Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i iechyd meddwl yng nghyd-destun plismona a dalfa'r heddlu
HSCS(5) MHP20
Ymateb gan unigolyn

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Mental health in Policing and Police Custody

Evidence from an individual

Background

I was an operational police officer for 23 years until my retirement in June last year. During my service I was a Divisional Supervisor responsible for providing the initial response to incidents and also worked as a custody sergeant. Many of the incidents I supervised had a mental health element to it; and a large proportion of the 1,000s of prisoners I was responsible for suffered from mental health conditions; not all of them obvious or diagnosed.

My daughter was detained under the Mental Health Act (MHA) and I was involved in a parental capacity in those situations.

Operational Issues

There will always be a role for the police to play in dealing with people who are in crisis, and it is naive to think there will ever be a situation where the police will never have involvement with anyone who has been diagnosed or suspected of having a mental health problem. Officers deal with all members of the public. However once the immediate emergency has passed the police are often left abandoned by others agencies caring for a person without the relevant training, skills or resources. This does not mean the police should be given more training or resources; the gaps need to be filled by the correct and proper agencies. To illustrate this point I will provide two examples.

The family of a 14 year old autistic boy who was suffering a seizure called for police assistance as they had been restraining him for a prolonged period. He had also been given the maximum amount of medication allowed. The restraint was no more than gentle pressure to prevent him from harming himself or others as he was unable to control his limb movements. Because it was said he was kicking and punching he was classed as being violent and the Children and Adolescent Mental Health Services (CAMHS) refused to send anyone and the family were instructed to call the police. His punches and kicks were the jerking spasms of his seizure. My officers assisted the family in keeping him safe whilst I spoke with the ambulance service and mental health services on the phone. They refused to come out as he was "violent". It was only when I insisted it was a medical

emergency an ambulance was sent. Even then the crew had been instructed to tell the police to take the boy to hospital in a caged van. Once I had explained that the police had no more powers than any other member of the public in this situation and we did not have the same medical expertise or equipment as an ambulance crew they relented and he was taken to hospital.

My daughter was in crisis and intent on harming herself, either with an overdose or by cutting. She was trying to leave the house but was prevented by my wife and I. The police were called, and I have no issue with the officers attending, as they were correct agency to deal with the emergency. Because the incident had happened in our home she was detained under common law to prevent a breach of the peace. This meant that, because she had not been detained under Section 136 MHA, she was not allowed to be taken to Bro Cerwyn to be assessed and the only option available was for the police to take her to custody. Wrongly the staff at Bro Cerwyn were of the belief that the only place she could be taken to was police custody for an assessment.

Custody Issues

Persons are brought to custody for a number of reasons and broadly they fall into 2 categories - criminal and non-criminal. However, they all have differing needs depending on their personal situation. If they are detained under the MHA then it is a requirement for an assessment to be carried out. If they have been detained for other reasons the custody sergeant will be the decision maker on what level of care and support the detainee will require. To assist the in the decision making process the sgt will seek information from intelligence systems, the arresting officer and the detainee. There are scripted questions in the risk assessment and the use of trigger words often bring a scripted response, which ignores the situation at that particular time. When the words “self-harm” “suicide attempt” are mentioned it can provoke a response for the detainee to have their clothing removed and placed in an anti self-harm suit. Consider two prisoners with the same risk factors which causes the custody sgt to remove their clothing. For one detainee it could be beneficial as they feel they are being looked after and the risk of self harm is removed from them. For the other it could be devastating as they can be made to feel that once their clothing has gone they have nothing left and upon release from custody they will take their own life.

For many who work in custody, police and support staff, there is the fear of an adverse incident which will impact on their career and they take the most risk averse approach to their duties, however inappropriate it may be. This is not helped when organisations, such as Inquest, and politicians use headline figures linking the number of deaths in police custody and the number of prosecutions arising from those deaths. Not every death can be avoided. I have had many prisoners take ill whilst in my care and because of the expert first aid provided by detention officers this prisoners survived. The impact of lengthy blame seeking investigations benefits no one.

Missing Persons & Preventable situations

When a person is admitted to hospital as a voluntary patient they must be allowed to leave as voluntarily as they entered. On many occasions a person may be detained by the police and as part of the assessment they are given the option of being a voluntary patient or being sectioned; that is not consent; it's a threat. When that person decides to leave, because they are not subject to the MHA there is no legal power for the police to force them back to the ward. This causes legal problems for officers as they will be aware that a recent assessment has been conducted whereby the person was not detained under section, and there is no lawful authority to remove them against their will. If they utilise section 136 MHA and the person is admitted voluntarily, then is reported missing again we are back to square one, and so it goes on.

Many of those missing persons reports are avoidable but are not prevented by mental health services. xxxxxxxxx died in 2012 after she was allowed to leave Bro Cerwyn and at the subsequent inquest the coroner highlighted the lack of security of the ward. Over subsequent years there were hundreds of reports missing person reports from the same ward. The police raised concerns regarding the ease with which patients were able to abscond over the fence, yet nothing was done. Every time such a report is made police resources are deployed at some considerable cost to locate and return the person.

Planned operations

There needs to be greater collaboration between agencies at an early stage when it is known that the mental state of the person involved is a significant factor in any planned operations. Too often police are left picking up the pieces due to a lack of preparation or reluctance from other services.

Police will be asked to assist in executing a warrant issued under section 135 MHA and I will give an example I was personally involved in where poor information sharing, planning and execution caused excess and unnecessary work for the police. It also made the situation worse for the person involved.

A request was received for police to attend and assist in conducting an assessment of a person their own home and when I asked for the legal authority upon which the request was based it became obvious there was none and they were hoping to be gain consent. My response is if you have consent you don't need the police, we will assist if there is a requirement to use force. The following day I was informed they had a warrant and I was asked to have a couple of officers to meet them there. Only after I asked some questions when conducting a risk assessment I was informed the subject had access to a weapon and had made threats. This changed the dynamics and it took some time for a firearms response to be put in place. By the time that had happened the assessing doctors and social worker had gone home, resulting in armed officers arresting the subject on the basis of the threats previously made. He was kept in custody for 24 hours

before a MHA assessment was conducted. It transpired he had no weapon nor any mental health issues. It was false information from an ex-wife. Had there been earlier consultation this fact could have easily been discovered.

It is not unusual for the police to be contacted at the point where doctors and social workers are at the house wanting police assistance, where there has been little or no planning and no transport organised.

Patients as victims

Where a patient reports a crime or incident access to the patient is hindered or prevented with the reasons given that they lack capacity or have mental health issues, or their complaint isn't taken seriously. As well as a police supervision matter it is an issue for the staff on the wards. A recent example is where a patent reported being assaulted on the ward and as the report was being made a staff member spoke with the police on the phone stating it did not happen, yet that person was not on duty when the incident is alleged to have happened.

Summary

Many of the concerns I have about demands on policing are the result of matters outside the control of the police and the focus can become on the actions of police when they have been placed in a situation which should never have occurred on the first place. I hope this submission highlights some of these concerns and I would be willing to provide more evidence if required.