**CONSULTATION RESPONSE**

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| **TO** | **Royal College of Nursing** |
| **FROM** | **The Independent Police Complaints Commission (IPCC)** |
| **REGARDING** | **Consultation on draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools** |

## The IPCC and its remit

The IPCC's primary statutory purpose is to secure and maintain public confidence in the police complaints system in England and Wales. We are independent, and make decisions independently of the police, Government and interests groups. We investigate the most serious complaints and incidents involving the police, as well as handling certain appeals from people who are not satisfied with the way police have dealt with their complaint.

The IPCC was established by the Police Reform Act 2002 and became operational in April 2004. Since that time our remit has been extended to include:

- Police and Crime Commissioners and their deputies
- the London Mayor's Office for Policing and Crime and his deputy
- the Serious Organised Crime Agency (SOCA) (now disbanded)
- the National Crime Agency (NCA)
- Her Majesty's Revenue and Customs (HMRC)
- staff who carry out border and immigration functions who now work within the UK Border Force and the Home Office
- certain non Home Office police forces (including the British Transport Police and the Ministry of Defence Police)

The majority of complaints against the police are dealt with by the relevant police force (or agency) without IPCC involvement. However, certain types of complaints and incidents must be referred by the police to the IPCC, including when someone has died or been seriously injured following direct or indirect contact with police. We then decide what level of involvement we should have in any investigation of the matter. We may choose to conduct our own independent investigation, manage or supervise a police investigation, or decide that the matter can be dealt with locally by the police without IPCC oversight.

The IPCC does not usually operate in health and social care settings and its primary purpose is not to investigate or oversee health and social care professionals who do. However, many of the complaints and incidents that we investigate or consider on appeal involve individuals who have been restrained, or subject to other uses of force or restrictive practices, by the police. Furthermore, a proportion of those cases concern incidents which cut across both police and health and social care settings and in which both police and health and social care professionals have been involved.

In all cases in which there may have been a breach of Article 2 of the European Convention on Human Rights (ECHR) by the police, the IPCC has an obligation to begin an independent investigation. All deaths that occur in police custody and some deaths that occur following police contact potentially involve a breach of Article 2. Our remit when investigating such cases is not limited to looking only at police involvement in the circumstances surrounding the death. We may also need to look at the role of other members of the public, professionals and agencies, and at events which occurred prior to the individual's contact with the police.

## The IPCC's comments on the consultation

### Principles underpinning the draft guidance

Through its work the IPCC is aware of the wide range of injuries that can be sustained when an individual is physically restrained or is subject to other uses of force. We have also investigated incidents where tragically individuals have died following restraint by the police and/or other professionals or members of the public. This includes individuals who were especially vulnerable due to their mental or physical health.

We support the overriding aim of the draft guidance which we understand seeks to reduce the use of restrictive practices including restraint and to ensure that when they have to be used, it is in the least damaging manner. We also agree that it is crucial that individuals' human rights are protected, including in particular their rights under Articles 2 and 3 of the ECHR.

### Police attendance

We note that the draft guidance states *"The police or security should not be used as an alternative to the management of behaviour that challenges"* and that *"The police should only be called if all other efforts have been unsuccessful to manage a crisis situation*." We agree that the most appropriate response to an individual's mental health crisis, or other challenging behaviour in a health and social care setting, will nearly always be the use of highly trained and skilled therapeutic staff who are well-informed as to the cause or causes of the person's behaviour and are able to use physical restraint, if necessary, but within the context of the person's treatment. It is often entirely inappropriate for police officers with no knowledge of a patient, who are uniformed and carry self-defence weaponry, to become engaged in these types of incidents, particularly in secure unit settings. However, we recognise that there will be situations where police assistance is required and where it is necessary for police to attend.

**Responsibilities and duty of care**

We see that the draft guidance states:

> *"It is important to note that if the police are invited onto health and social care premises the lead health or social care worker is still responsible for handling the situation."* (p7)
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> *"Health and adult social care staff should have a clear local protocol about when the police are called in to support with handling a crisis situation and that when they are called in the health and social care staff retain the duty of care for the person. The police are proposing improved training to deal with such situations. It is expected that the local protocol will set out that the police will only be called as a last resort and therefore the police will use the appropriate methods for the situation."* (p7)
>
> *"When the police attend an urgent situation on health or social care premises it is essential that care and support professionals continue to coordinate a collaborative response."* (p19)

We agree that there should be local protocols between police and health and social care providers in place. Health and social care staff and police officers and police staff (including control room staff) need to be familiar with the arrangements under these protocols and with the roles, responsibilities and expectations of each party. The IPCC has previously identified problems relating to the quality of communication and co-ordination between police and health and social care staff, some examples of which are discussed further below.

We would also highlight that while health and social care staff have a duty of care for individuals with whom they come into contact during the course of their duties, police officers who are involved in dealing with an individual will also have their own duty of care for that person.

**Information sharing**

It is important that there is good quality communication between health and social care staff and police officers attending an incident, and that officers are provided with any relevant information (for example relating to an individual's physical or mental health or other vulnerabilities) which may help them in communicating with the individual or which may affect their decisions about using any restraint or other type of force. Similarly, there needs to be good communication when health and social care professionals attend non-healthcare settings such as police custody suites.

The IPCC's study of deaths in or following police custody from 1998/99 to 2008/09[1] showed that in a number of those cases the IPCC had criticised the way information had been shared between the police and other agencies, and that the criticisms centred mainly on healthcare matters. Among other points, our investigators identified instances where:

- There was a lack of communication between the police and staff at a secure mental health unit, which meant that a detainee's need for constant ongoing supervision was not known by custody officers and staff.
- Disagreement existed between the police and the NHS trust about how best to restrain a detainee at hospital in order to best protect him, the arresting officers and hospital staff.

[1] http://www.ipcc.gov.uk/page/deaths-custody-study

- NHS Trust policies on the management of violence and aggression, and the guidelines for rapid tranquillisation of disturbed patients, were not followed.
- The actions of a detainee's psychiatrist and mental health crisis team when sectioning him caused him to be aggressive. He later died of positional asphyxia.
- After arresting a man, a police officer requested an ambulance crew attend, but when it arrived, the officer did not provide paramedics with full details of the man's apparent state of health leading up to the incident. Neither did the ambulance service communications officer who took the police officer's call ask why the ambulance was required.

Following an investigation by the Independent Advisory Panel on Deaths in Custody (IAP), an information sharing statement was produced to provide national cross sector guidance on the protocols of sharing information and healthcare records. The IAP has identified possible issues in relation to the dissemination of the information sharing statement and that certain frontline staff (including those who have responsibilities in relation to custody) may not have seen it. It has recommended that all organisations cascade the information sharing statement again in a manner which targets the ground level staff likely to have responsibility for custody, and that the responsibility to share information should be incorporated within the professional practice guidelines of all agencies.

**Restraint**

The IPCC study also examined deaths involving police restraint. It found that 29% (98 people) of the sample were involved in a struggle or violence on arrest, or while in custody or hospital. 42% (140 people) were handcuffed either on arrest, or while in custody or hospital. 26% (87 people) were physically restrained by officers on arrest, during transportation or while in custody or hospital.

People aged between 25 and 34 years old were significantly more likely to be restrained than other age groups, and people from BME groups were significantly more likely to be restrained than White people. The most common restraint technique was being held down by police officers, used on 54 occasions during arrest and 21 occasions in custody or hospital.

For 16 people (5%) cause of death was classed as restraint-related (either primary or secondary cause of death). Of these deaths 12 people were White, three were Black and one was Asian. For four of the 16 people, cause of death was also classed as positional asphyxia.

Although the study was focused on deaths in or following police custody, many of the recommendations coming out of it have wider application. These include:

- Control room staff should ask for details on the clinical condition of the detainee, and of other patients on the premises when police officers are called to restrain detainees at medical facilities. This will enable the officers on the ground to make a judgement on whether to exercise restraint and on how to do it safely.
- Custody sergeants, as part of a risk assessment, should ask the arresting officer(s) whether they or any other person have used any restraint techniques on the detained person. This information should be shared with healthcare professionals attending to the detainee; any concerns should be noted on the custody record by the healthcare professional.
- ACPO should ensure that training manuals clearly state which restraint techniques are unauthorised, and which should only be used for a maximum length of time (for example, restraint in the prone position).

We are currently undertaking a wider research study examining police use of force, including restraint. We will not only be drawing on the cases we investigate and oversee, but also wish to explore the views and experiences of the public, police and other stakeholders. We would welcome the opportunity to work with the Royal College of Nursing to learn more about its experiences of and perspectives on uses of restraint and other force in health and social care settings.

We are conscious that there is particular concern about the use of prone restraint. This is one of the issues we will be examining closely in our review and we are aware that it is also being looked at by the College of Policing.

**Tasers, pepper sprays, CS gas and other uses of force**

We note that the draft guidance sets out that *"the use of tasers, pepper sprays and CS gas are not appropriate in health and social care settings".* We have previously expressed concerns about how these types of equipment have been used in healthcare settings and on individuals who are vulnerable due to their mental or physical health.

The presumption must always be that where police officers need to use force, they use the minimum level of force required. They must also be able to personally justify any decision to use force. We have recently conducted (but not yet published) a review of complaints and incidents involving police use of Taser. The IPCC plans to look further at the use of Taser, including where it sits in the continuum of force and at areas of particular concern such as its use on people with mental health issues and in the custody environment.

**Post incident reviews**

We see that the draft guidance sets out that organisations have a responsibility to ensure post incident learning takes place and that those involved in or witness to the use of restrictive interventions have access to post incident debriefing. Organisations may wish to consider the role of police in these reviews and consider sharing any relevant learning with police forces or other policing stakeholders.

**Recording**

We also note that the draft guidance emphasises the need for clear and accurate recording of the use of restrictive practices and highlights that all services will need to commit to gathering data on the extent of their use. We recognise the importance of having accurate data on which to monitor and assess the use of, and risks associated with, certain practices. We are currently pressing for the routine recording and monitoring of use of force by the police.

**Independent Police Complaints Commission**

13 February 2014