HOUSE OF COMMONS

Home Affairs Committee

Oral evidence: Policing and mental health, HC 202

Tuesday 1 July 2014

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Written evidence from witnesses:

- Revolving Doors Agency
- INQUEST
- Black Mental Health UK

Watch the meeting

Members present: Keith Vaz (Chair); Ian Austin, Nicola Blackwood, Mr James Clappison, Michael Ellis, Paul Flynn, Dr Julian Huppert, Yasmin Qureshi, Mark Reckless, Mr David Winnick.

Questions 1 - 87

Witnesses: **Matilda MacAttram**, Director, Black Mental Health UK, **Dominic Williamson**, Chief Executive, Revolving Doors Agency, and **Pat Kenny**, Member of Revolving Doors' National Service User Forum, gave evidence.

Q1 Chair: This is the Committee's first session in our major inquiry into policing and mental health. Could I ask any Members present to declare any interests that are not already in the Register of Members' Interests?

Could I welcome our witnesses today, Matilda MacAttram, Dominic Williamson and Pat Kenny? This inquiry is probably due to last a few months. It will certainly go over the recess period. We are very glad that you could join us for the first session.

I should say that there will be a vote during your evidence. When there is, I will adjourn the Committee but we will come back if members still have questions to put to you.

Can I begin with a question to each one of you about what is regarded as a crisis in the mental health system? It was the outgoing president of the Royal College of Psychiatrists, Professor Sue Bailey, who said as recently as 27 June that the mental health system is in crisis: "It's a car crash waiting to happen." Do you agree with that, Dominic Williamson?

Dominic Williamson: That is a big question. I think there is an awful lot of pressure on the system. There is pressure coming from lots of different points—not just funding and the availability of beds in the secondary mental health system but lots of other pressures in society more generally—that point to a potential for some significant increases in the level of unmet need within the community. Whether I would call it a car crash or not, I don't know.

Chair: Pat Kenny, is it a crisis? Do we need to act quickly or is it not a problem at the moment?

Pat Kenny: Car crash—I think the paramedics are on the way to the scene right now. Across the board mental health is in deep crisis. Mental health is taking the backlash of all the cuts going on at the moment.

Chair: Matilda MacAttram?

Matilda MacAttram: Car crash waiting to happen. For the communities that Black Mental Health UK has been set up to serve, it was beyond a crisis, I think, at the point of the "David Bennett Inquiry Report". What we have now is a community in which every family has a relative touched by this and the fear of how they will be treated at the hands of the police and the system. It is beyond crisis.

Q2 Chair: The concern for this Committee of course—we are not the Health Committee—is we are specifically looking at the criminal justice system and the intervention of the police. That is what I want to ask you about first, Mr Kenny.

Do you think that the police are adequately trained to deal with those with mental health issues? Do you think that they need more training? Why do you think it is that so many people with mental health issues end up in custody and then eventually in prison?

Pat Kenny: From my own experience, my belief is that the police are ill-equipped to deal with it because they are not aware of the circumstances. They come across somebody in crisis and they automatically assume it is due to alcohol consumption or substance misuse. When they do realise your issues, they berate you, belittle you, handcuff you and criminalise you for having a mental disorder.

Q3 Chair: Is it because they do not realise that the person is suffering from a mental health disorder? If they did, do you think that their attitude would be different?

Pat Kenny: Not really. When I have been admitted to A&E I have found even they don't know what to do. So if the professionals like them can't do it, I can't expect the police to step up to the mark.

Q4 Chair: Mr Williamson, this is a wide area and colleagues will have other questions but tell me specifically about the intervention of the police. Obviously there is a concern. What do you think is the way to deal with this concern?

Dominic Williamson: The police are the one frontline public service that is there all the time in the streets dealing with the issues. We can either focus on whether the police have got the right response or we can focus on why people in mental distress, with the complex problems they often have, are left without any other part of the public system providing the kind of help and support they need.

While I think the police are always inevitably going to be the first on the scene—and I absolutely agree with Lord Adebowale saying that mental health is core police business—the real question is how we make sure that our public services are reaching out to people, providing crisis care to people and supporting people effectively in the community, so the police do not have to be our first aid response to mental distress.

Q5 Chair: Matilda MacAttram, the police themselves have said—and I have heard it for myself at the Police Federation conference earlier this year—that they do not really want to get involved in these issues but they are forced to get involved. What is the intervention point for the health professionals?

Matilda MacAttram: Police intervention when somebody is in need of mental health care is an indication of failure of statutory services. In my submission at point 14, I have made it very clear that the way that people from the UK's African Caribbean community come into contact with the police is when they are in crisis. When they are in crisis it is because many other parts of the system have failed.

From the perspective of the stakeholder groups that Black Mental Health UK has been set up to serve, we see that the police have no place when it comes to mental health care. In light of cases like Leon Briggs, Sean Rigg, whose family members are in the room, Olaseni Lewis—we could go on and on and on, the cases go back almost three decades—we are very clear we want nothing to do with them, because when black people come into contact with them, lethal levels of force are too often used.

Q6 Chair: Is this irrespective of whether they identify the person as being someone who is mentally ill or has mental health issues, or is this just generally? You are making the general point, are you?

Matilda MacAttram: A clear case of that would be Olaseni Lewis who was detained under the Mental Health Act. I think all Committee members are aware of the fact that no one needs to use 15 people to restrain one person for 45 minutes. I don't know why that level of force would be used. From our community's perspective—knowing these cases, which resonate very clearly and strongly with them because these people look like their relatives—they do not want people who would do that to a loved one to come anywhere near them.

Q7 Chair: If you were looking to change the system—and we are not asking for instant solutions; we are just starting our inquiry; you are the first witnesses—what is the one thing you would change at the time of police intervention, right at the beginning?

Matilda MacAttram: There have been many inquiries. This is a 30 year old issue when it comes to the UK's African Caribbean communities and there are some good recommendations in the David Bennett inquiry report, the Orville Blackwood report. They repeatedly say that community-based early intervention is what is needed. People do not just have a crisis. Many things have failed before they get to that point. The community agencies we work with have told us that when they identify someone who begins to become unwell they contact statutory services who tell them, "Call the police." That is the default response. We know what works—

Q8 **Chair:** Whereas they should be calling for help; they should be going to their health professionals.

Matilda MacAttram: Without a doubt. They should not have to wait until somebody reaches a crisis point before they have help. If they are showing signs of deterioration, help them then.

Q9 **Chair:** Mr Williamson, do you accept that, the fact that people have to call the police in the first place shows the failure of mental health services?

Dominic Williamson: People are always going to face mental health crises in our society, that is just the nature of mental health. There are two things, though, aren't there? The first is: are people who are already known to the system getting the right care in the community when they are plugged into the system? There is another group of people who my organisation are particularly concerned with: the people whose mental health often is below the threshold for secondary mental health care and often have other multiple and complex needs in the mix. They might be facing issues around alcohol and drug addiction and homelessness as well as the mental health issues—all those complex needs that people have. From our point of view, lots of the people who end up in the criminal justice system have that combination of needs. So we have to be a little bit careful about just assuming this is about fixing the mental health system, fixing the police system, and bringing those two bits together.

There is a bit of evidence that has come out very recently from Plymouth University—a study to be published very shortly that looked at the incidences of section 136 across Cornwall. It identified that nearly half of the people who were picked up by the police under section 136 were picked up and arrested as well within the next 12 months. So there is a significant overlap between people who are picked up in those different ways by the police, and often that decision can be quite a knife-edge between using section 136 and using the criminal justice system, which is why we welcome the improvements that there have been in the criminal justice system around mental health, such as liaison and diversion, which I hope we will talk about.

Chair: Mr Kenny?

Pat Kenny: Personally I have been under section 136 on several occasions and I have been dealt with in very different ways on each occasion—anywhere from being taken to

hospital, taken to a police cell, put in the back of a police wagon, to being tasered. Prevention is better than cure. There should be communication across everyone from the health service to the police to local government, because at the end of the day they pass the buck and there is no aftercare, no follow-up and you just slip through the gaps again.

Chair: Very helpful.

We are going to adjourn before Mr Ellis starts because there is going to be a vote shortly. When we return Mr Ellis will start the questioning. We will adjourn for 15 minutes.

Sitting suspended for a Division in the House.
On resuming—

Chair: The Committee inquiry is resumed.

Q10 Michael Ellis: Thank you, Mr Chairman. Ms McAttram, could I come to you first? It strikes me—it has struck me as I was involved in the criminal justice system for some time before being elected to this place—that there is an over-representation of African Caribbean people first of all in the criminal justice system full stop, but also in the coercive element of psychiatric care. Would you agree with that assessment? Do you think that there is an over-representation and how do you think we can ameliorate that situation?

Matilda MacAttram: The data does show that a disproportionate number of people from UK's African Caribbean communities are subject to detention under the Mental Health Act and have poorer outcomes. How can we ameliorate that? There have been a number of reports. The David Bennett inquiry report published in 2005 made recommendations. Had those recommendations been fully implemented, the perspective of Black Mental Health UK would be that you would see fewer people from the communities that Black Mental health UK has been set up to serve at the coercive end of psychiatric care. In our submission we have mentioned that it is community-based, culturally-appropriate, culturally-sensitive early intervention that will stop people who may need care going into the system and then not coming out again.

Our concern when people are in the system is the kind of treatment they get. When it relates to policing and mental health, one of the things we have raised in point 6 of our submission is the presence of police on psychiatric wards, which raises quite serious concerns under UN treaties because this is a vulnerable group. We have the Convention for the Rights of People with Disabilities, and even in the UK's Mental Health Act there is a principle of least-restrictive measures, yet what we find with this group is that the most restrictive or the most coercive kind of treatment and care is the default. So amelioration would be meeting people at the point of need, not at the point of crisis, so that is about resourcing the kind of services that understand this group and do not pathologise cultural norms and values, which I have also mentioned in the submission.

One thing that it might not be very comfortable to mention, but I think it is really important—that is point 3 in the submission that I have made to the inquiry—is the fact

that the Macpherson report highlighted the discrimination of institutional racism within the police and that might be a factor in the large numbers of people in the criminal justice system. If you are more likely to be stopped and searched or stopped then you are more likely—so it is a gateway. The David Bennett inquiry highlighted the same sort of discriminatory practices going on in psychiatric services, and now we are having a convergence of the two, or a recognition in Parliament of the two services, and this issue does need to be addressed in order to see a reduction.

Q11 Michael Ellis: Hopefully that is what this Committee's inquiry will address. That is really what I wanted to ask you—whether you see a convergence between effectively those reports, related to Macpherson, for example, and also to psychiatric care. Do you feel that there is discrimination within the psychiatric system that leads to a more extreme form of care, perhaps psychiatric detention, on improper bases?

Matilda MacAttram: One of the reference I make in the submission is the perception of race, and in the Orville Blackwood report, which is all to do with somebody who was in a health-based setting but it is relevant, that inquiry showed that race, as far as healthcare professionals goes, is an index of dangerousness. The report into his death was entitled "Big, Black and Dangerous". So somebody from the African Caribbean community, based on their physical appearance, is perceived to be more dangerous maybe when they are having a breakdown than somebody who might be, say, in their teens, white and female, who is having the same kind of mental health problems. The perception determines the label and also the treatment.

Q12 Michael Ellis: Okay, thank you. Could I just ask a question on a slightly different theme, but it follows on from that? Perhaps, Mr Kenny, you could address this, which is, looking at it from the angle of police, because, as I think you have already said in answer to questions by Mr Vaz, even medical professionals sometimes have not addressed the issues of mental health, in your experience, to your satisfaction. What can we expect of our rank and file frontline police officers, who make no pretence I am sure of being medical professionals, and who have an immediate assessment to make, perhaps at the scene of an ongoing incident, to deal with a situation commensurate with their duty to protect the public and prevent the commission of crime? Are we not asking and expecting a great deal of police officers? Is that reasonable?

Pat Kenny: Yes, I agree with that. If the healthcare professionals cannot take over, you have to expect the police to. But that is my point from earlier where communication, working together, can be the best way forward.

Q13 Michael Ellis: Okay. You think there is a way of achieving the desired end?

Pat Kenny: I have been hospitalised in mental health units and basically they have what they call nursing assistants—for all I know they do not even have a first aid certificate—and their first way of dealing with a crisis situation is going heavy-handed.

Q14 Michael Ellis: It is about training, is it, training and experience?

Pat Kenny: Yes, because I find with a lot of people I know who have been through the mental health system is they will go away and they will self-harm on their own, deal with their own wounds; they will not present themselves for medical treatment whatsoever and they have just fallen through the gaps.

Chair: Thank you, Mr Kenny.

Q15 **Mr Winnick:** Mr Kenny, if I can follow up one or two questions, because you have been somewhat involved with the campaign and you have personal experience of being held and apprehended by the police. Were you physically restrained by the police and, if so, what was the experience?

Pat Kenny: Well, I have been handcuffed with gaping wounds on my arms. Being a bit of a Houdini, I have a knack where I can get out of handcuffs, so I get berated for it, Alan keys come out and with gaping wounds on my arm I have had handcuffs put on at the tighter settings. Then I am held outside hospitals where I am continually berated by the officers and I am left waiting 12 hours before I get any treatment.

Q16 **Mr Winnick:** The point has been made to us, and we will hear more I am sure, that where someone has been sectioned they should be transported in an ambulance rather than a police vehicle. Indeed a couple who will be giving evidence over the tragic loss of their son feel very strongly about this. What is your view about this?

Pat Kenny: Well, I mean I was in a state of chaos, so on one hand I cannot blame the officers for their approach, but at the same time they shouldn't have been berating and belittling me. I felt like a criminal.

Q17 **Mr Winnick:** Basically, Mr Kenny, do we take it that your view is that the police, even now, have little understanding of those with mental health difficulties when it comes to apprehending them, as they obviously must do in some circumstances, for safety and indeed the individual safety of the person concerned? Are you saying to us that, despite what has happened in the past, the police have a great deal to learn about how to deal with these situations?

Pat Kenny: Yes. Education is everything. They join the force and they are trained in first aid, but they have nothing about mental health first aid.

Q18 **Mr Winnick:** Is it a lack of sympathy, do you think, on the part of the police officers or simply a lack of understanding?

Pat Kenny: I believe it is a bit of both, because when I am presented to A&E I am looked down upon by A&E staff because I have self-inflicted the wounds.

Mr Winnick: Thank you very much.

Q19 Dr Huppert: There is another issue throughout the health system about how little awareness there is of mental health. I think it is astonishing that GPs, for example, do not have to do a mental health course, but that is another issue. Can I ask about the section 136 detentions in general? I have questions to all three of you if that is all right. First, Mr Williamson, in your evidence you talk about how the people who are detained under section 136 are mostly then just released with no further action, no treatment and no support. Can you talk us through what happens to such people and what you think ought to be happening?

Dominic Williamson: There is a limit to what we know because the data is fairly limited about it. We know that in 2012-13 there were 21,814 uses of section 136; that is 60 a day across England. We know that, across the country, 34% of those were taken into police custody, so the rest would have been taken to a hospital-based place of safety. However, the joint CQC-Her Majesty's Inspector of Constabulary's report found a range between 6% and 76% in the numbers that were taken into police custody compared to a hospital-based place of safety, so there is a huge range in what is happening across the country.

Secondly, we know that of those taken to hospital, 17% are detained—further detained, under the Mental Health Act. So just 17% of the people that are taken in. What we do not know is what happens to the rest of those people. Some of them will obviously get some kind of follow-up. A proportion may not get anything. There is a real lack of information. We think there needs to be a much greater focus on looking at the immediate and the longer-term outcomes for people who are detained under section 136. We need to track people in the short and medium term to make sure that those people, even if they are not detained in hospital, are getting some kind of support or intervention. It is not acceptable that we do not know what happens.

What we do know is that some of those people then come around the system again and may be detained again under section 136. The study I mentioned from Cornwall found that some people were repeatedly detained under 136, so this is not a one-off life experience for some people. As I mentioned earlier, some of those people will show up in police custody on arrest at a later date.

Q20 Dr Huppert: Just to be clear, your first plea is for better data about what is happening to these people?

Dominic Williamson: Better data about the outcomes and better monitoring of the outcomes.

Q21 Dr Huppert: The second is that there should be intervention for everybody?

Dominic Williamson: If the police are picking somebody up because they are so concerned about their mental health that they are going to detain them and take them to hospital, it is not acceptable for people to be just then be left, if they are not admitted into the mental health system, with no intervention or no support. So we need to see that as an opportunity, even if it is not something that triggers a secondary mental health intervention, but we use that as an opportunity. That should in some cases be primary care.

Q22 Dr Huppert: Thank you very much. Ms MacAttram, I think in your evidence you talk about the use of police cells as a place of safety under section 4. One of the things you specifically say is we should be aware that health-based section 136 suites that statutory health providers have publicly stated are being run as an alternative are not in operation. Can you say a bit more about that?

Matilda MacAttram: Yes. We conducted some community engagement events post the Sean Rigg inquest verdict, because it is a very high-profile case and resonates with many people across the community, but particularly across the UK's African Caribbean communities. We understood there was very little confidence in the service the provider responsible for this individual's care had, so we held some community engagement events and at those events—the police were in the room as well—we were told that in the area of Croydon that there are community health-based places of safety. Somebody who has a relative who has broken down more than once said, "It is there but it is not open." So when their relative gets picked up the police will initially take them to a health-based place of safety, because that is what the police now have an understanding they need to do, but if it is not open, they are either staying in a car or going into custody.

I know the CQC has published a map of health-based places of safety, so we now know where they are available in the country, but one of the issues has to be staffing. If health providers are saying they are providing crisis care, there has to be a clear understanding that people do not have crises between 9.00 am and 5.00 pm; they need to be open and staffed 24/7 if they are to meet the need of this group.

Q23 Dr Huppert: So when you say this place in Croydon, for example, is closed, what you mean is that it is only open for some hours, or it is often closed?

Matilda MacAttram: The person was hushed up. The understanding was the place exists, the physical place exists, but without staffing. If it is not open then it is meaningless.

Q24 Dr Huppert: But is it that it is never open or it is only open between particular hours?

Matilda MacAttram: It had not been open for a period of time. It might be open now, but it had not been open for a few months. So it exists on paper, it exists physically, but it is not being used because it is not being staffed, it is not being resourced.[1]

Q25 Dr Huppert: Leaving people in a car certainly does not sound very helpful at all. Then, Mr Kenny, if we can come back to some of the questions that you were asked earlier about the experience of being tasered, how concerned are you about that? Have you seen more use of tasers and have you looked into any of the figures about how they are being used, how the records are kept of the need for that? I do not know if you have an answer to all of that.

[1] Note: Please see letter from South London and Maudsley NHS Foundation Trust, 23 August 2013, para 3: https://www.whatdotheyknow.com/request/170768/response/423244/attach/3/FOI%20response%20DMery%20136FOI%20130823.pdf

Pat Kenny: I have paperwork I will dig out for you later on the use of tasers. For example, for myself, I was bleeding profusely from my arm, I had the razor blade at my throat, and the jolt from the taser could have done my job for me; it was just lucky it went that way. I know they did try to calm me down and that. If I could come up with a better way of dealing with it I would tell you in a heartbeat, but straightforward taser use is not the way forward.

Q26 Dr Huppert: So you are definitely seeing more of it? This other paper that you have, is that evidence on how they are used more broadly?

Pat Kenny: Yes, it is the stats of how often they have been used.

Dr Huppert: I think it would be helpful if you could pass that on the Committee after this. Thank you.

Chair: Thank you, if you could do that, Mr Kenny, we would be most grateful.

Q27 Nicola Blackwood: I just wanted to follow up and ask a little more on section 136 and particularly the legislative basis. I just wonder if you think that it needs legislative reform in order to improve the response, because even though taking an individual to a place of safety in a police station should be a last resort, it does seem to be that nearly a third of individuals are ending up in police stations. I wonder if you think it is the legislation that needs reform, or it is the way the powers are being used that needs reforming. Perhaps you could start, Mr Williamson.

Dominic Williamson: I would agree with the CQC recommendation about it. In the legislation at the moment, it says that you can use police custody as a place of safety; in the guidance, it says that it should be in exceptional circumstances, and there is a call to put that on to the face of legislation. So at the moment it is guidance only, so police forces only have to have regard to it. That would be one change.

The other change would be that you stop police using police custody as a place of safety altogether. That is a lot more difficult as things stand because, as we have heard, the health-based places of safety often are not available in the local area. I guess what you could look at is whether you would want to put that into the legislation within a timeframe, which would allow local areas to put those health-based places of safety into place. That would very much depend on the local commissioners—the decision-making really is delegated down to local areas CCGs and the local commissioners of mental health services and therefore the health-based places of safety. You are very dependent on them recognising the need and making sure there is a 24-hour, seven days a week, fully-staffed place of safety available. The question is whether you want to put legislation in place before that is available, or whether you see the legislation as forcing the hand of those commissioners to ensure that they do put that in place. Nobody wants to see people in mental distress taken into police custody, but as things stand, I think we would agree with the CQC that would not be helpful immediately.

Q28 Nicola Blackwood: Ms MacAttram, do you agree with Mr Williamson on those points, but do you also think that there is a role for the third sector to step in, given the experiences that you have had with finding that some of the places of safety, which are on the map, are not even open?

Matilda MacAttram: First, we welcome the current review that the DH and Home Office are conducting on police section 136 and 135 powers. There is a consultation out at the moment that is looking at this issue, and our perspective is that crime fighters have no place in dealing with people who need healthcare. What we find more often than not is vulnerable people are criminalised by this process and it is very traumatic for them. As far as your question regarding the third sector goes, that is the solution I think. Early intervention and community-based places where people can go when in crisis and get the kind of care that they need, where their cultural norms and values are not pathologised, and where they do not run the risk of entering into a system, which they cannot get out of again, is definitely the way forward.

The current practice contravenes the Convention of the Rights of People with Disabilities. The treatment that Pat Kenny described violates article 15 of the CRPD. Right now what we are seeing is that routine human rights violations have become the norm within certain health providers and police. Just because it is happening does not mean it is right.

Q29 Nicola Blackwood: No, but looking for some practical solutions, because we have to come up with some recommendations, I am trying to find out how you could possibly find alternatives to police detention. Because clearly you have police being called to a site, trying to contain a situation, and looking for a place of safety to take an individual to, and not being able to find one. I am trying to come up with suggestions.

Dominic Williamson: There are alternatives now being developed. I think you will hear, if you have not already, about the street triage services. Early indications from those show that they are reducing the use of section 136. Very briefly, that is putting mental health professionals in the car with the police officer responding to a call around mental health, or in some models it is having somebody with mental health experience placed in the call centre so they can advise all the police on the patch around that. One of the really important things about that is having access to mental health service information about individuals, so very quickly they can determine whether that person is under the care of the mental health system and what alternatives might be in place. That person may already have a crisis care plan in place, which they can activate as an alternative to being picked up by the police and taken to a health-based place of safety. There may be things you can do with legislation, but there is a lot can you do in practice.

Q30 Nicola Blackwood: There is more you can do in practice. One of the points that Mr Kenny made was that there was no aftercare or follow-up following the use of a section 136. I just wonder if you thought that there were some measures that could be brought in around that specifically to make sure there was onward referral to perhaps community-based projects, and also whether you had any engagement with police and officers in your own area to communicate back some of your experiences with officers and to try to improve training in that way.

Pat Kenny: Last time that I was under section 136 was back in 2011. What happened was I was taken to hospital by the officers, treated and then discharged within 12 hours. The next follow-up I had was from a hypnotherapy group in the NHS. I was interviewed, accepted, and I am only starting that next month—waiting lists. Perhaps the officers would like to follow up and say, "Deal with this, it needs doing. We do not want to be dealing with it again," but the waiting lists out there are just too long.

Q31 Nicola Blackwood: Is it your impression that is the same across the country, because you are in Camden, are you not?

Pat Kenny: I believe so, yes.

Q32 Mark Reckless: The Government is piloting various initiatives to try and get the police and health service to work more closely together, so there is street triage and liaison and diversion services. How do you assess those? Are they working?

Dominic Williamson: What I should say, not necessarily to declare an interest, but just mention my involvement in this. Revolving Doors is contracted to support the Government in rolling out liaison and diversion services, so we have been very closely involved with the development, working with NHS England, of the national operating mode.

Q33 Mark Reckless: So how is it working?

Dominic Williamson: The new operating model is being tested in 10 local areas. NHS England, which is the commissioner of those services, has clear plans to extend those out to 100% coverage by 2017, subject to business case, and I think this is a really important bit of this. Next autumn, the Department of Health and NHS England have to present to Treasury a new final business case for liaison and diversion and that will be based on the learning and the evidence base from these 10 sites that are being delivered at the moment. The 10 sites are now all operational. They are schemes where, in all cases, there was already a scheme operating, but they are transforming from where they were before, which was quite a limited service, into the operation of the new national model.

There are a couple of very important things about the new model. One is that it is for all age groups. In the past, we had adult sites or young person sites. If you were in one area you might be lucky if you were a young person and you could get help from a young person's diversion service; elsewhere you might not. So the new sites are for all ages. The other thing about the model that is really important is it is not just about mental health on its own; it recognises that people have a mixture of needs and it has a core and extended team approach. Within that team working in police custody, there may be drug workers, there may be housing workers, there may be other voluntary sector organisations from the local community supporting the work in police custody and courts to make sure there are pathways. So the old model might have been about identifying

severe mental illness and getting people into hospital, whereas this is much more about recognising that people have lots of different things going on at the same time and making sure they get a proper pathway into the community.

It is early days in terms of the new model, but we think that it is very promising and the early signs are that it is working.

Q34 Mark Reckless: Do any of you have any experience of the street triage pilot? Is that something any of you have come across?

Matilda MacAttram: I am aware of the street triage, but just on the liaison and diversion and the 10 pilots that you have mentioned, I think it is important to note that, even with the pilots, we were informed in Lambeth of the fact that the nurses had their hours cut back, so they were only part time. To hear that this is going to be rolled out when, at the moment, the pilots are in the demographic where detention rates under the Mental Health Act are the highest in the country, from the perspective of Black Mental Health UK it is not promising. When something is apparently looking good on paper, I think we should be very cautious. What I would really urge is there needs to be monitoring of the pilots from the outset, so that what is said in the public arena matches the experience of vulnerable people who do not have a voice on the ground.

Dominic Williamson: Can I come back on that point? So one of the things that we are going to be helping NHS England with is making sure the voice of service users is included in the consideration of the new operating model and how it is being implemented. Over the next few months, we are going to be running a series of workshops, making sure that we get the voice of different communities and different groups that are experiencing services to make sure that is brought into the consideration of the operating model.

Q35 Mark Reckless: Mr Kenny, in your experience over the years, have you seen any change in the sort of culture and attitude of the police? Are they more willing to or do they seem to understand mental illness and differentiate their behaviour in that sense?

Pat Kenny: Personally, for myself, since my last event, I have been involved with Revolving Doors and I have just been too busy to do anything. We are working with NHS England, Public Health England, IPCC—we are working at all levels now. Coming here today shows our commitment and involvement in it.

Q36 Mark Reckless: Were these sorts of interfaces previously available? Were you able to liaise at the level that Mr Kenny describes? Is that element new and reflecting of a greater focus on trying to deal with this issue properly?

Matilda MacAttram: I think, as I mentioned at the beginning of my submission, the experience of people from the UK's African Caribbean communities who use the services is slightly different—I would say markedly different in some cases—to the rest of the population. I think that is also reflected in the amount of engagement at all levels.

I just wanted to pick up on the point on taser though. I thought what you mentioned was quite important, and City Hall produced a report last year on the use of taser, which shows that in the last 12 months the use of taser among people who use mental health care has gone up by 30%. One of the concerns that Black Mental Health UK has is the use of taser on mental health wards. It is not therapeutic nor lawful and so we are happy to submit evidence on that. It is a huge concern given that people, particularly from the UK's African Caribbean communities, have been given higher doses of antipsychotics, which means they sometimes have more physical health conditions, i.e. they are more likely to have coronary heart disease, diabetes, and so on, which means that this non-lethal weapon for somebody who is physically healthy could be lethal for somebody in a mental health setting. That is my point.

Q37 Chair: Ms MacAttram, Mr Williamson and Mr Kenny, thank you very much for coming to give evidence to this Committee, our first witnesses on this very important inquiry. If, after this session, you feel that there is information, or indeed other witnesses, other examples, to give colour to the issues that you have raised today, please do not hesitate to write to me with that information. We are very keen to take the Adebowale report forward with some positive recommendations for the future. We are most grateful to you for coming here today. Thank you.

Examination of Witnesses

Witnesses: **Deborah Coles**, Co-Director, INQUEST, **Tony Herbert**, Father of James Herbert, and **Barbara Montgomery**, Mother of James Herbert, gave evidence.

Chair: Deborah Coles, Mr Herbert and Ms Montgomery, thank you very much for coming to give evidence today. Could I start with you, Mr Herbert and Ms Montgomery, on behalf of the whole Committee, to pass on our condolences following the death of your son James. He was only 25 when he died, and it must have been a terrible, terrible shock to both of you. Can I, again on behalf of the Committee, commend the way in which you have taken this issue forward in raising awareness? So many other people who would be grief-stricken would not want to do what you have done, but what you have done has been extremely valuable. We are most grateful to you for coming here to share your experience with us.

Tony Herbert: Thank you.

Barbara Montgomery: Thank you.

Q38 Chair: You said, I think, at the time of your son's death, "No person should have been subjected to that journey, let alone a mentally ill one in a highly distressed state. It was inhumane. His life and his future were stolen from him." You obviously miss him every day that he is not here, but could you tell the Committee where you think the most effective intervention point should have been in respect of James and his problems on that fateful day? What should have happened that did not happen?

Tony Herbert: I think the first point really is the time when James was on the Bath Road and he was in a very distressed, but not violent, state. He was wandering in and out of traffic. A PCSO had been called to the scene and the PCSO, who was kind of shepherding him, needed backup and called a police officer; some members of the public became involved at that stage. When the police officer came, James was on the ground and restrained pretty quickly. What didn't happen was that there was no attempt by the police officer to de-escalate. Barbara, his mother, was 400 yards away and eventually came on to the scene towards the back end. So the first point where things go completely wrong: the police officers were fully aware that James had mental health issues, both historically and through his behaviour that day; they were also aware that there was no history of violence or aggressive behaviour.

Q39 Chair: When you say, "They were aware", obviously from the description that you have given this Committee—we are not doctors here—it is very clear that someone observing the scene would have realised that this was not normal behaviour.

Tony Herbert: Correct.

Q40 Chair: To be going out into the middle of summer in, I understand, a big overcoat, and running through the traffic on a busy road. When you say, "They were aware," how would they have been aware of that?

Tony Herbert: They had contact earlier in the day, both from Barbara and from members of the public, who had reported James behaving bizarrely and James was known to the police in Wales as having mental health issues. In 2009, about 14 months before he died, there had been a visit from the mental health people to our house and they had assessed him and decided that they were not able to section him because his mental health at that stage was not seriously bad enough. I think the witnesses also, as you said, are very clear that the police officer, when he was called on to the scene, commented to control, "Is that the chap whose mother has been asking for some help and we are going to try and give her some information?" The answer was, "Yes." Perhaps because the situation was out of control, with members of the public involved at that stage; there just was not an attempt made to take a step back. If that step back had been taken, then James would be alive today.

Q41 Chair: Ms Montgomery, you told us and you have told others that on the way to police custody you—not you personally, but James—passed two hospitals.

Barbara Montgomery: He would have passed two small hospitals, community hospitals.

Chair: Either of which could have been —

Barbara Montgomery: At the end of the journey, they would have also passed Yeovil Hospital, which is the main hospital.

Q42 Chair: So, your plea when you rang the police was to ask for help. You wanted help, did you?

Barbara Montgomery: The police had been to the house earlier in the day because—I did not know at the time—James had been out of the house acting strangely earlier in the day and people had reported this. The police knew where James lived, where he was living, and they had come to the house. Later in the day, James had left the house and disappeared with one of the St Bernard dogs and I was very concerned because of the police coming earlier in the day and the way that he had perhaps been acting earlier. So I had gone out looking, and when I could not find him I decided to call the police to ask if they could help locate him.

Q43 Chair: So, you did not ask for help with him; you asked to find him. That is why you rang the police.

Barbara Montgomery: When I first rang that is what I was asking for.

Q44 Chair: Did you also ring a doctor, nurse or a paramedic in the first instance?

Barbara Montgomery: No, I didn't. I went back out and looked. The police rang me back and they told me that he had just been seen by an officer on Bath Road and that he was perfectly okay and fine. So I went straight out on to Bath Road to see him, to try and bring him back. I managed to get the dog and to bring her back, but James didn't really communicate with me very much. He was not acting strangely in the sense of doing anything what might be considered crazy at the time, he just went off down an alleyway.

Q45 Chair: Just help the Committee in this way: at the point where the police officer found him and restrained him, is it right that you would have liked him to have gone to seek medical help?

Barbara Montgomery: Absolutely, absolutely. You see, as things went on, I took the dog back to the house, but the other people had been phoning the police. I was ringing Tony to try and explain to him what was happening, and I could see out of the front window, as I was stood on the phone, a police car go very quickly down past the bottom of the road. So I immediately ended the call and went back down on to the scene. By the time I arrived there James had been restrained and he was in the back of a van—a van that he could barely fit into, the space was unbelievably small.

Q46 Chair: Was he a tall lad?

Barbara Montgomery: He was 18 stone and he was big built, but a very gentle chappie as it happens, but they had squashed him into this very dreadful space. I managed to get into the side of the van. When I saw him, I could see that there were very strange things going on physically and I pleaded with the police to please take him to hospital, to please get some sort of medical help. "No." I asked them, "Please can I come with him? Please let me travel with him." "No." They would not let me go. Nobody travelled with him in the back of that van. He was left isolated, totally restrained, in the back of a van with no

help, in a van that was too small for him, on a boiling hot summer's day, totally restrained, and no monitoring—there was nobody in the back with him. That was for a journey of over 40 minutes.

Tony Herbert: He stopped breathing 11 minutes after he arrived at Yeovil Police Station.

Q47 Chair: Was that the last time you saw him alive, Ms Montgomery?

Barbara Montgomery: Yes.

Q48 Chair: So, looking at that history that you told the Committee, you think that immediately he was restrained, he really ought to have had —

Barbara Montgomery: He ought to have had help, yes, absolutely—medical help, without doubt.

Q49 Chair: Do you blame the police for this or do you blame the fact that there was not this kind of provision available? I know there was an IPCC investigation, which has happened because of your campaigning, but if you were to put your finger on how it could have changed and how he could still be alive, what would that be? What would be the institutional change that should have occurred?

Tony Herbert: At the time, as far as we were concerned, James was purportedly detained under section 136 of the Mental Health Act. We learned that afterwards that is the reason he had been detained. We did not know why he had been taken away: it was not explained, there was no witness. The PCSO who was on the scene did not know what section 136 of the Mental Health Act was. So the whole thing was very detached from what we are now discussing.

I live in the West Midlands, and in the West Midlands I understand the protocol is that if somebody is detained under section 136, then they call an ambulance to take them to one of three places: a hospital place of safety; the emergency room, which is where James, by the time he had been restrained, needed to go; or to a police station. The ambulance, the paramedics, are given sufficient training to be able to work with the police to get certain kind of flags that indicate where they should go. Had an ambulance been called on to the scene, James would still be alive. So that was the second big thing. The journey in the end I think was lethal. I still feel bitter, angry, I still find it unbelievable that a distressed psychotic person was restrained for over an hour with two sets of limb restraints, with handcuffs behind him and was not monitored on a journey that took him from one place to another over 43 minutes. Even at the other end when he was unresponsive, nobody looked at him and said, "This is not right, let us call an ambulance." They took him out of the police van, they put him in a police cell, they did a cell extraction as if he was still a violent prisoner, which is all on CCTV, and then he stopped breathing.

Q50 Chair: He eventually died in the police cell?

Tony Herbert: He died in the police cell, yes. He was pronounced dead in the hospital. He was dead within a few minutes of arriving at the police station. As often in these cases, the post-mortem is fairly non-committal about the cause of death, because it is a number of things that seem to work together. But, yes, he clearly struggled against restraints and it is very clear that the kind of fighting against the restraint that happens from a person who is psychotic and in crisis is qualitatively different from that of a criminal. I am not a police officer, but from a commonsense point of view, if somebody keeps fighting against restraint beyond their own endurance, then a warning light should go on to say, "This is not right."

Chair: I think the whole Committee is astonished by these circumstances and we are aware of your distress, but even through that distress you have come here and told us about this, and members of the Committee will ask you further questions on this in a moment.

Q51 Ian Austin: When I read Lord Adebowale's report on this, I think the thing that struck me was his comments on the number of times that the police were involved because when people ring 999 it is coded as a sort of criminal situation rather than a medical one, which is exactly this point that I think you have been making. What do you think should be done to treat these situations as mental health crisis situations and not as criminal situations?

Tony Herbert: Potentially, from a public place, a section 136 detention is correct. It certainly requires a better trained police force with an entirely different culture than the one that we experienced four years ago. It requires meaningful partnership with the National Health Service and I think particularly the paramedics. I was quite moved by some of the evidence that we heard earlier about the actual experience of somebody on the receiving end of section 136. That needs to be expanded and work better.

Barbara Montgomery: I would add: communication. Communication in the sense that, for example, James was known to the police and there did not seem to be any communication about the situation. There seemed to be a complete failure of that. I have come across it talking to other families as well. So that I think perhaps in certainly a number of cases the police are aware of the person that they are dealing with, they are aware that they do have mental health issues.

Q52 Ian Austin: How common is it in situations like this that the police have this sort of prior knowledge of the person?

Barbara Montgomery: I could not give you figures at all.

Q53 Ian Austin: Do you know this? How typical is it that the police have known the person before and ought to be aware that there are mental health issues?

Deborah Coles: I think either they have known beforehand, or information is or should be obvious at the point of the police involvement. That is largely because a number of

the cases have involved members of the public ringing up to express concerns about somebody's behaviour, which then prompts a police response or, as Barbara said, there have been situations where families have called upon the police to assist. The very sad thing about the experience that you have just heard from Barbara and Tony is that this is by no means an isolated case and I think the frustration that I feel, looking back on INQUEST work in this field for nearly 30 years, is that there has been a pattern of cases involving very, very similar issues where the learning that should come out of these deaths to inform changes to policy and practice has just not been implemented.

Many of you will be aware of the death in 1999 of Roger Sylvester in Metropolitan Police custody in a psychiatric unit. That prompted a review of mental health and policing and restraint by the Metropolitan Police. Then one fast-forwards to the death of Sean Rigg in very, very similar circumstances and one questions how we as a society learn from these deaths. While we are seeing emerging pockets of good practice, I think the one fundamental concern that we have is the lack of a national response and strategy to develop a really coherent understanding of what is happening on the ground, but also a safe policing and mental health response to people who are in mental health crisis.

Just one other point I would just like to flag up that emerges from James' death is what we are seeing is an increasing use of restraint equipment. Tony mentioned that James was handcuffed behind his back, and he had restraints on his ankles and his thighs. Now, you imagine somebody who is undergoing a crisis who is not only restrained but then subject to restraint equipment. It is absolutely terrifying. I really took onboard what Pat, the previous witness, was saying about how, when you are going through crisis, the situation is absolutely terrifying.

There is another thing which raises fundamental concerns about training and attitudes and assumptions towards certain groups of people. I think Matilda alluded to this—the perception of people with mental health problems as "mad bad and dangerous". There is the double discrimination that we then get; if somebody is from the African Caribbean community they get that kind of double perception. We see that time and time again and that is largely to do with training, but it is also to do with sometimes people losing sight of the fact that the people we are talking about here are extremely vulnerable; they are in crisis, and they are worthy and deserving of humanity and dignity. Too often these cases demonstrate that is lost sight of in the spur of the moment. The immediate response is to restrain. It is use of force rather than monitoring the situation, de-escalation, talking down. Whether or not some of the schemes that are being implemented are going to impact on that kind of use of force remains to be seen.

Tony Herbert: I am obviously not an expert on the subject, but one thing that bothers me in terms of section 136 is the increasing publicised concept virtually that if somebody is violent then you can only take them to the police cells. In James' case, he was not violent, but that misses the point that somebody who is violently fighting against restraint is a medical emergency. In James' case they tried to portray him as being violent pre-restraint, and that made it somehow okay that the police cell was where he should go. Very clearly it was inappropriate, and it is going to be inappropriate for anybody in that

position. Somebody who is violently fighting against restraint, or even somebody who is so distressed that their behaviour is slightly dangerous, needs help; they do not need to be locked up.

Chair: Thank you, Mr Herbert. I am afraid, colleagues, we need to move on. I know lots of you have questions on this.

Q54 **Mr Clappison:** I have a question, which follows on from the evidence we heard and I put this first to Deborah Coles. How are families who have just been bereaved treated in circumstances such as this in general?

Deborah Coles: I am glad you have asked that question. One of the key problems in this whole area is a lack of immediate advice and support. If families contact INQUEST or are referred to INQUEST, obviously we can in a sense help families navigate through that whole process, but there are some fundamental concerns. I would say the first one is the extraordinary delay in the investigation processes that ensue—that is delays both in terms of the Independent Police Complaints Commission investigations, any subsequent decision-making by the Crown Prosecution Service as to whether or not any charges will be brought, and then delays in the inquest being held. Couple that with problems with restrictions now on legal aid and families having to go through a very protracted intrusive process to apply for funding to be represented at the inquests. Just on that, of course unlimited largely public funds are available for the police, both in terms of the Chief Constable or the Metropolitan Police Commissioner, individual officers, and then individual maybe private companies or police doctors to be represented. So there is a real problem in terms of inequality of arms.

I would like Barbara to say something about the experience that she had at James' inquest.

Q55 **Mr Clappison:** I was going to ask about that next, because I know there was a delay in that case before they were informed what had happened. You mentioned the IPCC. Does the involvement of the IPCC help things to be brought to resolution and people to have confidence or not?

Deborah Coles: Given I gave evidence in front of you previously about the Independent Police Complaints Commission, I think that things are moving slowly. Following on from the experience of the Sean Rigg family and the shamefully inadequate investigation into the death of Sean Rigg—Sean's sister is behind me—one positive thing that has emerged has been that the IPCC now recognises that as part of their investigation they need to also look at issues, for example, like mental health and the involvement of other agencies outside the police in these kind of cases, which is a move forward.

One of the concerns, however, still is around the delay in the investigations. You may be aware that of the case of Seni Lewis, another case that we referred to in our submission, there is a reinvestigation into his death, and the last communication I had with their lawyer and the family was that there are appalling delays in getting that reinvestigation

underway. So there are still real problems about the way that these investigations are conducted overall.

The only other thing I would say about that, that one of the things that we have seen in relation to two of the more recent deaths, that of Terry Smith and Leon Briggs, is that unusually the investigations are being treated as criminal investigations, which means that there is a degree more of scrutiny in terms of the individual police officers.

Q56 Mr Clappison: Following on from that, can I ask Barbara or Tony for any reflections you have and particularly on the delay I think there was in your case in being told what had happened as far as James was concerned?

Tony Herbert: That was certainly the case. Barbara was told over four hours after James died, and we felt that was so that the police could get their stories straight. The first IPCC investigation was fairly prompt in our case. We felt that it did make some points, but it missed a great deal. Barbara had a very difficult ordeal being cross-questioned by the police's counsel at the inquest. There was a distinct effort by the police during James' inquest to shift the blame back to the family for James' death, which was pretty traumatising. We made several complaints, including that, after the inquest. The IPCC are reinvestigating that.

Q57 Mr Clappison: This was the counsel who was acting on behalf of the police?

Barbara Montgomery: Yes.

Tony Herbert: Correct.

Q58 Mr Clappison: So presumably on instructions from the police.

Tony Herbert: We believe so, but that is yet to be—

Chair: Thank you, Mr Clappison, most grateful.

Paul Flynn: Could I echo what the Chairman said about the account you have given? It was a very moving and vivid account and the way that you have given your evidence today—I think in the circumstances you are entitled to be extremely angry and you have given us some practical ways forward. I am sure that the whole Committee feel that what you have told us has convinced us that this is a subject of very great importance.

Chair: We are going to adjourn the Committee for the votes and then we will return. We will begin as soon as we have a quorum.

Sitting suspended for a Division in the House.
On resuming-

Chair: We will return to Paul Flynn's question when he arrives. I am sorry about this interruption. The wheels of parliamentary democracy have to proceed.

Q59 Dr Huppert: Thank you all very much for coming to talk about this. I am struck by your comments about going past so many hospitals. Just so that we are clear, do they all have A&Es?

Barbara Montgomery: No. Going past the hospitals you are talking about, yes?

Dr Huppert: Yes.

Barbara Montgomery: They had access to two community hospitals within about five minutes and then they also drove past the main hospital, Yeovil, to go to the police station.

Q60 Dr Huppert: Yes, that definitely has an A&E. Thank you. I just wanted to clarify that. My question is about training and the amount of training that is provided for officers and other people who are involved. What is your assessment of the minimum amount of training that should be available to all officers in mental health?

Barbara Montgomery: I think that obviously at the moment it is far too little. Quite a lot of resources need to be put in to make all officers aware of when they are in situations like that and the possible outcomes, and how they can manage them better. Perhaps more training on de-escalation—being able to communicate and approach people without just going in with brute force that then totally makes the situation escalate out of control.

Without a doubt there is so much more training needed to be put in place. Something that I feel I must say is that I believe you can put in all the training you want, you can have your triage and all the rest of it, but until the police become accountable and transparent you will not have the learning that you need, because any learning depends on the police being truthful, not just to the victims—I will say "victims" for want of a better word at the moment—but to themselves, so that they can learn very valuable lessons and move forward. But my experience has been that the accountability, the transparency and the learning that I was promised on the morning I learned of my son's death just does not happen in reality, because the police go into denial. They do not want to accept any sort of responsibility. They do not want to look at how they may have failed or how they might do something better in the future.

Deborah Coles: I just want to endorse everything that Barbara said, and rather than repeat it I just want to say something about training. Training, of course, is important but it is of all staff, and that should be at the level of those who receive 999 calls—in other words, the handlers, and that was a very important feature in the case of Sean Rigg's death—but given that the police and 999 is often the first port of call for people who are concerned about vulnerable individuals, then training must go at all levels. It is not just for police officers. It should go right up to senior grade, and any kind of training must also engage with attitudes and assumptions. It is the point I made earlier around discrimination and racism.

I would absolutely agree with what Barbara said about accountability. One of the real problems in the process that follows when deaths occur is that there is very little accountability. In fact, the police are very good at evading accountability when things go wrong. The defensive nature of the investigation and inquest process means that the issues regarding how we best learn too often get lost. The process means that by the time the inquest happens, that is the first opportunity to have proper public scrutiny and coroners can make some very well-informed findings and recommendations, but there is no mandatory responsibility on the part of anybody to implement those recommendations or, indeed, the IPCC recommendations. That is where the problems of organisational memory and learning get dissipated.

Just one final thing in terms of training: I think it absolutely vital that any training these officers have involves mental health service users, but also bereaved families, because there are a lot of families like James Herbert's family who would be more than happy to talk about their own experience. That would probably be the best training that police officers could receive.

Q61 Dr Huppert: This is all very helpful and we have looked at police accountability in some of our other reports so it applies here as well. Could I just pick up one particular thing? If we look at some of the figures we have had from the Police Foundation, Avon and Somerset police had the fourth highest number of people detained in police cells in 2012-13. I do not know if it has changed since then. I notice that West Midlands, who are a larger force, have a much smaller number. They have a system, as I understand it, where there are some police officers who are very highly trained to assist in crisis situations. How much do you think that is the way to go and how much do you think it is about lifting everybody up? Clearly, both would be ideal, but which one do you think is more important?

Tony Herbert: I am not qualified to say, but I do follow through Michael Brown's blog what happens in the West Midlands, and that strikes me as being a very good national example. But I absolutely concur with INQUEST's point that what is needed is a national strategy. I am not qualified to say what that national strategy should be but I think it needs to be national and intuitively I feel it is the West Midlands approach.

Chair: That is very helpful and we will, as a result of what you said today, Mr Herbert, be looking at the West Midlands approach, because we want to know about good practice as well as circumstances where the system has failed, as it clearly did fail in your case.

Q62 Nicola Blackwood: I would like to thank Mr Herbert and Ms Montgomery for your very moving evidence. I am very grateful to you for coming today. I know that it must be very difficult to talk about this situation. I wanted to ask a little bit about the relationship as you understand it between the hospitals and the medical care and the police. I certainly know of instances where ambulances have been called or an individual with a mental illness has been taken to A&E and the police have then been called to restrain. I just wonder what you think might be done to try to address that situation because clearly, had your son being taken to the hospital, medical intervention might have been possible. But had he gone to the hospital first, the police might have

been called, and I wonder if it might have caused a problem even then. I wondered what you might think would be helpful.

Tony Herbert: To me, and again I am not an expert in this subject, if somebody is correctly taken to an A&E setting particularly and they are proving to be difficult for the doctors and nurses there to treat or approach, then I think the police have a role to keep the nurses and doctors safe. I believe under section 136 that their responsibility does not finish—even if they go to the emergency room that is not the finish of the police's responsibility. That can be a point of safety for a while, but they are still going to be assessed later. James did not get that far. He did not get to A&E. We know with our son that because of his temperament, had there been any attempt to de-escalate, to communicate with him rather than overpower him, his nature would have meant that he would have been peaceful. He did not do anything violent through all of his life until he struggled against the restraint, which is not, in my view, violence. Having said that, somebody should go to A&E if they are in a situation where they need emergency help. It is their human right. The police do need to keep the doctors and nurses safe, but I bet you it is not often they need to do that, I really do.

Q63 Nicola Blackwood: In terms of your call for a national strategy, do you have a position on the interaction between ambulance response and police response, because I think this does fall down on occasion?

Deborah Coles: There is no doubt it falls down. It covers some issues. I think it is not just the police who need training. It is also a question of how one engages with both the emergency services, particularly in terms of ambulance responses. There has to be greater awareness that people who are in mental health crisis should be treated as medical emergencies, in the same way we are trying to talk about parity of physical and mental health care. If somebody is going through a mental health crisis for whatever reason, everybody needs to understand that is a medical emergency.

There must be much greater awareness about the serious risks of restraining somebody in that situation because I think that is another area where we are seeing cases, as the previous witness talked about, involving police being called to psychiatric units. That is completely unacceptable. It is ironic giving evidence when the Department of Health has issued its own guidance paper on the fact that restraint should be used very much as a last resort and for as short a time as possible, because of the recognition of the dangers of restraining somebody and the fact that that can exacerbate somebody's mental distress at a time when they are already vulnerable.

The point around the relationship between the police and health services is a really important one and that is where we are seeing some examples of extremely good practice. West Midlands, was flagged up earlier. This was in response to a very high profile death, Mikey Powell, and a lot of the work that his family did in trying to talk to the police and other agencies about a much more integrated approach. It is also reflective of good leadership in terms of making sure staff are trained but making sure

that there is a proper partnership working between the police and mental health services.

Q64 Nicola Blackwood: Clearly you were aware of your son's mental health history and you asked for him to be taken to hospital knowing that was the right course of action to be taken in that situation, yet your request was not acceded to. What role do you think family members or carers should have in the initial response where they are on the scene or contactable?

Barbara Montgomery: I can only speak in the situation I found myself in. The police had access to me. I was literally round the corner from where the van was at the time. As I said, I saw the police go across the bottom of the road. They had me there towards the end of the episode when James was in the back of the van. They could have used me to talk to James to calm him down. I would have travelled with him. I asked to travel with him. I was not allowed to. I wanted him to go to a hospital. At the time what I was saying was that I could see he was physically not right as well, because of various signs on his forehead and things. I was asking for him to go straight to a hospital or wanting an ambulance for him to go straight to hospital because of the physical things I could see.

Q65 Nicola Blackwood: Because you knew him.

Barbara Montgomery: Yes. I knew James. I knew.

Tony Herbert: The police could have sent him home as a place of safety.

Q66 Mr Winnick: I just want very briefly to go to the situation that I do not think we have asked about when sadly and tragically your son died. As we understand it, on the information given, the Yeovil hospital staff contacted the police around 11.00 pm, shortly after James died, to ask the police if the family would be coming to see him or should they transfer his body to the mortuary. They were told to transfer the body as the family would not be visiting. The point we have is how could you possibly have visited because "the parents were not told until 1.30 am"? That is the information given, wasn't it?

Tony Herbert: That is absolutely right.

Barbara Montgomery: I was woken up at 1.30 in the morning. We have no knowledge before then that James had died and they could not possibly make that assumption because we had not been told. I would have been straight there.

Q67 Mr Winnick: That was a blatant lie on the part of the police, wasn't it? There is no other way to describe it.

Tony Herbert: Yes.

Barbara Montgomery: The police told many lies there, I am afraid. They were talking to me on the telephone because I was so concerned about what was happening. I talked to the police to get put through to Yeovil and they said something about, "Busy at the

moment, they will ring you back any minute." The police rang me back probably one minute later and they started asking me lots of questions about James and his medical background, who his doctor was and all that type of thing. At that point he was dead and he did not tell me.

Tony Herbert: In fact, on CCTV we saw the custody sergeant telling the person who was making the call not to tell them anything. The only conclusion that we could take from that was that the police needed that space to get their story straight. Whether or not that is right, that, of course, was a totally unacceptable four-hour delay between James being declared dead and us being told. In fact, had we been told when he collapsed, there was some possibility that Barbara at least could have been with him in the emergency room at the hospital. The coroner said that was totally unacceptable. Again, another issue where the police need to be brought to book on it because it is immediately—we did not learn about exactly the reason for the delay until the inquest nearly three years later, but it was a very, very bad shock.

Q68 **Mr Winnick:** It was six days before you identified your son.

Tony Herbert: It was six days before we could see him, yes.

Barbara Montgomery: Before we could see him and it was six months before we got his body back and we could have a funeral.

Deborah Coles: I just wanted to say that unfortunately this is not an isolated experience that a family has had. It was the same experience that Marcia Rigg and her sister and brother had following Sean's death. Likewise, the Thomas Orchard case shows a frightening similarity to James' case. One thing I just wanted to say in the context of this is that a lot of the time the police will say that they have nowhere to take people with mental health problems because there is no place of safety. One of the things I hope you take from some of the case stories we have put in our submission is that too often these are people who clearly had mental health problems or were exhibiting signs of being in mental health distress where section 136 of the Mental Health Act was not even used. Despite concerns of members of the public or, indeed, of the family, they were taken into a very dangerous environment, which is obviously the police station. It also raises concerns around issues of risk assessment and then the quality of medical care that is within the police station, and that is also an issue around the role of forensic medical examiners.

Chair: Thank you. That is very helpful. I should say we will be calling the police of Avon and Somerset so that we can hear for ourselves exactly what happened in respect of your son.

Q69 **Michael Ellis:** Mr Herbert and Ms Montgomery, can I just say how sorry we all are for your loss? I am flabbergasted by the facts of this case and I am not unfamiliar with cases of this sort. I would just like to take a step back to the point around the police arrival and the way they dealt with James. You say it was a warm evening and he was wearing a heavy coat.

Barbara Montgomery: Yes.

Q70 Michael Ellis: He was restrained in such a way, using restraint equipment on the wrists, thighs and ankles.

Tony Herbert: Yes.

Q71 Michael Ellis: Was he in a contorted position with his arms and legs behind him?

Tony Herbert: In the van he was, yes. He was originally restrained on his back, handcuffed to the front. When there were seven people restraining him they turned him over. At that time they put the restraints on and put the handcuffs behind him. Then they carried him into the van. They put him into a particular position. Barbara, when she arrived on the scene, saw him move into a different position and his position was awkward. We subsequently understand now the position he was in at the other end was potentially not necessarily an asphyxia position, but it was nevertheless an extremely awkward and uncomfortable position.

Q72 Michael Ellis: He was a heavyset person, I think you have described.

Tony Herbert: He was 17 stone 3 lbs, yes.

Q73 Michael Ellis: He was 17 stone 3 lbs, over-clothed for the weather, in a constrained, awkward position and in an enclosed space in a caged area in a small police vehicle. Is that what you are saying?

Tony Herbert: Yes, for 42 minutes, yes.

Barbara Montgomery: It was one of those small ones that looked more like a dog van. I forget the proper name of them. Can you remember?

Tony Herbert: It was a Mercedes Vito van.

Q74 Michael Ellis: There was a particularly long journey back of over 40 minutes to the police station. It strikes me as devoid of common sense that no one was keeping an eye on him and he was clearly in distress from an early stage.

Tony Herbert: Yes.

Q75 Michael Ellis: I understand the verdict was highly critical and the coroner wrote to the chief constable after that, expressing concerns about detention in the circumstances. Is that right?

Tony Herbert: Yes, he did.

Q76 Michael Ellis: Do we know what the cause of death was? Was it postural asphyxiation?

Tony Herbert: No. His cause of death was respiratory and cardiac failure following restraint and a violent struggle against restraint, so it was kind of non-specific, as often is the case. The pathologist came up with a group of ideas, basically, as to what the mechanism of death is. I think they are beginning to understand that better.

One issue that we faced, that again is a common death in custody issue, is that the words "excited delirium" were used, and excited delirium is consistently being used—it is probably increasingly less used—as a kind of police get out of jail free card, i.e. they treat somebody in this way but the force was not lethal, and therefore something else caused them to die.

Q77 Michael Ellis: Account has to be taken of the state that the individual is putting himself into, the distress.

Tony Herbert: Indeed, and in fact it is very clear in James' case, and the pathologist agreed, that if there was an acute behavioural disorder it started after the restraint, not before.

Q78 Michael Ellis: Because we are focused on policing and mental health as opposed to the pure medical issues, another thing that strikes me as extraordinary is the fact that when he was taken out of the vehicle and into the police station, despite his non-responsive state, there does not appear to have been an immediate call for medical assistance even then.

Tony Herbert: Yes.

Q79 Michael Ellis: Apparently his clothes were removed from him in the cell. They must have therefore been quite cognisant of the fact that he was non-responsive and still nothing was done.

Barbara Montgomery: Still nothing was done.

Tony Herbert: The only thing they did was to remove the mattress from the cell to make sure he died on a concrete floor.

Barbara Montgomery: They closed the cell door and they looked through quite quickly but then when they decided that they should perhaps get some medical help the sergeant in charge—this is on CCTV as well—decided, well, why is it his job to get an ambulance? He phoned and did not ask for the correct help. He said, "We have a violent prisoner here playing up and we need some help." So then, so the paramedics was—

Q80 Chair: Some of this is subject to the IPCC inquiry so we do have to be extremely careful about saying what other people may have said.

Barbara Montgomery: But they did not get any medical help.

Chair: Thank you. That is very helpful.

Q81 Michael Ellis: Because we are looking at the conduct of police in terms of how they deal with people in mental health crises, you would accept, would you, that very often the police will want to restrain people not only to protect themselves and others but to protect them from themselves? It is just a question of how they go about doing this and the circumstances and the attention that they give. In James' case there was clearly an appalling failure. Do you feel that the police ought to have acted at every step of the way differently—for example, how they dealt with him at the time of his detention, travelling and in the police station?

Barbara Montgomery: Yes.

Q82 Michael Ellis: What would you say would have been the best result most likely to avoid the death of James? What could the police have done differently?

Barbara Montgomery: They could have listened to me and they could have had an ambulance there.

Chair: Thank you. You have said that. Thank you very much. Thank you, Mr Ellis. Sorry, we need to press on. Paul Flynn, we interrupted you during the division so could you restate your question to Mr and Mrs Herbert?

Q83 Paul Flynn: The question has largely been covered. The chief shock in this is the barbaric restraints they used on your son. Clearly there are going to be dangers to someone in those circumstances with that particular background. Have you come up with any ideas or alternatives that can be used if someone was a threat—your son was not presenting a threat of violence—and could be less dangerous? Do they exist? Is there any suggestion that they should be used rather than tying someone's hands behind their backs?

Tony Herbert: If, after an attempt is made to de-escalate, the restraint has to take place, which could have happened in the case of James—although we thought it would not have done because of his temperament—then the next step must be under those circumstances to call an ambulance and to convey them wherever they are going by ambulance, not by police vehicle.

Deborah Coles: I would say constant vigilance and risk assessment at every stage, because the situation we are talking about here, as I said, is not isolated. The police are well aware of the dangers of restraint; they have been trained specifically on this as a result of previous deaths. In this case the coroner found that the lack of a continuous risk assessment from the point of his detention through to the transfer in the van and through to the cell, he was just ignored. I think they lost sight of the fact that he was a vulnerable human being.

Q84 Paul Flynn: I understand. One of the ways of dealing with terrible grief of this kind is to campaign, to make sure they will be no similar victims and I hope that we as a Committee can help to ensure that there will be reforms that will avoid such tragedies in the future.

Tony Herbert: We deeply hope that too.

Q85 Chair: Thank you Mr Flynn. On behalf of the whole Committee, again we are full of admiration for the work you have done. Your son died four years ago last month and you have waited three years for the inquest and now there is another IPCC investigation, as we found out from taking evidence from Marcia Rigg about her brother's case. It is clear that you have had to ensure your campaign has shone light on a system that is in crisis and we are extremely grateful to you. We will use this case as a case study in the inquiry we are beginning today into policing and mental health so we may come back to you, but we will have before us Avon and Somerset police to hear from them what they have done. Obviously, irrespective of the IPCC investigation we will also want to hear from those witnesses. Deborah Coles, thank you for coming in. Just one final question from me: has the number of deaths in custody declined over the last few years? I have figures showing that in 2012-13 15 people died in custody, half of whom had mental health issues.

Deborah Coles: That is correct.

Q86 Chair: Is that on the decrease or on the increase?

Deborah Coles: I think it is going to be roughly about the same. My understanding is the IPCC's most recent figures will be coming out on 15 July so we will have a better understanding. The only thing I would just add to that is around the worrying increase of the number of people who take their own lives following release from police custody, many of whom have mental health problems. I know that is possibly outside your remit but obviously they are people who have been in the custody of the police and of that group we are working on a number of cases of young people, 17, 18 year-olds. I would urge you to look at the figures with some interest.

Q87 Chair: Of that percentage, half is still roughly the same?

Deborah Coles: Yes, and my understanding is, certainly in terms of INQUEST's current casework, I would say that of those who die, mental health features in the majority of them.

Chair: Thank you. Deborah Cole, Tony Herbert and Barbara Montgomery, thank you very much for coming.

Tony Herbert: Thank you.

Barbara Montgomery: Thank you.