult their Health Care Portal and raise any issues to the Custody Sergeant. Any concerns or risks discussed will be recorded by the Custody Sergeant on the Risk assessment and care plan within the custody record.

LDS Nurses can only see a detainee with permission from the Custody Sergeant. Generally, LDS will also make an entry on the CR Detention Log themselves and they will bring any concerns/ considerations to the attention of the Custody Sergeant so that their care plan can be reviewed in accordance with new information.

4. Memorandum of Understanding between Midlands Partnership University NHS Foundation Trust, Sussex Police and Mitie

The draft MOU provided left concerns from you that it did not adequately address the practical issues facing the LDS and police to ensure appropriate management of mental health assessment and ongoing care whilst an individual is in custody.

The concern raised goes on to say:

there is an absence of local or national 'Standard Operating Procedures' or guidelines as to when to obtain a mental health assessment if an individual is intoxicated, a lack of formal documentation procedures, or steps to be taken to encourage further sharing of available information".

We have reviewed the current operating procedures and guidelines regarding when to obtain a mental health assessment if the individual is intoxicated, and the following provides the process and/or gives guidance to Sussex Police:

1. Officers and staff in custody are required to record identified risks and control measures, per PACE Code C, paragraph 3.8.
2. The custody officer is also responsible for the detainee receiving appropriate clinical attention. If a healthcare professional is required, the custody officer shall ask their opinion on risks/problems, when to carry out an interview and safeguards per PACE Code C, paragraph 9.13.
3. There is APP Guidance from the College of Policing on detention and custody risk assessments (**appendix 3**)
4. There is APP Guidance on alcohol and drugs (**appendix 4)**
5. There is APP guidance on mental vulnerabilities and illness **(appendix 5).**

The APP guidance is therefore clear that:

- Decision making concerning health care matters should be made by clinically trained professionals and not police officers;
- Officers and staff must risk assess detainees throughout their detention; and
- Officers must always consult a health care professional in prescribed circumstances regarding those who appear intoxicated.

We have very carefully considered the need for a MOU between the operating partners, reviewed the guidelines already in place, sought independent legal advice to assist with our decision making and assessed whether an MOU could assist. We have concluded that we do not believe it is the correct approach in the circumstances.

We believe creating a MOU would be a disadvantage due to it codifying, in a separate document, procedures that are already stated in National Guidance. This could be problematic should the National Guidance change and/or there could be a perceived conflict between the existing guidance and the MOU.

We understand that this is a different position to that taken during the latter stages of the inquest and we do hope we have explained why. Changes to guidance could not be adopted as quickly by Sussex Police should a MOU exist and we would prefer to work

closely with our partners in a practical and realistic way, addressing concerns as they arise as opposed to being led by a MOU that could quickly become outdated.

I hope the additional information provided herein reassures you that your concerns have been addressed.

As an organisation, we remain committed to learning and improving our processes wherever we can and please do let me know if I can be of further assistance.

Yours Sincerely

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A/ACC Local Policing