HOUSE OF COMMONS

Home Affairs Committee

Oral evidence: Policing and mental health, HC 202

Tuesday 28 October 2014

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Written evidence from witness:

- Devon & Cornwall Police
- British Transport Police

Watch the meeting

Members present: Keith Vaz (Chair); Ian Austin, Mr James Clappison, Michael Ellis, Paul Flynn, Lorraine Fullbrook, Dr Julian Huppert, Mr David Winnick.

Questions 183 – 281

Witnesses: **Sergeant Ian Kressinger**, Devon and Cornwall Police, and **Sergeant Andy Shaw**, Essex Police, gave evidence.

Q183 Chair: Could I welcome Mr Kressinger and Mr Shaw? Thank you very much for giving order—giving evidence to the inquiry, which, of course, is very orderly, into criminal justice and mental health. In particular, I want to thank Devon and Cornwall Police for the work that they have done on this issue. One of the reasons why you are here before this Committee today is that when I was attending the Police Federation conference with colleagues we knew of the motion that you had put forward in 2012 about this serious issue. Though we are taking evidence from the good and the great—we have a number of chief constables and others coming to give evidence to us—you are, of course, on the front-line and every single day of the week you are dealing with people with these issues. If I could start with you, Mr Shaw, how serious is mental illness as a problem for those who work in the jobs as custody sergeants and those on the front-line?

Sergeant Shaw: I think for custody sergeants and custody staff it is almost an everyday occurrence now whereby someone being arrested for a criminal offence will present themselves with mental health issues and/or they have been detained under 136 with mental health issues. It is quite a strain on the staff to deal with those issues.

Sergeant Kressinger: Yes, I would agree and I would also say the same with the staff on the ground, patrol officers, who are put in a very difficult position having to deal with people who have mental health issues and are having to make decisions about how best to give them the treatment that they need.

Q184 Chair: Do you think that there is enough training given to officers on the front-line to deal with the issue of those with mental health conditions? Were you, for example, trained in this area when you took up your post?

Sergeant Shaw: I think I was quite lucky in my particular force. We have had a two or three-day session in relation to classroom-based mental health training. Talking to colleagues across the country, I think training is a bit ad hoc. We have a national package, which is computer-based training, which seems to be the way that training goes for the future nowadays. It is all computer based.

Sergeant Kressinger: Ours is very similar. The probationers get training in the classroom. They get e-learning and they get practicals. I believe that is a day, and that is very similar with custody. We get a four-week training package now and there is a day specifically around mental health.

Q185 Michael Ellis: Sergeants, good afternoon. Can I just say thank you very much for the work that you do in this area, which is clearly a challenging area of policing and mental health? I am sure it is appreciated by everyone. I just want to establish how common incidents of self-harm and attempted suicide are in your custody. It may well be that you are not able to speak about the situation more widely, but you are custody sergeants, are you not? How frequently does it happen that there is an incident of self-harm or suicide attempt?

Sergeant Shaw: It is difficult to quantify. There are occasions whereby—

Michael Ellis: Can you speak up?

Sergeant Shaw: Sorry. There are occasions where detainees might try some self-harm. We try to deal with that when they first come into the police station through risk assessment and try to provide the level of care to prevent that from happening, but it is not always successful because sometimes the detainees might become frustrated as to the reason why they—

Q186 Michael Ellis: It is a cry for help, isn't it?

Sergeant Shaw: Yes, usually.

Q187 Michael Ellis: I am not seeking to criticise; you are not 24 hours a day, seven days a week observing someone, so it may well be that they are able to harm themselves or attempt suicide. Is it relatively frequent? Would there be an incident of self-harm every week, for example, every month?

Sergeant Kressinger: I would certainly say weekly.

Michael Ellis: Weekly?

Sergeant Kressinger: I expect it is at the very least weekly, if not perhaps every other day.

Michael Ellis: Every other day?

Sergeant Kressinger: I would guesstimate. It is very difficult. We have policies in place and things that we do to minimise the risk when they come into custody, but you are never going to eliminate the risk.

Q188 Michael Ellis: When you are referring to every other day, these are relatively low-level manifestations of an attempt to harm oneself? They would not be suicidal if brought to fruition? What type of incidents would they be?

Sergeant Kressinger: It could be. You have an idea before they come into custody. They might be banging their head against the van on the way in. They could be trying to harm in the charge room when you are getting details, again head, hitting themselves. Again, it is trying to eliminate the risk before they go into the cell.

Q189 Michael Ellis: The last point from me, which is when someone comes in, how do you look to identify someone as being a risk of self-harm or a suicide risk? What are you looking at? What sort of characteristics do you look for to do the best that you can to identify these risk factors?

Sergeant Shaw: When we start booking people into custody, we go through the formal risk assessment and we will ask them questions in relation to have they previously attempted suicide and/or self-harm. Usually, they are pretty good in answering. It is how you deal with them and it is the experience when you are dealing with them that they will reply to you and give you a straight answer. If they do not, if they have come into custody before we do check previous records. There may be markers on the Police National Computer, which will give us an indication as well.

Q190 Michael Ellis: Finally, if they do present in your opinion as a self-harm risk, what do you do about it?

Chair: Can you hold that thought? We will go and vote. It is unrelated to Mr Ellis' question, by the way. We will go and vote and come back, if you would excuse us, because the Division is on. We have 10 minutes. As soon as we are quorate, we will start again.

Sitting suspended for a Division in the House.

On resuming-

Q191 Chair: We are going to restart. Even though you were in the middle of answering Mr Ellis' question we will come back to him and he will ask it again. Moving on to Dr Huppert, police time and resources.

Dr Huppert: Thank you to both of you for coming along to help us out with this. Could you give me some sense of what proportion of people who come to your custody suites have some sort of mental illness or learning disability and are not charged with a crime? Do you have a sense of what that would be like?

Sergeant Kressinger: I can tell you the figures for those that are arrested for a 136 under the Mental Health Act and how they are then finalised, but clearly there are a lot more people who come into the custody environment who have some kind of mental illness or vulnerability that may not be recorded. Certainly, in the last 12 months we have had 767 people in our force arrested under section 136. I will just find some more figures for you.

Q192 Dr Huppert: It is under 136 and no other criminal—

Sergeant Kressinger: That is just that they have been arrested, detained, whichever way you want to put it, under 136. Of that, those people then that were no further action or released, 434, and those who were then the subject of a Mental Health Act diversion, say, was 321.

Q193 Dr Huppert: Most of them no further action at all?

Sergeant Kressinger: Yes, but please do not get the idea from that that that is to say then that there was not anything mentally wrong with the person, because when an officer is faced with somebody who may have some kind of mental illness or is saying they want to self-harm, at the moment they see that individual they have to make a decision. Were they to walk away from that person, who knows what is going to happen? Clearly, they have to make a decision at that time. If they think they are suffering from some kind of mental illness and in need of immediate care, I am sure then they will arrest them.

Q194 Dr Huppert: Sergeant Shaw, I will come over to you in a second, but can I also just come back? You may have to estimate rather than having the figures. You said there are a number of other people who have mental health problems or learning disabilities who come in through other routes, not just through section 136. Do you have a sense of what sort of fraction that is?

Sergeant Kressinger: Having listened to this previously, I know Inspector Mike Brown has given the figure at around 20%.

Dr Huppert: I would rather hear your figure than his figure.

Sergeant Kressinger: My view is I think it is higher than that, I would say. I think that has gone progressively worse. I have been in custody a number of years and certainly the people that pass through me who have some kind of illness, some personality disorder, depression, anxiety, under medication for something like that, in my opinion—I cannot give you statistics but in my opinion—it is certainly higher than 20%.

Q195 Dr Huppert: I am not going to hold you to a number, but do you mean 25%, 50%, 90%?

Sergeant Kressinger: I would not go as high as 50% but I would estimate 40% in my opinion.

Q196 Dr Huppert: Okay. One last question and then I will turn over to you, Sergeant Shaw. You say that that has increased. Do you think that is because there is a greater prevalence of mental health or because officers are picking them up more or is there more awareness, that people just would not have realised that was a problem 20 years ago?

Sergeant Kressinger: The first two things I would say are that if someone is in some kind of crisis when a police officer gets there, then somebody has failed them beforehand. I would say we would have to look at our health partners to say are they picking up the work that they should be. From a practical operational point of view, I would say the legal highs, if you want to call them, the new psychedelic-type drugs, are more prevalent now and I think that is having an influence on people.

Q197 Dr Huppert: We will be debating, in fact, the new psychoactive substances in Parliament on Thursday. Sergeant Shaw, can I ask you exactly the same set of questions?

Sergeant Shaw: Yes. I do not have figures in relation to my particular force, but I think the area that I work in is quite lucky in its healthcare provision, albeit it is not 100%. The amount of people that come in presenting to me with mental health issues, whether arrested for a crime or falling under 136, is higher now than it was probably five or 10 years ago. Whether that is because of better awareness or that is how medical people, doctors, deal with it now, I am certainly ticking the boxes when they declare mental health issues.

Q198 Dr Huppert: It is a fairly high proportion for both of you and going up. Presumably, these people require more attention from you. How much of your time do they take up?

Sergeant Shaw: From our perspective, they can take up an amount of time, but it depends on the level of care they are required to have. Sometimes it is advice from doctors and medical professionals in relation to them or it can go down the full extreme of having full assessments dealt with as well. Depending on their issues that they present at the time of the risk assessments that we do, it can mean officers having to sit with them to prevent them from hurting themselves or having a mental health episode in custody.

Q199 Dr Huppert: A large demand on your time?

Sergeant Shaw: Yes.

Sergeant Kressinger: Yes, I would echo that. Exactly as Andy says, there are numerous occasions now where staff either at the police station or custody unit have to be with that individual to ensure their care or they are spending literally hours at a supposed place of safety awaiting the arrival of a section 12 doctor or an AMP or both. Again, that is taking up their time.

Q200 Lorraine Fullbrook: I would like to ask a supplementary. Sergeant Shaw, you said that the number of people has increased in the last year. Is that because people who are intoxicated or drunk are included in those figures?

Sergeant Shaw: Well, people that get brought into us when they are intoxicated or drunk, we still deal with the same risk assessment as someone brought into us that is not intoxicated or drunk. They will still to a certain degree be able to communicate with us what their medical issues are and that is when it is identified. If they are not able to communicate with us and they have been into police custody before, we are usually able to find out from previous records. From my perspective from some years ago, my personal opinion is it is on the increase, people with mental health issues, not so much having a problem with them and being able to deal with them through their GPs, but it is on the increase from my perspective.

Lorraine Fullbrook: Can I ask my main question?

Chair: Yes, indeed, if you would.

Q201 Lorraine Fullbrook: I would like to ask you both about section 136 and places of safety. One of the recommendations from the 2013 HMIC report, "A Criminal Use of Police Cells?", asked

custody officers to, “Ensure that a full explanation is recorded in the custody record as to why a person detained under section 136 has not been accepted into a health-based place of safety”. Do you do this? What are the common reasons for the recording of this?

Sergeant Kressinger: We have recently introduced a mental health reporting form in our force to assist us in gathering evidence as to why people are not being taken to places of safety. When someone comes in, if they are brought into the custody unit, we will document on the record the reasons why they have been brought in, what efforts they have made to take them to a place of safety, and then every person that comes into our custody units now under section 136, the sergeant or a person in that unit will fill out a mental health reporting form. This is fed through our organisation through to our ACC, who is the lead for our mental health, to tell him basically why it is they are coming to a custody unit.

Q202 Lorraine Fullbrook: Sergeant Shaw, would you like to add anything to that?

Sergeant Shaw: Yes. If we have an incident of somebody the mental health assessment unit are not able to take, it is usually escalated through the chain of command to say, “This needs to be addressed”. The custody record is documented to that effect as to why they are at the police station and not at the mental health unit where they should be.

Q203 Lorraine Fullbrook: Is there any other relevant data that you record?

Sergeant Kressinger: In what sense?

Lorraine Fullbrook: On that particular night, for example, if they have not been offered a health-based place of safety, do you record any other relevant data if they have had, say, past history of being not included in a health-based place of safety and so on?

Sergeant Kressinger: Again, as Andy was saying earlier, we do carry out checks. We will know if they have been detained before and brought in and what has happened previously. Certainly, on that day we have to take it as they come in. If they present and they are not taken to a place of safety, we just have to deal with it as they come in then.

Chair: Thank you. Michael Ellis is back.

Q204 Michael Ellis: I went to vote in the Chamber, of course. Can I go back to the question that I was asking before? When someone presents to you with suicidal tendencies or you feel that they may be at risk of self-harm, what do you do about it?

Sergeant Kressinger: Can I very, very quickly set the scene, if I may? If someone is detained on the street now through 136, the officer will believe then that they are in immediate need of care, so they will bring them in. We know pretty much straight away when they come in they have threatened to harm themselves. This is where I think custody is not really the place for people under 136. We will go through their rights and we offer them a solicitor for one thing. That automatically sets them thinking, “What have I done wrong criminally?” when we are there trying to help them. We have a listen to the account from the officer. If they have tried to harm with a knife or they have a blade concealed or something, we may well have to strip search them just to make sure they do not have anything concealed in an orifice. That, while degrading, needs to be

done and it is not the ideal place in custody. They may have to be placed in anti-harm clothing, which again is another factor to cause them stress.

Q205 Michael Ellis: This is like paper clothing that can't be used as a ligature?

Sergeant Kressinger: We have a suit now that is specifically designed to be worn in custody, which should be rip proof.

Q206 Michael Ellis: Do you ever put them in with somebody else who might be relied upon—

Sergeant Kressinger: Never.

Q207 Michael Ellis: Because I understand in some jurisdictions overseas one of the ways of dealing with it is to put such a person in with another prisoner, the idea being that that prisoner would raise the alarm if that person—we do not do that?

Sergeant Kressinger: No. We have different levels of observation now and if anybody causes us any concern we can have them in a cell being monitored on a camera or we could have an officer or two officers sat with them in close proximity to them.

Q208 Michael Ellis: Finally from me, does it change in any way? Do your procedures change if the person is a child, a person who is under the age of 18?

Sergeant Kressinger: Well, firstly, I should say it does not happen. At the minute, as it stands, we do not have any place of safety in Devon and Cornwall where we have beds allocated for under-18s. Now, this is going to change because one unit in Plymouth is going to have one bed, hopefully, and one in Cornwall is going to have a bed.

Q209 Michael Ellis: What do you do if someone presents who is 15, 17, something like that? How do you deal with that situation? You have to keep them in the cells?

Sergeant Kressinger: Ultimately, that is what we would have to do.

Q210 Michael Ellis: You do not do anything differently from if they were 50 or 30?

Sergeant Kressinger: Because of the age, we would try to get them to the place of safety. There is section 140 of the Mental Health Act, in which case we could then try to get hold of an AMP, approved mental health worker, and say, "Please find a bed in a local hospital as an emergency admission", but in my experience very rarely does that happen.

Q211 Paul Flynn: When people come in for a mental health assessment under s136, could you describe the process of what happens? How long does it normally take to get the assessment?

Sergeant Shaw: It depends on what area you are working in. You could be lucky enough to be working in a fairly metropolitan area where doctors or healthcare professionals will come out fairly rapidly. Then some stations have medical people on the station at all times, but it has been

known if you were waiting for a section 12 or an AMP you could wait, especially if it is at night, several hours.

Q212 Paul Flynn: I think PACE says that you should get an assessment within 24 hours. Is that reasonable or should that be changed or does it work well now?

Sergeant Shaw: From our perspective, looking after these people in police custody, police custody for section 136 is not the right environment for them to be in. Our view is that they should be dealt with quicker. What we try to do is to establish a rapport with the assessment unit as to when a bed or an assessment opportunity becomes available, then get permission to transport them to hospital.

Q213 Paul Flynn: What are your relationships with the local health people?

Sergeant Shaw: Mine in particular is usually pretty good, but we do have the instances where they do not have the resources to deal with the acceptance of a 136.

Q214 Paul Flynn: Is it their level of expertise or what resources do you mean?

Sergeant Shaw: Well, from personal experience, I have been aware of a situation where the assessment unit did not have the qualified level of staff on to accept 136 detainees.

Q215 Paul Flynn: Do you think the system is working well without any additional laws or recommendations?

Sergeant Shaw: Well, I think it needs more resources placed and more beds available for 136 detainees nationally. I am talking to colleagues up and down the country. That does cause issues within the custody environment because obviously you can have umpteen detainees to deal with for criminal offences as well as someone that may be there for 136.

Paul Flynn: I am very grateful to you. Thank you.

Sergeant Kressinger: Could I answer that?

Chair: Yes, of course, Mr Kressinger.

Sergeant Kressinger: I do not think the system is working with us in health. I think the relationship is good to speak to, but when people are detained under 136 far too many people who should be going to a place of safety are not because of lack of staff, lack of facilities, and they are brought into custody. That is completely the wrong environment.

Q216 Paul Flynn: The problems that arise from that are the consequences that people are kept in unsuitable surroundings, which results in what?

Sergeant Kressinger: Just by way of example, vulnerable people or with mental illness do not like bright lights or shouting, and yet we are putting them in a police cell where we have to put a bright light on them so we can see them. Potentially, the person next door could be banging and shouting and it is completely the wrong environment.

Paul Flynn: I understand, thanks.

Q217 Chair: If you look at the figures of those detained under section 136 in police cells, in 2012-13 it was 7,761. I am just looking at the differences in the police forces. We are going to hear evidence shortly from the Chief Constable of Leicestershire, Simon Cole. They have a very, very small figure, probably about 30 or 40, but then you look at the Sussex Police; they seem to have 900. If you look at Devon and Cornwall, your own police force, it is up to 800. Why is there such a wide variation between different police forces?

Sergeant Kressinger: I think the relationship between the police, certainly in our force, and our partners perhaps is not the same cohesive or whatever it may be as other forces. I would certainly make a plea that while strategically documents like the "Crisis Care Concordat" are a good statement of intent and they are saying how things should be working, it is not happening on the ground.

Q218 Chair: It is something of a postcode lottery, isn't it?

Sergeant Kressinger: Very much so.

Q219 Chair: Depending on where you are you will be detained. If you happen to live in the West Midlands, you are less likely to be detained than if you live in Avon and Somerset, for example. That is not right, is it? The same standard of care should be available throughout the country?

Sergeant Kressinger: Absolutely.

Q220 Chair: What about in terms of the use of handcuffs and leg restraints? This is still something that both of you will see occurring, is that right?

Sergeant Shaw: It does happen on occasion. It depends on the circumstances presented to the response officers attending those incidents concerned. It depends how it is dealt with and it also depends on what they are met by that individual. I know it says that we should use restraint as a last resort, but sometimes it has to be done for everyone's protection as well.

Chair: Indeed.

Q221 Dr Huppert: Can I come back to this issue about detention of children? I think Mr Ellis did raise it but we moved on fairly quickly. The figures that we have from the Royal College of Psychiatrists is that in 2012-13 there were 580 under-18s detained under section 136, about half in police custody. Is that right? Does it sound about right to you?

Sergeant Kressinger: Sorry, I missed it. Could you say that again? I thought you were talking to Andy, I am sorry.

Dr Huppert: If you think the answer is something different I am happy to hear it.

Sergeant Shaw: Obviously, people displaying mental health episodes and detained under 136 can vary in age. It depends on obviously that individual concerned and their needs. I personally have not come across that many people under 18 that have been detained under 136 but I am not

saying it does not happen because obviously the figures speak for themselves. They will be dealt with appropriately as someone detained under 136 and to deal with their needs when they come into police custody.

Q222 Dr Huppert: The Care Quality Commission said that children were substantially more likely to be taken to a police station than adults. Again, does that fit with your experience or you do not recognise that?

Sergeant Kressinger: Well, generally, I do not think you will find that the place of safety will take them under the age of 18 anyway.

Q223 Dr Huppert: In your experience, there would be no alternative other than a police station?

Sergeant Kressinger: That is correct. Like I say, I believe, to be fair, I think that might change, but I have examples here of other custody sergeants who have detained juveniles where they have been in for lengthy periods of time. One, a young female, ended up biting her toes when she was in there. It is quite time-consuming to ensure these people are as well cared for as we can while they are in custody.

Q224 Dr Huppert: Presumably, one of the consequences, particularly for more rural forces, is that it would often be a lot further to take a child to any sort of place of safety than an adult, having to spend more time transporting them in a police vehicle. Is that right?

Sergeant Kressinger: Well, as you know, I am from quite a rural force.

Dr Huppert: Indeed.

Sergeant Kressinger: We have one place of safety in Cornwall, which again is quite rural, but then if you look at the definition of the Act, any place could be a place of safety if the person there temporarily is willing to accept them. I do not stand the argument that just because a specific place of safety cannot take a person they could not then be taken to another hospital, a care home. There are other alternatives that could be explored.

Q225 Dr Huppert: Children do sometimes get taken to hospitals, care homes?

Sergeant Kressinger: No, I am not saying they do. I am saying that they could be. I think there is an avenue that should be explored, but that is really I think for our partner agencies to perhaps embrace more.

Q226 Chair: You are on the front-line. We are going to hear next from ACPO in the guise of Simon Cole. If you were sitting round this table, what is the first question you would ask them?

Sergeant Shaw: They are sitting behind us. At the end of the day, from a custody sergeant's point of view, 136, a police station needs to be removed from the actual Act because these individuals are ill and they need to go to the hospital to be dealt with, not a police station or a police cell. That is not the right environment to get the help that they need.

Q227 Chair: At the moment, you are not equipped? You are not trained enough, you do not have the resources, the ability to move them away because there is no one to move them away to, is that right, Mr Kressinger?

Sergeant Kressinger: I think our force is quite progressive now. They are latching on to the importance and the prevalence of mental health. That is getting better, but I do get very frustrated at other partner agencies. Like I say, strategically it is fine, it sounds good, but it is just not happening on the ground.

I might pose another question as well, if I may. I echo what Andy says. I think everybody is saying—the CQC, HMIC, the Concordat—that it is not the place to take them. I do not want to set the cat among the pigeons, but Sir Paul Beresford, who I am sure you know, has made an amendment to 136, which would then allow police officers to enter private dwellings and detain. While I can see there are occasions, such as the example that he highlighted, where that would be useful, I would say I think this needs an awful lot more research before we start allowing police officers to go in. I can see agencies, instead of going for a 135 and going to a justice of the peace and getting a warrant, will then be getting hold of the police and saying, "I believe there is somebody in this address who is suffering from an illness. Can you please go in and deal with them?" We are not equipped to go into addresses and start making assumptions or beliefs or form opinions about people when we have not had that level of training.

Q228 Chair: Indeed. Thank you. On behalf of the Committee, can I thank you both again for coming here and for the work that you do on the front-line? In particular, could you go back, Sergeant Kressinger, to Devon and Cornwall and thank them for their interest that has been going on for a number of years? It is a direct result of your motion to the Police Federation and your conference that we have asked you to come here today.

Sergeant Kressinger: Thank you.

Chair: Obviously to the Essex Police, thank them for the work that they do on this very important issue. You are welcome to stay to hear ACPO's answer.

Mr Winnick: Not to ask questions.

Examination of Witnesses

Witnesses: **Chief Constable Simon Cole**, Leicestershire Police, Former ACPO lead on mental health, and **Mark Smith**, Head of Suicide Prevention and Mental Health, British Transport Police, gave evidence.

Q229 Chair: Mr Cole and Mr Smith, thank you very much for coming. I am going to open the questioning and then I am going to hand over the chair to Dr Huppert. I hope you will excuse me, but I wanted to start with Mr Cole because obviously we do not see enough of each other.

Chief Constable Cole: No, Chairman.

Q230 Chair: Can I start with you? This is a very sad story that has been told. We have had so many reports. We have had the Adebowale report. Ministers are obviously concerned about what is happening. There is clearly an economic case for getting it right in this time of heightened austerity. Why are we still failing to do the early intervention that Mr Shaw and Mr Kressinger talked about? Where have we gone wrong?

Chief Constable Cole: Well, firstly, I agree this is a really serious issue, and the two sergeants who have given evidence, I was nodding vigorously throughout because I agree with their description of what is happening. My sense is now that there have been lots of reports. There now needs to be consequent action on the ground. I do believe genuinely that the Crisis Care Concordat offers that opportunity, but I also agree absolutely with what has just been said by my colleagues, which is at the moment that is a strategic document. There are only 10 of them been signed off nationally. This is something that was agreed in theory in February and it is not making a difference on the ground to the level that it could.

But there are examples, Chairman. Very quickly, there are things happening that I think are positive. The general trend is towards less people being in police cells for 136, but it is still far too high. I absolutely share the view expressed by your two previous witnesses that police custody should not be in the Mental Health Act as a place of safety. It is just plain wrong. Street triage and liaison and diversion are things that I think are taking the debate forward.

Q231 Chair: We know you have a good story to tell and we are coming on to that slightly later. My concern is the number of people with mental health problems and concerns who have died in custody. I think the figure is two-thirds of people who commit suicide shortly after contact with the police have mental health problems. Why is it that inquest after inquest is coming up with evidence and verdicts that suggest if the police had handled it differently, had better training, these people would not have died?

Chief Constable Cole: Well, I think the first thing I want to make abundantly clear is that "prevent all deaths" is part of what our role should be. If a death can be prevented, we should be absolutely engaged and committed. You have highlighted and I know you have heard stories of dreadful personal tragedy and I would want to acknowledge that as a start point. In terms of numbers, deaths in contact with police, the last set of figures, deaths in custody there were 11, which is the lowest figure for a decade; around a million, 1.1—

Q232 Chair: Yes, but if I stop you there before you go on, of the 11, four had been detained due to mental health concerns?

Chief Constable Cole: Yes.

Q233 Chair: That is a very high proportion, isn't it?

Chief Constable Cole: Absolutely it is and it perhaps indicates some of the complexities and some of the realities. Of course, the fact that they were in a police cell is because two of those, I believe, were 136 detentions and two of them were arrests for other matters. Certainly, those two would not have been in a cell if that was not an option.

The other point I think you made, Chairman, was around subsequent suicides, of which there were 68 in the most recent IPCC report recorded. My colleague Mr Smith is doing some work nationally on that that I think the Committee might find useful. Can I ask him—

Chair: No, thank you. I will invite him, thank you.

Chief Constable Cole: Could I ask you to invite him, Chairman?

Q234 Chair: I will. That is why he is sitting next to you, Mr Cole. Mr Smith, just as an overview, we have specific questions to you. When we originally decided to have you, people wanted to know why and, of course, it is because of the number of people who commit suicide and are ill in those circumstances when on transport and, therefore, you are on the front-line. Are these on the increase or is it stabilising? Please give us some figures.

Mark Smith: Okay. I think it is stabilising at the moment. We did have a period in 2013 where we were very concerned about the growing numbers. I think we got to about August of 2013 and we had a 34% increase.

Q235 Chair: But in terms of sheer numbers?

Mark Smith: In sheer numbers, 325 people took their own lives on the railways in 2013-14. A further 91 attempted and survived with injury. On top of that—

Q236 Chair: But those are huge figures, aren't they, 300 people?

Mark Smith: They are. To extend the scope of it, there were over 4,000 suicidal incidents in 2013 on the transport network. It is not just the people that unfortunately take their own lives; there is that whole raft of other incidents that involve people threatening to take their own life, attempting and surviving with injury, attempting with no injury, 999 calls from concerned people who are missing. It does create a huge demand.

Q237 Chair: How are your members equipped to deal with this? This is extremely difficult to deal with someone who is about to throw themselves under a train or on a track. How on earth do you include that in training? It sounds to me some of the most sophisticated and esoteric methods of training that one could imagine.

Mark Smith: We have different layers of training. At the recruit stage, we give them an input on suicide prevention, not only the force policy and approach but also some of the softer skills that might help give officers confidence in dealing with somebody that is obviously in crisis and distressed. We also try to get as many people through the Samaritans' Managing Suicidal Contacts course. We have about 1,000 of our officers trained in that course. We also have trained our control room operators to know about our response policies and the other aspects that they can help front-line officers in terms of direction. We also have a course that uses police hydra technology. I do not know if you have heard of that before, but it is a computer immersive training where you get feeds of audio and written tasks. We give that to sergeants and inspectors to test decision making around vulnerable people. Part of that is suicide.

Q238 Chair: In terms of your officers, how much training do they receive in terms of hours?

Mark Smith: In hours? We attempt to give all of our officers at least one day's training on mental health and suicide prevention. The inductions at recruit level are quite short, only two hours. The Managing Suicidal Contacts course is another full day.

Q239 Chair: It is not a huge amount of time?

Mark Smith: It is not huge, but one of the things I have been talking to our—

Q240 Chair: Would you like them to have longer training?

Mark Smith: I think always longer training in these issues; they are very important. What we have done is increase the confidence of our officers to go and proactively look for people who are in distress on the railway. In the last 12 months—

Q241 Chair: Sure. Have you ever had to do that?

Mark Smith: I have. I was a serving officer for 31 years and I have been involved in many incidents involving death and attempted suicides on the railway. I have done the Managing Suicidal Contacts course with the Samaritans.

Q242 Chair: Do you ever keep track? Once you have found someone who was about to commit suicide and you have intervened to stop this happening—I do not know how many times this has happened—

Mark Smith: 140 in the last 12 months.

Chair: For you?

Mark Smith: Not for me personally, no, British Transport Police, the local police, members of the public and rail staff.

Q243 Chair: Who keeps track of these 140 after they have been, in effect, saved?

Mark Smith: We do. British Transport Police has two joint police and health teams. We have one in London, one in Birmingham. The London one is funded by NHS England, London Underground, BTP, and the one in Birmingham is funded as part of the DOH street triage programme. Basically, everybody that comes to our notice, all of those 4,000 people, will have a risk assessment approach applied, which was designed for us by the Oxford Centre for Suicide Research. Then we basically look to our health colleagues to help place those people into care pathways.

Q244 Chair: Yes. Do you have any joint training with other organisations, for example, paramedics, or training with mental health charities like Mind?

Mark Smith: We have at a local level, but not a nationally agreed programme at this time.

Q245 Chair: Would you like to see a nationally agreed programme?

Mark Smith: I think that would be very good, yes.

Q246 Chair: Mr Cole, it is quite different. What Mark Smith is doing with his team is quite different to what your officers are doing. By the time they get into the custody suite—and I know you are the chief constable, but you must go to custody suites very, very often in Leicester and Leicestershire. It is a busy place, isn't it?

Chief Constable Cole: Yes. I think British Transport Police have a real specific need because of the volume that you have highlighted. The national training package that was alluded to by the sergeants earlier, there is a national e-learning package, which won awards and 88,000 officers and staff have done. I think that is a good start point. I would like to see more face-to-face training. I think that that is of value. You have highlighted already yourself, Chair, it has to be interagency training. This is about shared risk, about people who are ill, and it may be they are a repeat caller. It may be they are an offender going through the cell block. It may be they are detained under section 136. There is a whole set of issues that play around policing and mental health. It is not just around 136.

Chair: Thank you. We have other questions.

Q247 Michael Ellis: I would like to ask you, Chief Constable, about two things briefly. The first is the street triage situation. I understand Leicestershire works well and closely with Northamptonshire, my own local police force, and work together, which is good. I would like to ask you about street triage inasmuch as this is a new diversion type service, is it not, which is being piloted in Leicestershire?

Chief Constable Cole: Yes.

Q248 Michael Ellis: How does it work and is it working well?

Chief Constable Cole: Broadly, there are nine Home Office-funded street triage pilots in nine different forces and then there are another 16 forces who have now, with their local health partners, created triage. They are all slightly different, but the broad basis of them is in the Leicestershire model, from 7.00 in the morning until 3.00 in the morning there is a crewed police officer with a trained mental health nurse who will be deployed and is available to advise any incident involving mental health. What are the advantages of that? Shared information. Straight away you have what is on the police computers. You have just asked a series of questions around how sergeants would know. One of the ways people would know is on the Police National Computer. It may be indicated that somebody has a tendency to self-harm or be violent. Also, then, health data as well, so the health practitioner can talk about the health records and that means better decisions are made.

What does it mean? We have been going since January 2013 in Leicester. About a 30% to 40% reduction in the use of section 136 powers. The numbers your predecessor as Chairman has alluded to around detentions going to police cells, we are at around about 30 in a typical year.

Q249 Michael Ellis: This is a system whereby it is like a utility that you can use. Is it county wide?

Chief Constable Cole: Yes, absolutely.

Q250 Michael Ellis: You have one mental health nurse attached to a police officer?

Chief Constable Cole: In effect, yes.

Q251 Michael Ellis: That you can call to anywhere in the county if you think it is necessary?

Chief Constable Cole: Yes.

Q252 Michael Ellis: It is like deploying a specialist unit?

Chief Constable Cole: Yes, and they are based in our central custody hub so they can also provide advice there. They can provide advice over the phone. It is a combination.

Q253 Michael Ellis: It has reduced by 40% your admissions under the Mental Health Act?

Chief Constable Cole: Our use of the 136 detention power.

Q254 Michael Ellis: The other point I wanted to ask you was about this. There has been a report today by one of the committees of this House about children feeling alienated by their contact with the police and this causing a lasting negative impression, which can be passed down the generations. Those children grow up and end up with a negative impression of the police. What can you do to ameliorate this situation?

Chief Constable Cole: That is a more general issue. It is not specifically around mental health.

Michael Ellis: No, it is not. It can relate to mental health as well, but it is a more general issue.

Chief Constable Cole: Yes, and, indeed, the Office for National Statistics' most recent survey said 90% of young people trusted the police. I have not seen the report; I have just seen the reporting of the report, if that makes some sense. What can we do? We can make sure that we have coherent engagement strategies, we are engaged in schools, places of education, cubs, youth groups, all of those kinds of things.

In relation to mental health, a really key issue has been highlighted by those that have just given evidence before us, which is the significant lack of provision for young people. If you are a young person suffering from mental illness, we are detaining you in a cell. You are more likely to be detained in a cell than an adult and there are literally no places. I could give you from my own force examples where it has taken us over 60 hours to place a mentally ill 15-year-old girl. She spent those 60 hours in a police cell in Leicester, the nearest bed being Manchester at one point. There is a profound issue.

Q255 Michael Ellis: I take your point, but isn't it also the case that if young people have a negative view of the police it may often be because on the few occasions that they come into contact with the police, the police are in a position where they are seeking to reprimand them or they are in

trouble for something? Perhaps if the police engaged more with young people in a non-suspect type scenario that might encourage more people to have positive impressions of the police.

Chief Constable Cole: It would, although other data suggests 90% of young people trust us. I guess the bottom line for us is we are an enforcement agency and young people are most likely to be victims and most likely to be offenders. That age group between 14 and 25 is the age group that is likely to be inside that line.

Michael Ellis: I accept that. Thank you very much.

Q256 Dr Huppert: Thank you for that. Can I move back to the idea of places of safety, which we have talked about? It touches on the rather horrific example you just gave, Chief Constable. The Police Federation in their evidence to us talked about hospitals operating informal exclusion criteria around drugs, alcohol, aggression, children and learning disabilities, so a fairly extensive list. Is there any progress being made on breaking down those barriers?

Chief Constable Cole: The barriers you have described are specifically not barriers according to the guidance from the Royal College of Psychiatrists, whose evidence to this Committee I would really commend to you and I think nails a lot of the issues. Is there progress being made? Well, hopefully, the concordat will force that progress: the production of more meaningful data; the production of the challenge that you talked about in terms of why people have been refused. But even as recently as last week the Care Quality Commission report, "A Safer Place To Be", highlights an example of a 16 year-old who had been going to kill themselves on the railway, it taking four and a half hours to get to a place of safety that might vaguely accept them, and when they got there being asked to be breathalysed before the 16-year-old, who was vulnerable and about to commit suicide, would be allowed in. These things are still going on. Has there been progress? I think there has been significant progress and you can see that in the numbers of 136s and where they are now going, but the variation is stark. Mr Vaz has highlighted that variation; from the West Midlands where there is virtually nobody going to a cell, my colleague from Devon and Cornwall has described nearly 800 people going to cells.

Q257 Dr Huppert: Again, on the issue about refusals—I will come to you in a second, Mr Smith—HMIC suggested that data should be collected on any time somebody is brought to a health-based place of safety by police and is not accepted and why. Do you think that would help to break through this?

Chief Constable Cole: Yes. Being candid, until three or four years ago the data collection around the whole piece was pretty inadequate. I was involved in some work with Inspector Siobhan Barber, who is behind me here, who did a lot of the hard work around trying to get some data together. I think some of the data that you have been quoting yourself during this session has helped draw it together. We need to understand what routes people go after 136 is used. What is then always quoted is how many were sectioned. Well, I do not think that is a dreadfully legitimate test. The test is did that person receive care that supported them at that point of crisis. That might have been a care plan. It might have been working with friends. It might have been a referral to another agency for another day. The data set is getting more coherent. There is work going on nationally. I think one of the reasons that 136s are believed to be going up might just be about better data collection.

Q258 Dr Huppert: Interesting. Mr Smith, BTP must have particular challenges with places of safety because there are so many around that you cannot know them all. Do you experience the same sort of problems?

Mark Smith: We do, and one of those cases that Mr Cole referred to there was one of our cases. We find exactly what has been described, which is a very ad hoc, patchy situation across the country. There are areas where there are few problems involved in the whole arrangements around section 136, particularly in London. We have been working and seeing great improvements in the arrangements there. The actual number of people going into police cells in London has been reduced to—I will ask colleagues behind me—but I think it is under 20 this year, down from about 80 last year.

We also need to go in and take some action sometimes. In the cases that are quoted in the Care Quality Commission report, members of my team will go and see managers within health at the location to try to resolve the issues, which are often due to different interpretations of local policies. One thing BTP does struggle with is the mental health codes of practice say there should be local policies to govern how section 136 is managed locally. Of course, BTP would struggle very much with 43 different policies.

Q259 Dr Huppert: Do you get help from the local forces in each area?

Mark Smith: Yes, undoubtedly. BTP have a policy that we do not ever take any section 136 detainees into our own custody, but they are in London where there is a good provision. BTP officers outside London will take people to local police stations if that is the only alternative and then will be working under the local arrangements. Yes, we have seen opportunities to improve things where you can build relationships with health and understand each other's position. If you do not do that, then there are problems.

Q260 Dr Huppert: One last question from me and then I will bring in Lorraine Fullbrook. You have this interesting role of head of suicide prevention and mental health in BTP. Do other police forces have equivalent roles?

Mark Smith: Other police forces often have heads of mental health, heads of safeguarding, which covers a breadth of issues around adult and child issues, so in most forces there is a senior lead for mental health issues.

Q261 Lorraine Fullbrook: The Home Secretary in her speech to the Police Federation in May held up Leicestershire and, I understand, Cleveland and Scarborough as best practice on the street triage project that you have set up. The initial results show outcomes are better for vulnerable people, show quicker solutions for police—

Chief Constable Cole: Definitely.

Lorraine Fullbrook: —and reductions of the section 136 in the initial results. She would like to see this rolled out across the country. She stated that additional money would be made available this year for four new pilots to be identified by the police. Do you know where those areas are? Are you involved in sharing the best practice that you have found throughout your project in the four areas?

Chief Constable Cole: The answer to do I know where those four areas are, no, I do not off the top of my head, I am sorry. There are now nine Home Office-funded triage pilots and, as I think I said, another 16. The point about triage, Her Majesty's Inspectorate of Constabulary has picked up in their report issued about three or four weeks ago on core policing where there was a recommendation that every force should look at the business case and the business benefits of street triage and, depending on the outcome of that assessment, every force should then make a decision about progressing with health partners street triage. The spreading of that has come from the HMIC report around 136 and custody.

The other thing that I would make the Committee aware of, which is just starting, is the Care Quality Commission are doing inspections of crisis care mental health. They have just done a couple of test inspections. One of the test inspections was my own force area with health partners. They have announced this morning another 15 areas where they are going to inspect the crisis care response, so looking at availability of places of safety, provision for young people, transport, which is a key issue. The data—I think we probably both have the same data pack, which is good—suggests that individuals should be transported by ambulance and medical staff and that is not happening in 75% of cases. I think there are a lot of positive things that are going on in terms of that spread.

There is a proper assessment being done by the Home Office of the nine projects, but the other thing that we have done nationally is share the criteria of that assessment with the 16 self-starters so that there is an assessment done on the same basis. I think you have nailed it. The outcome is there are lots of organisational benefits. There are cost benefits. It is more efficient. I think the Chairman started off by talking about the time. This is about an individual's life and the police laying hands on them because they are ill and taking them to a cell is not the best option for those individuals. It is just not.

Q262 Lorraine Fullbrook: As you are the expert, if you like, on street triage—

Chief Constable Cole: I have never been called that before.

Lorraine Fullbrook: —how can you insert yourself right in the middle of that to spread your best practice that you have built up over the time that you have been doing this?

Chief Constable Cole: To be fair, you have mentioned the Home Secretary.

Lorraine Fullbrook: How can you be pushy and get in there?

Chief Constable Cole: To be fair, the Home Secretary and Norman Lamb have both been hugely supportive of this agenda with their different responsibilities. I think they both get the issue that is at the heart that individuals are getting a service that we should not all be proud of between us. That has been spread.

The HMI has used us as an inspection test bed as a force on a number of things. We are cited in that recent HMI report as best practice. I would want to stress there are other versions of that. I think in Devon and Cornwall the triage is within the control room access to mental health expertise, mental health nurses and the data. Because of the geographic spread, physically setting off to get from Exeter to Land's End is apparently a long way, so they have had to find a different solution. I think that more than half the forces in the country now have a triage scheme of some sort.

Liaison and diversion offers similar opportunities. There are currently 10 of those schemes centrally funded, about £25 million worth of funding. They are being empirically assessed and then there is another nine to be announced in the new year. That will be again half the country has liaison and diversion in cell blocks.

Q263 Dr Huppert: Would you say the issue about street triage is not about whether it helps, whether it works, but whether it is affordable?

Chief Constable Cole: No. That is a really interesting question. I think it pays for itself really quickly because it is much cheaper to give someone the right option straight up than it is to take them, wait for six hours at a place of safety, wait another six hours for an assessment and detain them. The other thing I would think—and I know you had Michael Brown here, mental health cop, who I would say has done a fantastic job and I would want that put on the record. There is an element of street triage that it is a plaster to fix a current problem. The optimum system probably does not have triage because it has shared information. It has accessible care plans. It has got upstream of the problem. Where we are at the moment we need something to get us there and street triage I think is that tool.

Dr Huppert: Thank you, and I am sure Inspector Brown will be pleased to hear the comments.

Q264 Mr Winnick: Just one or two questions. Chief Constable, I was rather interested in what you said about the West Midlands, which is my part of the world. Is there any particular reason why the situation is so much better? I think that is a good way of putting it.

Chief Constable Cole: Because I left about 10 years ago could be the answer.

Mr Winnick: Which would be perhaps challenged by your successors, but carry on.

Chief Constable Cole: I think there has been a mature partnership discussion. Michael Brown was personally involved in it because he was doing some of the work for the chief officers there who took some particular leadership. I think there were a couple of specific issues involving deaths involving the police that forced a real hard look at what was happening and why things were happening. As a consequence, there is a mature partnership that is delivering what I believe the Act and the guidance to the Act and the nationally agreed guidance, which is here, say. That is being delivered and the Crisis Care Concordat in the West Midlands is broadly being delivered already, so there is something about leadership, the will to deliver, having accountability structures, and making it happen on the ground.

Q265 Mr Winnick: Good. Mr Smith, if I understand the position, you are, in fact, currently in your very responsible position within the British Transport Police a civilian, but you were a former senior police officer?

Mark Smith: I was, that is correct. That is correct. I was a detective chief superintendent. I was an area commander and I served a short period, about a year, as an acting assistant chief constable for crime.

Q266 Mr Winnick: Your period in total with the police service?

Mark Smith: With my current service it is now 34 years.

Q267 Mr Winnick: In your present position?

Mark Smith: Eighteen months.

Q268 Mr Winnick: Basically, as I see it—and for both of you, in fact, the question—is the lack of sufficient co-ordination between the National Health Service and the police force. I get the feeling that while nationally the situation is satisfactory, that is not necessarily on the ground locally with the concordat. Would that be the position, Mr Smith?

Mark Smith: My thoughts are that locally you need very good relationships, conversations and opportunities to exchange information and data about risk with health to make things work more effectively. Locally, we do suffer some areas where that is difficult to get the traction that we require. In other areas, you have pockets of excellence where we have had really good reception. In fact, BTP's scheme in Birmingham is funded as a part of the street triage pilot schemes. I was very impressed with the cross-city CCG there for accepting the challenge of hosting a service that runs from the Scottish border to Land's End in terms of the coverage. We work with the Birmingham and Solihull Mental Health Trust, who obviously also supply to the West Midlands street triage. The relationship there is excellent and I think wherever we can build effective relationships with health locally we can break down the sorts of issues that would hamper co-ordination. When you get that right and you share data about people and risk—and our street triage is not about reduction of section 136 per se, it is about reduction of inappropriate use of section 136. Our whole scheme is about outcome. It is about getting people from crisis to care, and that is what that is about.

Q269 Mr Winnick: Chief Constable, anything you wanted to add?

Chief Constable Cole: I would endorse all of that. I would add two things. I think it would be really helpful if the police service was able to be a member of the health and wellbeing boards that are created in every area. In many areas, we have been invited to be but we are not a statutory requirement, and that seems to me to be something of a gap.

The other thing is in the new health model the relationship and understanding of those commissioning services is as important as any of the operational relationships that you have just described. The commissioning of the shape of those services—and clearly health has gone through enormous change in recent years with CCGs being created and the like—what that commissioning model looks like and the commissioning guidance given is really important. I would want to stress the nature of these committees is always that we talk about what is wrong; there are lots of places where things are going really right and you have just highlighted the West Midlands, your area. There is lots going really right there. Our relationship, our triage, is because of a good relationship with the Leicester NHS Partnership Trust who have committed to it people and money.

Q270 Mr Winnick: You gave alarming figures to the Chair at the beginning of the evidence that the two of you have given regarding suicide incidents or what could be potential suicide. One could make the frivolous comment on a very, very serious and tragic situation the attraction of "Anna Karenina", the episode at the conclusion of the novel, but is there something about trains that

attracts people unfortunately in that state of mind, which one wishes with all the will in the world that their lives will be preserved?

Mark Smith: This problem has confounded us for a while. We have worked very closely with Network Rail, Transport for London, Samaritans and academics on the question why people come to the railway because then we can do more to prevent it. One thing we do know is that people who try to take their own life or do take their own life on the railway live very near to it. Even in rural areas, the people will live near railway lines, so it is an available means within their daily life.

Other research suggests—and this is from academic journals—that there is something around people's thought that it might be lethal, a sure means, which is not, in fact, completely the case. The likelihood of a fatal injury if you jump in front of a tube train is about 55%. The reality is 45% of people will have life-changing injuries. We work with Network Rail and with Samaritans and the train operators. We have a joint research programme going on at the moment, which has been funded by Network Rail and commissioned by the Samaritans to look at those wider issues to see what we can do to stop it.

The issue around, I suppose, showing railway deaths on films or in books or in media reporting, we do seem to see a connection. When you get media reporting around suicide, then we have spikes of events. We try to work with the media. There are media guidelines, as you know, for editors to try to do that responsibly, otherwise we do see an effect in what happens on the ground.

Mr Winnick: Very interesting.

Q271 Dr Huppert: That is very interesting indeed, Mr Smith. A few final questions, if I can. Before I come on to a few factual things about the Mental Health Act, do you have particular problems with people who are at risk or suicidal and a long way from home? Is that a particular challenge?

Mark Smith: Yes.

Q272 Dr Huppert: Particularly, do you ever have problems with getting local health services to take somebody who is from somewhere a long way away?

Mark Smith: Yes, we do. We do, and although it should not happen—I have had discussions just yesterday about this—we do have regular events where because the person is presenting with an issue outside their home area there is a reluctance to do an assessment in that area. I had a case where I had to personally intervene not so long back where an individual was taken off the railway lines trying to kill themselves. They had a physical injury so we went to A and E nearby. We then walked next door to the mental health unit, who assembled all of the staff that were required to do the assessment and then discovered the person was out of their home area. Then we got into difficulty and we had to intervene at a senior level to get that done.

Q273 Dr Huppert: It seems very strange given this is clearly an emergency situation. It is not as though you can wait a few months.

Mark Smith: I know, but it does happen. I think issues around funding unfortunately come into this.

Chief Constable Cole: The example I quoted earlier from the CQC report about the 16- year-old, if you read that report one of the places of safety refuses to accept the 16-year-old because they do not live in that area. You mentioned I think, Chairman, Sussex along the way. Sussex has been mentioned. Sussex and Beachy Head is a particular and unique issue. That is why their numbers are as they are. People head from all over the country to Beachy Head and it presents a particular demand. Sussex's use of 136, a lot of the numbers relate to that geographic location.

Q274 Dr Huppert: We should perhaps try to find if there are ways of disaggregating those numbers, at least to understand what is happening in the rest of Sussex. Can I finally ask you both a few specific questions about changes to the Mental Health Act? Can you give relatively brief answers, if possible? I am not trying to truncate your answers. Firstly, to be clear on the point that was raised by the custody sergeants about changing the Mental Health Act to allow the police to access private property to detain people who are in need of care, are you supportive, not supportive?

Mark Smith: We have a specific issue with this inasmuch that the power applies to people who are in a place to which the public have access. Railway lines are a place to which the public do not have access, so our officers need to remove somebody from a place of danger, get them to a public place, and then make that judgment as to whether they need care and control for the power to be made out and executed. Now, albeit there is some legal precedent that would support us doing that because we do have powers to remove people as trespassers from the network, it is a clunky way of doing things. It is not dissimilar to perhaps colleagues that need to find a route around the problem in private premises.

Q275 Dr Huppert: You would like to find some sort of arrangement for that?

Mark Smith: Yes.

Dr Huppert: Chief Constable Cole?

Chief Constable Cole: I do not support the extension into a private place for the reasons expressed very eloquently by my predecessor from Devon and Cornwall in terms of giving evidence. I understand absolutely why a lot of operational cops would wish for it because at the moment they are sitting and waiting and waiting and waiting for warrants to be sworn for people to get to private premises, but I just do not support it. I believe if the system operated as the law currently describes—and I do think there is a pretty profound issue for Parliament, which is: does Parliament want to enact something that means that the response to mental illness is the police have a power to enter a place?

Q276 Dr Huppert: You have been helpfully clear. Again, a few other quick things, and hopefully quick answers. Do you think there would be any problems in reducing the detention clock under section 136 from 72 hours to 24 hours?

Chief Constable Cole: It is absolutely outrageous that you can be detained for 72 hours for being ill and 24 hours for murdering somebody.

Q277 Dr Huppert: You would support 24 hours?

Chief Constable Cole: Yes.

Dr Huppert: Okay.

Chief Constable Cole: The PACE reviews should be done with a medical practitioner there. At the moment, if you are in custody, the inspector has to do it. It should be a review done with a medical practitioner.

Q278 Dr Huppert: I have two more questions that will be very helpful for our report. There have been suggestions to extend police powers under the Mental Health Act, such as the power to detain, to other professionals; paramedics, for example. Would you support that or not?

Chief Constable Cole: I would.

Mark Smith: I think in a setting where there is no need for police support, then that is a good option.

Q279 Dr Huppert: Thank you. That is very helpful. Last question: have you, as an organisation, formally asked the Government to change the law relating to section 135 or section 136?

Chief Constable Cole: I have been involved in the consultation process that is ongoing. I believe the review intends to report later this year, early next year.

Q280 Dr Huppert: You have fed in all of these lines?

Chief Constable Cole: I have met with the review, Dr Mason.

Mark Smith: We have, and the distinction is that we have asked for the power to extend to places where people are trespassing, not to extend to people entering private premises. If the individual is there as a trespasser, either on the railway or on the top of a high building, then the power can be used. That is what we have asked for.

Q281 Dr Huppert: Okay, thank you. Mr Smith, Chief Constable Cole, thank you very much for coming to give evidence.

Chief Constable Cole: Chairman, could I indulge three one-sentence points?

Dr Huppert: Yes, why not?

Chief Constable Cole: Thank you. Firstly, I think there is an implication to consider about police detaining mentally ill people and taking them to cells in relation to CRB checks, because the question we are then asked is: has this person been detained in a police cell? We say, "Yes, they have". The postcode lottery alluded to by Mr Vaz then applies to your subsequent CRB check where if you have been taken to a health-based place of safety you might have a different CRB check than you do if you have been taken to a cell.

Dr Huppert: That was a long sentence, but very helpful.

Chief Constable Cole: I know, but it had some commas in it. The point made by the sergeants around the law does not say a place of safety has to either be a place of safety or a police station,

it says it can be anywhere. It can be a doctor's surgery. It could be a community nurse. It could be anywhere appropriate and we should not lose that.

Lastly, your point, Chairman, around the suicide prevention role, every area is required or used to be required to have a suicide prevention strategy, which was a partnership suicide prevention strategy. There is still a national suicide prevention strategy, which suggests areas should have a local strategy. The answer is forces should be feeding into that strategy, which is a multiagency partnership strategy.

Mark Smith: Could I just say one thing? Is that possibly allowed?

Dr Huppert: One and only one.

Mark Smith: One and only, I promise.

Dr Huppert: The Members of the Committee are supposed to be elsewhere.

Mark Smith: One of the things that we have also contributed to discussion on is the Care Act. We were hoping that it would allow us to refer people at risk of self-harm and suicide into the multiagency arrangements for the care of vulnerable adults. The current legislation at the moment does not include that class of people in the at-risk category.

Dr Huppert: With those very brief sentences, Mr Smith, Chief Constable Cole, thank you very much.

Chief Constable Cole: Thank you.

Mark Smith: Thank you.

Dr Huppert: That concludes the session for today.