Multi-agency systems review to identify the learning following five homicides in Devon (2018-2019); with a focus on mental health care and management in custody.

July 2023

Report Advisory Notice

This report deals with difficult subjects relating to mental health conditions, care and treatment, and serious incidents. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where this information is necessary, for example, where a psychiatrist or doctors' opinion has been quoted or a specific act has been documented and this is relevant to the case. We do advise caution in those who may be triggered by reading information which might be sometimes distressing, particularly, that they are helped to read this report in a safe and supported way.

Author: **Dr Carol Rooney, Director**

First published: **July 2023**

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Report has been written in line with the Terms of Reference. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report was commissioned by NHS England and cannot be used or published without their permission. No other party may place any reliability whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the ‘Final Report’ should be regarded as definitive.

Niche Health & Social Care Consulting Ltd
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Contents

1 Executive summary

Overview

1.1 This review was commissioned by NHS England and Improvement (NHSE) and the Torbay and Devon Safeguarding Adults Partnership (TDSAP). The review is intended to scrutinise and assess areas of concern identified following a number of homicides committed in Devon in 2018 and 2019. These individuals all had a history of mental illness, and the review has also identified specific learning in terms of the health management of one of them[1] whilst they were in custody.

1.2 The primary focus of this review is, however, on the learning from three homicides that occurred in 2019 by the same individual, referred to as Mr A.

1.3 A Multi-Agency Incident Panel[2] was set up as a steering group for the review, meeting regularly throughout the process. The Panel had oversight of the development of the report and the development of a set of outcome-focussed recommendations and an action plan.

1.4 Three separate NHSE independent investigations were carried out:

- Care and treatment of Patient A prior to the homicide of a man in Barnstaple in August 2018
- Care and treatment of Mr A prior to the homicides of three elderly men in Exeter in February 2019.
- Care and treatment of Mr S prior to the homicide of a man in Newton Abbot, and the subsequent suicide of Mr S in June 2019.

1.5 System learning from these investigations is incorporated into this review (see Section 12), which will also focus on the provision of emergency mental health care in Devon, scrutinising and assessing areas of concern.

1.6 In discussion with the affected families, the management of mental health emergencies in custody was identified as their key area of concern.

1.7 During the trial of Mr A concerns were also raised about how local agencies work together to provide mental health care in emergency situations.

[1] Referred to as Mr A.

[2] The agencies were: NHS England, Devon County Council, NHS Devon CCG, Devon and Cornwall Police, G4S, Torbay & Devon Safeguarding Board, South Western Ambulance Service NHS Foundation Trust, Devon Partnership NHS Trust.

1.8 A detailed examination of the critical events and decision making points with reference to the events of February 2019 has therefore been carried out, which is followed by a review of the relevant systems across agencies.

February 2019 events

1.9 In the early hours of the morning on 11 February 2019, Devon and Cornwall Police received a report of a man acting aggressively at an Exeter hotel. Mr A was arrested and taken to Exeter custody suite. He was subsequently detained under Section 2 of the Mental Health Act 1983 (MHA)[3] and was transferred to a mental health hospital.

1.10 A central issue in the review is the question of how Mr A was managed after his previous arrest on 9 February 2019 for an assault, and how the various agency policies, procedures and statutory obligations impacted on decisions to release him on 10 February 2019. It was after this release that the three homicides occurred.

1.11 Three elderly men were found to have been killed in their homes in Exeter on 10 February 2019. Enquiries led to the rescinding of Mr A's detention under the MHA and his arrest for the homicides.

1.12 In November 2019 Mr A appeared in Exeter Crown Court charged with the three homicides in Exeter in February 2019. A jury found him not guilty of murder by reason of insanity and the judge issued a hospital order with restrictions under Section 37/41 MHA[4] which ordered his detention in a secure hospital for treatment.

1.13 Niche cannot provide definitive statements on acts of law as this is a matter for the judiciary. However, through our review we did not find evidence of obvious breaches - by any of the agencies involved- of the Mental Health Act, the Police and Criminal Evidence Act or of individual agency policies, in relation to Mr A's release on that day. We did, however, find that there were visible gaps in the way the system worked in a joined-up way that allowed Mr A to be released when his mental state was relapsing.

1.14 Mr A and his family have cooperated in the publication of this report. They welcome any recommendation which brings about an improvement in practices, procedures and conduct but cannot agree with nor accept the findings of the report.

1.15 Serious incident reviews should draw out system learning to minimise the risk of a reoccurrence and are not intended to apportion blame, and we have

[3] Admission to hospital for assessment for up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2

[4] Powers of courts to order hospital admission or guardianship. https://www.legislation.gov.uk/ukpga/1983/20/section/37 Power of higher courts to restrict discharge from hospital. https://www.legislation.gov.uk/ukpga/1983/20/section/41

analysed the contributory factors that influenced the decision to release Mr A (Appendix E).

1.16 In our view the primary root causes of his release are as detailed below:

Primary root cause
Mr A's clinical history was not available to G4S[5] on the evening of 9 February 2019.
There was a perception that Mr A's detention would continue through the following day, to allow further health assessment on the morning of 10 February 2019.
There was a separation of Police and Criminal Evidence Act (PACE)[6] process and healthcare perspectives, with no communication about the various limits and timelines.
Aggregate root cause
Custody healthcare is not commissioned by the NHS, with no information sharing system in place.

Recent developments

1.17 There have been a number of local developments since 2019, some linked to learning from these tragic events.

1.18 G4S have developed a structured induction and professional development programme for all their healthcare professionals, with external accreditation.

1.19 The single point of access across Devon Partnership NHS Trust was replaced in March 2020 by the Access and First Response Service (AFRS), providing a service seven days a week, 365 days a year. This is an urgent mental health service for people with mental health and learning disability needs. Contact can be made by professionals, or directly by an individual or family member.

1.20 The new 'emergency access to secure bed' protocol has been agreed across agencies and has been applied in real situations.

1.21 We have seen proposals by South Western Ambulance Service NHS Foundation Trust for a model for an Ambulance Service Mental Health Response service. The figures for demands on ambulances to respond to mental health emergencies show a steady rise in the South West, with escalating Devon figures.

1.22 The proposals include a 'mental health desk', with a qualified mental health practitioner providing support to the ambulance dispatch team. The intention

[5] G4S Health Services provides healthcare services to custodial environments.

[6] The Police and Criminal Evidence Act 1984 codes of practice regulate police powers and protect public rights https://www.gov.uk/guidance/police-and-criminal-evidence-act-1984-pace-codes-of-practice

is to integrate resources so that responses to any emergency which involves both mental and physical health issues have appropriate resources. We understand that discussions are in progress about funding and commissioning this service development.

Good practice

1.23 We found the following examples of good practice:

1.24 Liaison and Diversion services (L&D) had been informed by Street Triage that Mr A was in Barnstaple custody suite and might need assessment. L&D phoned Barnstaple custody suite at about 11.20am on 9 February to ask whether Mr A needed to be seen.

1.25 After Mr A was remanded in custody to HMP Exeter, L&D staff forwarded notes of his recent history to the healthcare team at HMP Exeter and arranged a handover call with the mental health team. They also attended Court to ensure that all relevant agencies had up-to-date health information.

1.26 The Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons (2017) applies to people who "have not been convicted of, or cautioned for, any offence placing them in one of the three MAPPA[7] categories, but whose behaviour gives reasonable grounds that there is a present likelihood of them committing an offence or offences that will cause serious harm". Part of the aim is to allow the exchange of information which can assist if an individual who is deemed potentially dangerous or suffering from a mental disorder is taken into custody. There is a very clearly defined process for this, with the appropriate legal limitations.

1.27 The protocol for emergency access to a medium-secure mental health bed was developed and implemented with multi-agency commitment, in direct response to an identified systems issue.

1.28 In Devon Partnership NHS Trust, there are practice standards and principles in place to guide staff at the interface points between First Response Service, Liaison Psychiatry, the Home Treatment Team, Approved Mental Health Professionals and Bed Capacity. These standards and principles guide staff through the steps in a referral and assessment pathway.

1.29 There are multiple examples of professionals in both police and NHS health services working collaboratively together, seeking to find creative solutions and providing training. Many of the professionals from both police and mental health work with each other on numerous multi-agency committees.

[7] Multi-agency public protection arrangements. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

Key learning points and recommendations

1.30 One of the priorities in the NHS Mental Health Implementation Plan 2019/20 – 2023/24[8] is Mental Health Crisis Care and Liaison. The workstreams are: Liaison Mental Health, Crisis Resolution and Home Treatment teams, Crisis Alternatives and Ambulance Mental Health Response.

1.31 Comprehensive crisis pathways are likely to include jointly commissioned and/or delivered services with non-NHS partners such as local authorities, police and voluntary community and social enterprises.

1.32 However, there is a gap in provision where criminal justice and/or custody structures become part of an individual's pathway through mental health services.

1.33 The recent thematic report[9] on individuals with mental health needs in criminal justice systems has made a range of findings about joint working, training, cross-system management and communication, and lack of consistency of services links, many of which resonate with the findings of this review.

1.34 The findings are discussed fully in Sections 5 to 10 of this report. These findings have been developed into a set of outcome focussed recommendations by the Multi-Agency Panel.

Recommendation 1: Devon ICB/DPT/NHSE

There should be appropriate available L&D cover in each custody suite in agreed daytime hours.

The L&D service should be designed and delivered in a way that meets contractual expectations.

Recommendation 2: DPT

Mental health assessments carried out by L&D should include a narrative description of the mental state examination.

L&D assessment forms should be restructured to provide more guidance in the mental health section of the form, ensuring it encompasses mental state examination.

Recommendation 3: DPT/DCC/Police/Police Healthcare Provider

There should be an agreed and implemented multi-agency protocol for Mental Health Act assessments in custody/under PACE.

[8] NHS Mental Health Implementation Plan 2019/20 – 2023/24. https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

[9] A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders. November 2021. CQC, Criminal Justice Joint Inspection and Health Inspectorate Wales.

There should be clear processes in place for making requests for MHA assessments in custody, aligning with NHS processes.

This should incorporate:

• access to L&D, AMHPs, First Response Service and taking PACE expectations into consideration

• escalation routes for police/custody healthcare personnel if there are mental health concerns about individuals detained in custody, including warning signs in a mental health state indicating deterioration

• Clinical advice and local mental health service advice available for forensic medical examiners

• actions when a mental health bed is required but not available.

Recommendation 4: Police Healthcare Provider/Police

Healthcare professionals providing police custody healthcare should have the skills and knowledge to make effective mental state examinations.

The Police Healthcare Provider should ensure mental health knowledge and training is enhanced to include:
• how to gather background information, mental state examination, risk assessment and decision making about requesting an MHA assessment.
• assessing clinical information rather than reliance on 'point in time' assessment.

Recommendation 5: Police Healthcare Provider/Police

HCP assessments should include clarity on the threshold for fitness to detain regarding mental health, and what mental health presentation changes would indicate that a new medical assessment was required and could be requested.

Police Healthcare Provider should provide clarity on threshold for fitness to detain and be evident in the medical assessment form including signs of deteriorating mental health.

Recommendation 6: ICB/DPT/Police Healthcare Provider

There should be an IT solution which allows access to health and other agency records.

The Police Healthcare Provider Healthcare Professional (HCP) should have multiagency agreement for access to NHS records, risk history and clinical information.

Recommendation 7: DCC/DPT

There will be sufficient capacity within the out of hours Mental Health Service to undertake Mental Health Act Assessments.

Devon County Council (DCC) and DPT need to recognise the lack of equivalence and the system pressures that impact on decision-making regarding Mental Health Act assessments out of hours.

Emergency Duty Service model of delivery of out of hours Mental Health Act assessments to be assessed against capacity and demand.

Recommendation 8: Police Healthcare Provider/Police

Clinical records should be available to custody healthcare professionals, which includes information about previous contacts, and tracks information requests and responses/outcomes.

The Police Healthcare Provider should develop:
• electronic clinical records
• an auditable process for information requests and responses / outcomes.

Recommendation 9: DCC/DPT

EDS staff should have access to and be trained in the use of relevant clinical information, when making decisions about out of hours MHAA.

Emergency Duty Service staff who have access to relevant clinical information about mental health should be confident in the use of CareNotes and how to navigate the system to access risk information.

Recommendation 10: Police

All agencies involved are aware of the individual PACE conditions and any changes of a detained person in custody.

Police should ensure that when there is a need for multi-agency healthcare input, all agencies involved are aware of the individual PACE conditions and any changes.

Recommendation 11: Police/Police Healthcare Provider

The overall sharing of information with the Police Healthcare Provider will be sufficient to ensure they can provide the best service possible with the maximum amount of information available.

Develop a Protocol between Devon and Cornwall Police in relation to Potentially Dangerous or Mentally Disordered Persons, which includes the Police Healthcare Provider and guidance for custody.

Recommendation 12: DPT/Police/ICB

Revised Peninsula Wide Section 136 policy in place and operational.

Set a timescale for the agreement and implementation of the Peninsula Wide Section 136 policy. This should include clarity on the process for using Section 136 if the person is already in custody.

Recommendation 13: DPT/Police

Mental Health/Police Liaison Committee should include clear reporting structures to the respective Executive Boards in Health and to the office of the Chief Constable.

Revision of the terms of reference of the Mental Health/Police Liaison Committee.

Recommendation 14: Police/Police Healthcare Provider

There should be structures in place to include the Police Healthcare Provider in local Memoranda of Understanding and information sharing agreements.

The Police Healthcare Provider should be included as a partner in custody/health Memoranda of Understanding and information sharing agreements related to custody settings.

Recommendation 15: TDSAP/DPT/Police/DCC/ICS

Local multi-agency risk evaluation processes should be in place for high risk individuals.

Development of multi-agency risk evaluation processes for high risk individuals.

Recommendation 16: DPT

There should be cohesive out of hours mental health service support for multi-agency partners.

Evaluation of the Street Triage and Joint Response Unit structures.

Recommendation 17: DPT/Devon ICS/DCC

The ICS Crisis and Mental Health Commissioning Group and TDSAP receive an updated system and oversight assurance report from the Urgent & Crisis Mental Health workstream. The report will seek to provide assurance that there is a coordinated responsive mental health service for the management of urgent mental health care in Devon.

There should be assurance that Crisis Care Concordat actions have been incorporated into urgent and crisis mental health workstreams.

2 Introduction and objectives

Overview

2.1 This review was commissioned by NHS England and Improvement and the Torbay and Devon Safeguarding Adults Partnership (TDSAP). The review is intended to scrutinise and assess areas of concern identified following a number of homicides committed in Devon in 2018 and 2019. These individuals all had a history of mental illness, and the review has also identified specific learning in terms of the health management of one of them whilst they were in custody.

2.2 The primary focus of this review is, however, on the learning from three homicides that occurred in 2019 by the same individual.

2.3 The three separate NHS England independent investigations are:

- Care and treatment of Mr A prior to the homicides of three elderly men in Exeter in February 2019.
- Care and treatment of Patient A prior to the homicide of a man in Barnstaple in August 2018.
- Care and treatment of Mr S prior to the homicide of a man in Newton Abbott in June 2019.

2.4 Learning from each of these investigations has been incorporated into this review. However, the main focus of this report is on the provision of emergency mental health care in Devon, scrutinising and assessing areas of particular concern which were identified as a result of the homicides committed by Mr A in February 2019.

2.5 Three elderly men were discovered to have been killed in Exeter on 10 February 2019.

2.6 In November 2019 Mr A appeared in Exeter Crown Court charged with the three homicides in Exeter in February 2019. A jury found him not guilty of murder by reason of insanity and the judge issued a hospital order with restrictions under Section 37/41 MHA which ordered his detention in a secure hospital for treatment.

Our approach to the review

2.7 The terms of reference for this review are provided in full in Appendix A. We have conducted a detailed analysis of the events and multi-agency decision-making over the period during and after Mr A's arrests in February 2019, and we reviewed protocols for mental health emergencies, inter-agency communication and oversight.

2.8 Serious incident reviews should draw out system learning to minimise the risk of a reoccurrence and are not intended to apportion blame. This review follows the guidance in the NHS England Serious Incident Framework. We have conducted our review applying a Root Cause Analysis (RCA) approach, by establishing a chronology, and identifying care and service delivery problems as well as contributory factors.

2.9 The terms of reference ask us to review and assess compliance with local policies, national guidance, and relevant statutory obligations. Where we have reviewed local guidance, we have referred to this in the text. Where we have considered other guidance, we have referenced this in the text and added a footnote for the publication we refer to.

2.10 We provide a guide referring to sections of our report to show how the terms of reference have been delivered, in Appendix B.

2.11 In order to deliver the project scope, we undertook:

- contact with the bereaved families[10] and affected individuals;
- a detailed chronology from review of Mr A's 2019 case records;
- a detailed review of individual management reviews (IMRs) from G4S, South Western Ambulance Service NHS Foundation Trust (SWASFT), the joint independent IMR commissioned by Devon Partnership NHS Trust and Avon & Wiltshire Partnership Trust, Devon County Council Emergency Duty Service, NHS Devon Clinical Commissioning Group, Devon and Cornwall Police, and information shared by the Crown Prosecution Service (CPS) Direct;
- a desktop review of key documents, including meeting papers and minutes, briefing papers, incident reports, corporate information, policies and procedures, contracts, court transcripts, national publications, and email communications;
- over 30 interviews (via videoconference) with current and former staff of Devon Partnership NHS Trust (DPT), G4S, NHS England Health in Justice, the Clinical Commissioning Groups, the local authority and other stakeholders with knowledge of the issues involved;
- a review of the findings of the three NHS England independent investigations.

2.12 We were provided with individual management review reports from Devon and Cornwall Police, Devon County Council (DCC), Patford House GP

[10] The families of the victims of Mr A

Surgery, SWASFT and G4S. An individual management review is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.

2.13 The Crown Prosecution Service (CPS) provided a written submission in answer to specific questions prepared by Niche and shared CPS decision making notes from February 2019.

2.14 We also reviewed the joint internal investigation carried out by DPT and AWP, and the psychiatric reports prepared for Court for Mr A.

2.15 Access to Mr A's full clinical record was provided by DPT, DCC and Patford House surgery. We were provided with documents directly related to Mr A's period in custody by Devon and Cornwall Police but did not have access to the full records held by G4S and the police. This was due to the need to provide information to other legal processes in progress alongside this review, and concerns about third party confidentiality.

2.16 We have referenced key documents in footnotes to the report and listed other key information sources in Appendix D. This report does not provide a detailed review of all communications or all events which have occurred within the chronology.

2.17 Where possible, we have supplemented the research undertaken through our interviews with documented evidence. Where we have referred to minutes from meetings, we highlight that these may not be a full record of the discussions which took place.

2.18 The investigation team at Niche comprised:

- Dr Carol Rooney, Director and Project Lead
- Dr Huw Stone, Consultant Forensic Psychiatrist
- Gary Goose MBE, Associate Consultant (Police expertise)
- Matt Walsh, Associate Consultant (Mental Health Act and Approved Mental Health Professional expertise)
- Dr Paul Kingston, Associate Consultant (Safeguarding expertise)
- Nick Moor, Partner for investigations.

Involvement of affected individuals

2.19 We have had contact with the bereaved families of the elderly men (two of whom were brothers) who were killed in Exeter and incorporate their questions into this review. A set of family questions is at Section 11.

2.20 We contacted the family of Mr A and heard his mother's views. We contacted the clinical team providing care for Mr A, and it was conveyed that he had decided not to take part.

2.21 We met with the farmer who was the victim of the assault on 9 February 2019 by Mr A, to hear their perspective on events.

2.22 We would like to express our condolences to the families involved. It is our sincere wish that this report does not add to their pain and distress and goes some way in addressing any outstanding issues and questions raised regarding the circumstances around the arrest and subsequent management of Mr A.

Structure of the report

2.23 Our report is set out as follows:

Section	Heading
Section 3	Context and agencies involved
Section 4	Timeline of events in February 2019
Section 5	Critical decision-making points on 9/10 February 2019
Section 6	Inter-agency communication and information sharing
Section 7	Protocols for mental health emergencies
Section 8	Out of hours mental health emergencies
Section 9	Oversight structures
Section 10	Culture, leadership, capacity and resources
Section 11	Family concerns
Section 12	Learning from NHS England independent investigations
Section 13	Key findings and recommendations

Parallel processes

2.24 We are aware that there have been several complaints and concerns about the events of February 2019, addressed to various agencies by families and individuals. We have not been privy to all of these details.

2.25 We were provided with a copy of the complaint to Devon and Cornwall Police, which was made in January 2020 by the family of the elderly brothers who were killed by Mr A.

2.26 An inquest into the three Exeter deaths has been opened and adjourned by the Coroner's office, and we understand will be reconvened after the NHS

England independent investigation reports and this review have been completed.

Investigation limitations

2.27 Although some agencies and services are commissioned across the South West Peninsula, and some NHS mental health services are provided separately, this review relates to Devon services only, excluding those provided by Livewell Southwest.

2.28 We were unable to interview police staff, and were informed this was because of parallel processes referred to above.

2.29 Overall, our investigation took 12 months to complete, which is significantly longer than the anticipated six months. We apologise for this. Our efforts were severely hampered by three main issues:

- It took several months to retrieve records and reference material. There were issues of security and confidentiality that were applied by agencies involved, which affected the pace of obtaining information.
- During our investigation we had to make several additional record requests to ensure that we reviewed everything we needed. We did not receive all that we needed until the autumn of 2021.
- This was a complex and wide-ranging review. The terms of reference covered many areas of concern. Our activity included investigating and reviewing contacts from six agencies, and issues of governance and oversight.

2.30 In addition, this report was carried out during the Covid-19 pandemic. This meant that there were significant additional delays due to agencies having to focus attention and divert resources to respond to the pandemic.

3 Context and agencies involved

3.1 A central issue in the review is the question of how Mr A was managed after his arrests on 8 and 9 February 2019, and how the various agency policies, procedures and statutory obligations impacted on decisions to release him on 10 February 2019. It was after this release that the three homicides occurred.

3.2 We are aware that this is a key question for the families involved, and the intention is to draw out the issues that guided and influenced decision-making.

3.3 Commissioners and health services provided:

Commissioners	NHS Devon Clinical Commissioning Group[11]	Several South West CCGs	Devon County Council	Devon & Cornwall Police
Providers	Devon Partnership Trust	SWASFT	Adult Social Care, Children's Social Care	G4S
Services provided	Liaison & Diversion service	Ambulance services	Emergency Duty Service	Custody Healthcare
	Street Triage		AMHP service	
	Joint Response Unit			

3.4 Custodial health services are currently the only stage in the criminal justice pathway where healthcare is not commissioned by the NHS.

3.5 As recommended by the 2009 Bradley Review of mental health and learning disability in the criminal justice system,[12] work has progressed across government to assess the feasibility of transferring commissioning and budgetary responsibility for custody healthcare services to the NHS. This recommendation has widespread support due to the clear benefits of integrating the healthcare pathway across the criminal justice system.

3.6 Currently however, police custody healthcare services for detainees in the UK are commonly outsourced to independent healthcare providers who employ custody nurses and forensic physicians to deliver forensic healthcare services.

3.7 In Devon and Cornwall, custody healthcare is delivered by G4S under contract to Devon and Cornwall Police. There is 24-hour on-site access to a G4S healthcare professional (HCP) who may be a registered nurse or paramedic. Medical staff (forensic medical examiners/FME) are available on

[11] Now Integrated Commissioning Boards

[12] The Bradley Report and the Government's Response: The implications for mental health services for offenders. http://www.ohrn.nhs.uk/resource/policy/SCHMBradleyReport.pdf

an on-call basis over 24 hours. In the county of Devon there are four custody suites, at Barnstaple, Exeter, Plymouth and Torquay.

3.8 It is known that there are high numbers of people with mental health, learning disability, substance misuse and other psychosocial vulnerabilities who enter the youth and criminal justice systems, who could be managed more appropriately in the community, or diverted from the justice pathway altogether.[13]

3.9 NHS Liaison and Diversion (L&D) services aim to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. L&D services provide a prompt response to concerns raised by the police, probation service, youth offending teams or court staff, and provide critical information to decision-makers in the justice system, in real time, when it comes to charging and sentencing these vulnerable people. L&D also acts as a point of referral and assertive follow-up for these service users, to ensure they can access, and are supported to attend, treatment and rehabilitation appointments.

3.10 In February 2019 DPT operated a single point of access for referrals for secondary mental health care. Since March 2020, emergency and out of hours access to DPT services is through the Access and First Response Service (AFRS).

3.11 Out of hours access to mental health care is also available through liaison mental health services based at hospital A&E departments. Access to advice and information is available through Street Triage; the Emergency Duty Service is provided through the statutory duty of the local authority to provide mental health act assessments out of hours. They have full access to DPT clinical records and can be consulted for advice.

G4S Custody Healthcare

3.12 Devon and Cornwall Police commission custody healthcare from G4S.[14] A core requirement for the service is to examine detainees to establish if they are ‘fit to detain’ and/or ‘fit to interview’. In addition, if a clinical assessment is requested by the detainee or a Police Officer then G4S are commissioned to carry out such an assessments. The G4S healthcare professionals have

[13] NHS Standard Contract for Liaison and Diversion services (2019). https://www.england.nhs.uk/wp-content/uploads/2019/12/national-liaison-and-diversion-service-specification-2019.pdf

[14] G4S Health Services (UK) Limited is a national provider of critical primary and forensic healthcare services for the public and private sectors. https://www.g4s.com/en-gb/what-we-do/health-services

access to the police Unifi[15] database, and some have access to the NHS Summary Care Record,[16] but there is no visibility of NHS care records.

3.13 A healthcare professional (HCP) is on duty 24 hours a day. They may be a registered general nurse or a paramedic by profession. Their responsibility is to check physical health, using a medical assessment form (MAF). Forensic medical examiners (FME) can be requested by the police to provide further medical review, or for specific tasks such as post-taser medical review or mental health assessment review. The FME is a doctor registered with the General Medical Council. One of the essential skills within the FME job description is "psychiatry experience", although most of the medical assessment work is in relation to physical health or substance misuse issues. FMEs are not psychiatrists, nor are they approved under the Mental Health Act 1983 (MHA) to make formal recommendations about the detention of a patient under the MHA (known as Section 12 Approved Doctors)[17]. G4S FMEs and HCPs have no legal authority or formal involvement in the MHA detention process. For this to happen there must be escalation to the L&D service and also involvement of Devon County Council, either through the Emergency Duty Service or the AMHP daytime service (see the 'Devon County Council' section below)."

3.14 All requests for HCP or FME input are made by the police directly, through a call centre operated by G4S. The call centre logs the request and conveys it to the locality, keeping a central database of requests. In 2019 all G4S health records were made on paper and were uploaded to a central system. There is a plan to move to electronic records in the future.

3.15 Requests for a medical assessment by a HCP, or for a review of 'fitness to detain' are made by the police, depending on the person's presentation. The MAF focusses on an assessment of physical health, although there is a section on mental health included. If there are concerns about mental health, the HCP may request that the police ask for a Liaison and Diversion service (L&D) assessment, or they can request it themselves.

3.16 An HCP may also be requested to carry out a 'fitness to release' assessment, but that is unusual and would apply only in very limited circumstances such as intoxication.

[15] Unified Force Intelligence system (Unifi)

[16] Summary Care Records (SCR) are an electronic record of important patient information, created from GP medical records. They can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care. https://digital.nhs.uk/services/summary-care-records-scr

[17] General provisions as to medical recommendations- Section 12 approval means a professional can make recommendations about the MHA. https://www.legislation.gov.uk/ukpga/1983/20/section/12

Devon and Cornwall Police

3.17 Devon and Cornwall Police are the territorial police force responsible for policing the counties of Devon and Cornwall. The force serves Devon, Cornwall and the Isles of Scilly, with the challenges and needs of both rural and urban communities.

3.18 The force serves approximately 1.77 million people, over an area of 3,967 square miles, and the area is estimated to receive an influx of over 10 million visitors each year. The Devon custody suites are based at Barnstaple: 13 cells, Exeter: 19 cells,[18] Plymouth: 40 cells and Torquay: 36 cells.

Devon County Council

3.19 Devon County Council (DCC) has a statutory duty to provide an Emergency Duty Service (EDS), which is a generic out of hours emergency service responding to social care emergencies (involving adults and/or children) which cannot be safely left until the next day.

3.20 The EDS is managed under the children's Social Care directorate but has a separate governance Board structure.

3.21 DCC also provides an Approved Mental Health Professional (AMHP)[19] service, working with DPT and Torbay Council, and has a statutory duty to provide this service. The AMHP service is managed directly by a dedicated Service Manager. The team are responsible for considering requests to carry out Mental Health Act assessments (MHAA) on individuals in certain circumstances. During office hours, the DPT AMHP daytime service coordinates Mental Health Act assessments under a Section 75[20] agreement.

3.22 Out of hours, there is an AMHP service provided by the EDS. However, the function of the EDS is to provide an out of hours service for all the statutory responsibilities of the local authority. These include child protection (Section 47 referrals)[21] and adult safeguarding (Section 42 referrals).[22]

[18] A new Exeter custody suite opened in April 2020 and now has 40 cells.

[19] AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act.

[20] Section 75 (S75) agreements allow for Local Authorities and health to pool funding to develop improved services and to maximise resources. Section 75s are a tool to facilitate joint working to improve outcomes for residents and can act as a key enabler for integration.

[21] Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare.

[22] Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

Devon Partnership NHS Trust

3.23 Devon Partnership NHS Trust (DPT) provides a range of NHS services to people with mental health and learning disability needs in Devon, the wider South West region and nationally. In Devon, DPT provide secondary mental health services across the county, excluding Plymouth where mental health services are provided by Livewell South West.[23]

3.24 Emergency and out of hours access to DPT services is through the Access and First Response Service (AFRS),[24] which has been operational since March 2020. This was not available in February 2019; at that time the Trust had a single point of access service only, which required a referral to be made by another healthcare professional. The FRS accepts self-referrals and is available as a telephone service 365 days a year, 24 hours a day.

3.25 NHS Liaison and Diversion (L&D) services aim to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. L&D services provide a response to concerns raised by the police, probation service, youth offending teams or court staff, and provide critical information to decision-makers in the justice system, in real time, when it comes to charging and sentencing these vulnerable people.

3.26 The essential elements of the service include: a clear definition of what constitutes a Liaison and Diversion service; connectivity across different local agencies with a local post-diversion infrastructure underpinned by a shared commissioning strategy; accessibility; skilled staff; outcome-focussed measures; and proportionate and minimal intervention.

3.27 The L&D service is predicated on four distinct and inter-related phases: case identification; secondary screening/triage, assessment including specialist assessment; and facilitating access to relevant services.

3.28 The local L&D service covers Devon and Cornwall and is provided by Devon Partnership NHS Trust (DPT). It is based at four Devon locations: Exeter, Torquay, Plymouth, Barnstaple, and there is also a direct single point of contact facility using email.

3.29 The DPT L&D service is commissioned by NHS England Health and Justice team to a national specification.[25] Prior to and during February 2019 the service was managed through DPT Adult Mental Health Directorate. Since

[23] Livewell Southwest is an independent, social enterprise providing integrated health and social care services for people across Plymouth, South Hams and West Devon. *https://www.livewellsouthwest.co.uk/*

[24] 24/7 Urgent Mental Health Helpline. *https://www.dpt.nhs.uk/locations/first-response-service*

[25] Liaison and Diversion Standard Service Specification 2019, NHS England and NHS Improvement.

April 2019 the L&D service has been directly managed by DPT Forensic Services.

3.30 Operating times are daily (seven days a week) within police custody suites. The local agreement was that there would be L&D staff available to each custody suite between the hours of 8am and 6pm. There were staffing pressures in February 2019 that meant it was not always possible to maintain a staff member present in each custody suite.

3.31 Street Triage staff in Devon routinely work remotely (from 10am to 2am) seven days a week. Street Triage provide police with information regarding whether an individual is known to mental health services, information about their mental health history and potential risks and support effective risk management and early access to mental health assessments.

Crown Prosecution Service Direct

3.32 CPS Direct [26]is the national charging division of the Crown Prosecution Service (CPS). Their role is to ensure that the police can obtain emergency charging advice on a 24/7 basis. Home-based prosecutors work on a shift pattern, which is managed to ensure that as far as possible the demands placed on the service can be met.

3.33 Police officers from Devon and Cornwall can access a prosecutor via a telephone system which connects them to the first available prosecutor.

3.34 At any one time, there is always at least one legal Shift Manager available to provide support and assistance to prosecutors and to deal with any appeals and urgent 'PACE clock'[27] referrals from the police. These urgent cases are managed through a priority email process which requires authority of at least Police Inspector level to access and request. The PACE clock is explained in detail in Section 5.

South Western Ambulance Service NHS Foundation Trust

3.35 South Western Ambulance Service NHS Foundation Trust (SWASFT) is the organisation responsible for providing ambulance services for the National Health Service (NHS) across South West England. It serves the council areas of Bath and North East Somerset, Bournemouth, Christchurch and Poole Council, Bristol, Cornwall, Devon, Dorset, Gloucestershire, North Somerset, Plymouth, Isles of Scilly, Somerset, South Gloucestershire, Swindon, Torbay and Wiltshire.

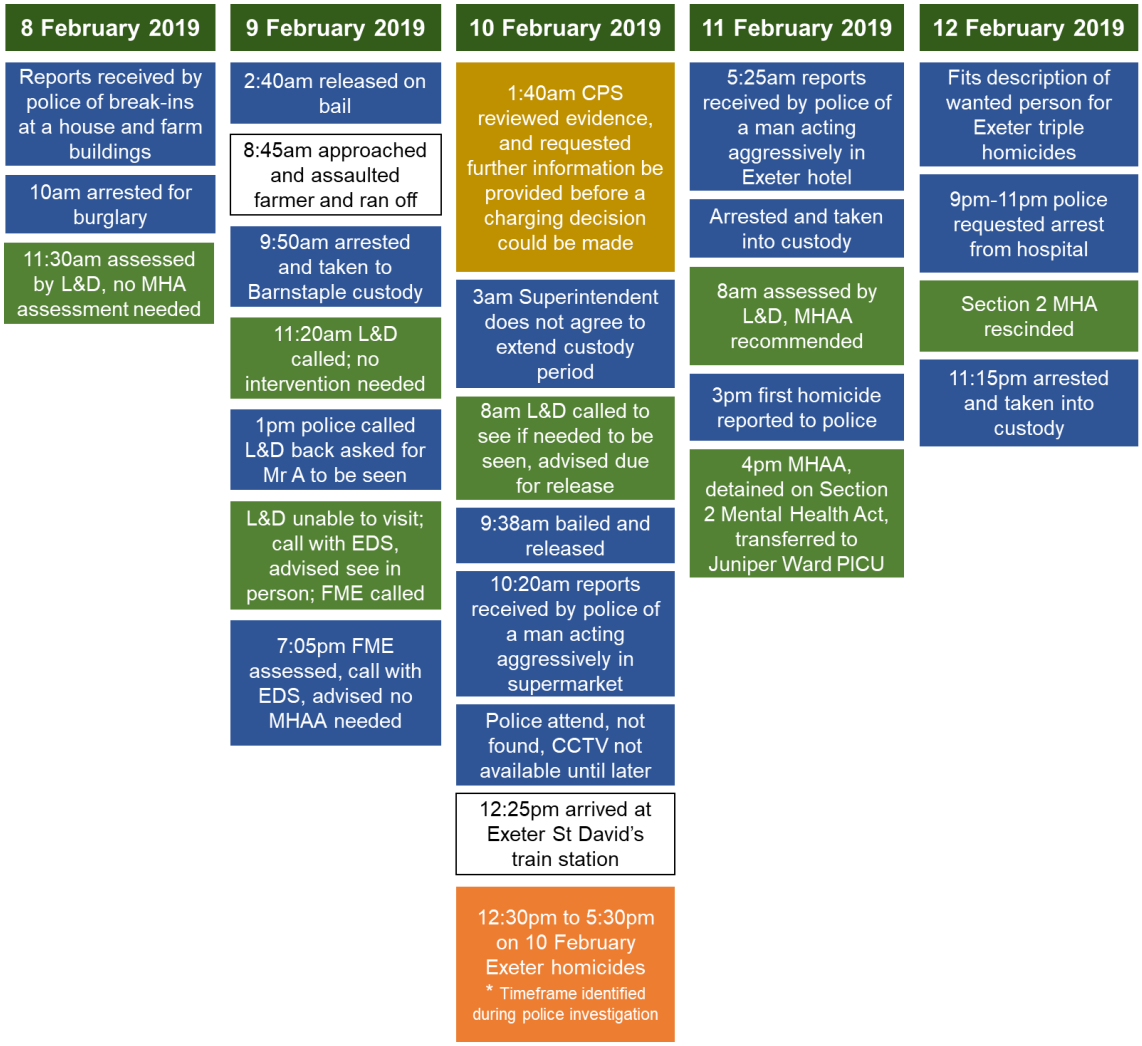
[26] CPS Direct provides charging advice/authorisation by phone and electronically to police forces at all hours. Prosecutors assigned to CPS Direct work from home to provide support outside of normal business hours. https://www.cps.gov.uk/about-cps/cps-areas-cps-direct-cps-central-casework-divisions-and-cps-proceeds-crime.

[27] 'Urgent referrals' are those cases which have a short time (currently less than 5 hours) remaining on the PACE clock.

3.36 SWASFT serves a population of more than 5.5 million, and its area is estimated to receive an influx of over 17.5 million visitors each year. The estimated figure for 2019 was 23 million, which has been increased further due to Covid-19. The operational area is predominantly rural but also has large urban centres including Bristol, Plymouth, Exeter, Truro, Bath, Swindon, Gloucester, Bournemouth and Poole.

3.37 The service headquarters are in Exeter, Devon. It has 96 ambulance stations and six charity-operated air ambulance bases within its area.

4 Timeline of events in February 2019



Friday 8/Saturday 9 February 2019

4.1 On 8 February 2019 police received a report from a local farmer about a burglary from some farm outbuildings on the previous day (7 February).

4.2 Later on 8 February police were called after a pub landlord complained about Mr A's behaviour. On the same day there were two police reports of a male acting suspiciously around some stables. Upon attendance, police officers quickly established that this was Mr A and that he was now suspected to be responsible for the burglary at the farm.

4.3 Mr A was arrested on suspicion of burglary and transported to Barnstaple custody suite and detained at 9.50am on 8 February.

4.4 He was initially cooperative but became more unsettled and aggressive. Police requested that healthcare staff see him for a 'fitness to detain'[28] assessment. He was seen by a member of the G4S custody healthcare staff on duty, and he mentioned a history of mental health issues and depression which was recorded. He complained of pains in his back and legs, and he was reported to be somewhat vague and dramatic in his speech. However, he was deemed fit to be detained and fit to be interviewed and not in need of an appropriate adult.

4.5 An assessment of his mental health was requested from the DPT L&D team, due to his history.

4.6 He was seen by a mental health practitioner (L&D1) at about 11.30am on 8 February 2019 and the L&D Peninsula Liaison and Diversion triage tool[29] was completed. His history of contact with mental health services was referenced and noted, and that Mr A declined a full assessment.

4.7 Mr A also declined the offer to provide him with the contact details of support services, including accommodation, and he reported that he was "staying in a van". He had informed custody staff that he was homeless but had been engaging in paid work. He denied that he was a current risk to himself or others. He agreed to update custody staff if he became willing to engage with the L&D service. It was recorded that it was a brief interaction, but L&D1 did not find any evidence that he lacked mental capacity.

4.8 Mr A was provided access to a solicitor, although he threatened to punch the allocated state-funded solicitor. This solicitor then declined to represent him, and without funds to pay for a replacement solicitor, it was agreed that he would be interviewed without a solicitor present. At about 10.00 pm, prior to his release, Mr A's mother contacted the custody suite to explain that she had "grave concerns" should he be released. Mr A consented to his mother being told that custody staff had found him a bed for the night at the local safe sleep centre. At his release, the custody sergeant recorded that Mr A was "orientated and lucid".

4.9 After interview he was charged with two offences; burglary and criminal damage (which related to him urinating in the police cell) and bailed to appear in court at a later date. He was released from custody at approximately 2.40am on 9 February and escorted to a 'safe sleep' centre in Barnstaple. The custody sergeant noted that he appeared orientated and lucid on release and was provided with leaflets for the L&D and Samaritans. In a later statement prepared for the coroner, the custody sergeant stated that Mr A did not present as in need of care or control at the time of his release, and it was

[28] If requested, G4S healthcare professionals will assess the health of a detainee.

[29] The L&D Triage Tool is used to structure the assessment.

therefore not felt to be necessary to instigate any police powers under Section 136 of the Mental Health Act.

4.10 Just before 6am on 9 February the safe sleep centre informed the police that he had just left of his own accord. This was noted, but there was no action for the police to take.

Saturday 9/Sunday 10 February 2019

4.11 At about 8.45am on a farm outside Barnstaple, Mr A was seen walking across a field belonging to an elderly farmer couple who lived across the road. Mr A approached the woman who was feeding the animals and tried to open the gates to let the farm animals out.

4.12 The woman called her husband, who approached him. Mr A had a long stick in one hand and was holding onto a four-foot logging saw. When the farmer approached, Mr A hit him with the stick and swung the saw at him at about knee height. The woman ran across the road to the house to call the police.

4.13 Mr A then moved quickly towards the man, swinging the saw at shoulder height, the farmer raised his arm to deflect this and sustained cuts to his arm. He then ran across the road and shut the gate which led to the house. Mr A approached the gate and started pushing at it, and then hit the farmer with the stick, which eventually broke. Mr A threw the broken stick at the farmer's head and swung the saw at head height, which also broke.

4.14 Mr A walked away, then crossed the field again to let the animals out and then ran away across the fields.

4.15 Police were called at about 9am, units were dispatched, police attended, and the farmer was taken to hospital by ambulance and treated for his injuries. He later made a statement at Barnstaple police station.

4.16 Mr A was located and arrested later that morning. Mr A was arrested for "Section 18 grievous bodily harm" (GBH)[30] with intent. This was used because the extent of the injuries was unknown, and the aggravating factor of a weapon led officers to believe this was the most appropriate offence at the time.

4.17 A further crime of burglary was reported that morning: an unoccupied house was found to have windows broken, and there was evidence that some property inside the house had been disturbed. On arrest Mr A was holding a

[30] Shooting or attempting to shoot, or wounding with intent to do grievous bodily harm. Section 18, Offences against the Person Act 1861. https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/18

metal key on a key fob which was later identified as having been stored within the house. He was therefore also arrested for burglary.

4.18 In custody Mr A became aggressive, he tried to take an officer's taser out of its holster and actively resisted officers who were trying to place him in a cell. As is usual, a health assessment was requested via the G4S call centre, with a request to assess an injury to his wrist and elbow and assess him for any mental health issues. Mr A was taken to the healthcare 'surgery' to be assessed for fitness to be detained, but he refused to speak to the G4S healthcare professional (HCP).

4.19 At about 10am the custody sergeant recorded Mr A as a "high risk detainee", with the reason given as "mental health". His behaviour in custody was described as erratic and unpredictable, and the content of his speech did not make sense.

4.20 L&D2 told us that they phoned Barnstaple custody suite at about 11.20am and spoke to police custody staff. They state that they were advised that the police did not currently have any concerns regarding Mr A, he had been in custody the day before but declined an assessment or any support from the L&D service. It was left that L&D2 would allow him to settle and call back to offer him an assessment.

4.21 He had minor injuries to his elbows and wrists, but no treatment was indicated. It was noted that he had been difficult and verbally abusive since arriving in custody. He refused to have any physical observations completed, and it was recorded that he seemed to understand but was deliberately choosing to misinterpret words. At about 11.40am the HCP noted in the custody record that Mr A was fit to be detained, fit to be interviewed and did not require an appropriate adult.

4.22 The Street Triage team were informed that he was in custody and had a mental health history, so called the L&D practitioner on duty (L&D2), who was based in Exeter.

4.23 Because of concerns about Mr A's presentation, the Custody Sergeant contacted the L&D team at about 1pm. The Custody Sergeant expressed concerns that some of his comments did not make sense and queried whether his mental health may be deteriorating: he told one officer that he was "sad because he had lost his unicorn". L&D2 called at about 2pm to speak to Mr A and was asked to call back after handover.

4.24 L&D2 spoke to Mr A over the phone at about 2.30pm, to carry out a telephone assessment. The Peninsula Liaison and Diversion Service Triage Tool was completed.

4.25 The assessment found that there was some evidence of paranoid thoughts, he was hungry but stated that he would not eat any of the food in custody as it was “tampered with” by the police. It was challenging to try and direct the conversation. Mr A was difficult to interrupt, he seemed agitated, talking rapidly, and talked over L&D2 frequently throughout the conversation.

4.26 He was quite eloquent in his use of language, repeatedly asking a question, listening to the answer and then repeating it back using different wording. He accused L&D2 of stealing his food, and then repeatedly said he had been assaulted.

4.27 Mr A said he was not taking any medication, did use cannabis but not had any recently, and was of no fixed abode. He was orientated to time and place but said he did not think his mental health was deteriorating and denied he had ever experienced any mental health issues. Mr A said he had a “duty of care to protect the environment, the animals and all sentient beings in the universe”. He felt that his last hospital admission was manipulated in order to prevent him from carrying out his “duty of care”.

4.28 L&D2 noted that there was a potential risk to the public in terms of further offending and his potential lack of insight into his mental state. L&D2 was concerned about his presentation, so called the Emergency Duty Service (EDS) (based in Exeter) to discuss options and spoke to EDS1.

4.29 A discussion about possible ways forward took place, without discussing details of Mr A’s circumstances. The following suggestions were made:

- a Liaison and Diversion (L&D) practitioner to undertake a face-to-face visit;
- a forensic medical examiner (FME) to undertake a face-to-face visit;
- police to use powers under Section 136 MHA; or
- psychiatric assessment to be undertaken in prison, should the nature of offence be serious enough for remand into custody.

4.30 The usual practice would have been that an L&D practitioner would make a face-to-face assessment, then if indicated, request a Mental Health Act assessment (MHAA) from the AMHP team in office hours, or from the EDS out of hours or at weekends. If this cannot be done or is outside the hours of work of the L&D service, a request is made for the G4S FME to assess and consider whether an MHAA is needed.

4.31 L&D2 at that time did believe Mr A required an MHAA but advised they did not have sufficient time in their span of duty to see Mr A face-to-face. They advised police at about 4.30pm to request an FME to carry out a face-to-face assessment. They planned to check the following morning if Mr A was still in custody, and to see if he would agree to an L&D assessment. Their form

concludes that he was “likely to be charged with the offence of GBH, if he is he will remain in court until Monday morning”.

4.32 As a routine check, the G4S HCP saw Mr A at about 4.40pm. They documented that he said he had low blood sugar and was lacking oxygen because he had been in the cell. The G4S HPC recorded that his behaviour was bizarre and ridiculous, and it was regarded as “premeditated” and there was no clinical explanation. The G4S HCP conveyed to police that at that time he was fit to detain, fit to interview and did not require an appropriate adult.

4.33 Police called the G4S call centre to request the attendance of an FME for a mental health examination. They were put through to the duty FME (Dr1). The history of Mr A’s arrest, the conversation with L&D2, and his current presentation were shared. Dr1 advised that it would take him about an hour and a half to arrive at Barnstaple custody, which was accepted, and the assessment was booked.

4.34 Dr1 arrived at Barnstaple custody at about 6.30pm and saw Mr A, who was found to be irritable and angry with the police. He said he believed the police were trying to poison him. He was not presenting as suicidal or a danger to himself. He was not regarded as a risk to anyone else, given that he was in custody. Mr A was not aggressive or confrontative in the conversation with Dr1.

4.35 Dr1 was concerned about Mr A’s statement that the police were trying to kill him and he believed he had called the EDS to talk over whether an MHAA was required at that time. This conversation ended with the decision that an MHAA was not required at that time, accepting there was some concern about Mr A’s mental health, but that he was safe in custody, not presenting a current risk, and could be assessed by L&D in the morning. Dr1 requested that an appropriate adult was provided.

4.36 When the appropriate adult arrived, Mr A was taken to the charge room by police to have his rights reiterated. Mr A entered an open cell and refused to come out, spitting at officers. At about 11pm he was interviewed in the cell because he refused to come to an interview room. At 11.20pm the appropriate adult has recorded that he was totally uncooperative, swearing, spitting, urinating in the cell and “talking rubbish”. His rights were read to him through the cell hatch, and it was noted that he could not engage in any sensible conversation, and it was not possible to approach him. When asked if he attacked the man with the saw he replied “yeah I did it, he’s a pervert”.

4.37 At 11.40pm officers sent an email to the CPS Direct inbox which contained the available witness statements and several internal police forms. The email requested that the case be reviewed for a charging decision and specified that the suspect was in custody and that a remand in custody is sought. This email included a copy of the Police Form MG3, which is the police report to

the CPS requesting a charging decision. This MG3 contained the following: 'This is an anticipated NOT GUILTY Plea based on the threshold test as a remand in custody is sought. There are three matters for consideration:

1. Burglary of a dwelling/farm between 7 February 2019 and 9 February 2019.

2. Assault occasioning actual bodily harm to (the farmer) on 9 February 2019.

3. Criminal damage to a police cell on 9 February 2019'.

4.38 The prosecutor reviewed the evidence at 1:40am on Sunday 10 February and discussed the case with the Officer in Charge (OIC) over the telephone. He reviewed the evidence and applied the Full Code Test[31] but concluded that the Full Code Test was not met. This was because, in the opinion of the prosecutor, there were key parts of the evidence missing including the need to establish the identity of the offender. This related to slightly differing accounts by the victim and the witness, and an Identification (ID) procedure was requested. To seek to address these evidential weaknesses, the prosecutor set an action plan which he sent to the police.

4.39 Before he sent the action plan to the police, the prosecutor asked that these enquiries be completed and returned for further advice within the time allowed under PACE (often termed the PACE clock). At the time of the charging request there were just under 8.5 hours left on the 'PACE clock'. The prosecutor acknowledged in their advice that in respect of the burglary offence, the further lines of enquiry could not be completed within the PACE clock. However, he did feel that the evidential deficiencies relating to the identification of the suspect for the assault on the elderly farmer could be rectified within the PACE clock.

4.40 Just after 3.00am, the OIC updated the custody record to explain that the CPS had asked for further work to be completed before a further referral to the CPS could be made. The police individual management review (IMR) states that the OIC believed that the tasks could be completed if there was a full 12-hour extension by a superintendent. A request to extend the custody PACE clock was made by the OIC to a superintendent just after 3am. The decision was that the superintendent had not been convinced that he was a significant risk and the necessity and proportionality needed were not present versus the option of bailing with conditions.

[31] The Code for Crown Prosecutors is a public document, issued by the Director of Public Prosecutions, that sets out the general principles Crown Prosecutors should follow when they make decisions on cases. https://www.cps.gov.uk/publication/code-crown-prosecutors

4.41 This decision was based on the earlier telephone call with the OIC, rather than any written material, and it was advised that Mr A should be bailed with appropriate conditions.

Sunday 10 February 2019

4.42 On the Sunday morning, L&D2 started duty in Exeter. Just after 8am they called Barnstaple custody suite and were told that Mr A was due to be released on bail within the next hour. A copy of an opt-in letter was sent to the police to give to Mr A, because for L&D to have any further contact, he would need to agree to their involvement once he had left custody.

4.43 The ID procedure involved serving Mr A with papers about the process, then arranging for him to be filmed. He was violent and resistive during this process and refused to be filmed.

4.44 He was bailed and released from custody at 9.38am on 10 February 2019 with conditions not to enter a local village and "not to be found on farm land, farm house or outbuilding". The police custody pre-release plan was completed, which stated that the HCP had not made a recommendation regarding the plan. The sergeant's witness statement to the coroner describes noting that he had been spoken to by L&D and seen by the FME. The custody sergeant provided Mr A with information for the L&D service but in answer to the question "has the HCP made any recommendations with regard to the exit plan?" they have indicated "no".

4.45 There were no concerns that he was at risk of harm from others. A call was made to the farmer to inform him of the decision not to charge Mr A, and it was noted that he was very unhappy with this decision.

4.46 The pre-release proforma asks if there are any concerns regarding physical or mental health, and these were identified:

- Mr A had a number of minor injuries to his wrist and elbow, and he was advised to call NHS Direct or see his GP.
- He had been seen by the forensic medical examiner (regarding his mental health) and L&D had requested their opt-in letter be given to him.
- He was of no fixed abode and was provided with the contact details of the Freedom Centre.[32]

4.47 It was noted that as part of the release plan the bail conditions were intended to reduce the chances of reoffending, and to reduce risks to the witnesses.

[32] Freedom Community Alliance (known as Freedom) runs the Freedom Drop-in Centre in Barnstaple, North Devon.

4.48 At 10.20am police received a report of a man acting aggressively in a local supermarket. Upon attendance, the suspect had left the location and an area search for him proved negative. This crime was allocated to an officer to investigate.[33]

4.49 Mr A's mother called the police at about 2pm, expressing concern for his welfare, and stating that his behaviour at that time was similar to that when he had previously had psychotic episodes. Mr A was logged as a "medium risk" missing person. Police contacted Street Triage at 3pm and it was noted that information about his contact with L&D services was shared with the police.

Monday 11 February 2019

4.50 Just after 5am police received a report of a man acting aggressively at an Exeter hotel. He had armed himself with a lamp and attacked the night guard and then walked throughout the hotel and back outside, attacking people at random and damaging parked cars. Upon police attendance, Mr A was found and refused to comply with instructions, which led to him being tasered and arrested and detained at Exeter custody suite.[34]

4.51 The police requested that the G4S HCP complete a 'fitness to detain' report after his arrest and taser. It was noted that mental health issues were a concern, and a medical examination is part of routine policy after a taser has been used. Mr A assaulted the HCP who tried to examine him, causing injury to their face and breaking their glasses.

4.52 Dr1, the G4S FME, examined him, and his opinion was that there were no medical concerns, and he did not need a MHA assessment. In his statement to coroner the custody sergeant noted that he did not agree with this assessment, and requested that this be discussed directly with the L&D staff in their office, which was nearby.

4.53 An L&D triage tool was completed by L&D3 at 8.00am, based on the information provided, noting the expiry time of the PACE clock (5.50am on 12 February). Police custody staff did not allow L&D3 to make an in-person assessment because of concerns about the risk of further unprovoked aggression towards health staff. The impression from the information provided was that he may be experiencing a relapse of a psychotic illness with a possible mood component.

4.54 L&D3 requested an MHAA to be carried out, although they had not seen Mr A in person, and this was convened for 2pm that day. He was seen by the AMHP and two Section 12 doctors, just after 4pm. It was noted that he had a

[33] Later CCTV images identified Mr A as the suspect, but these images were not available to police at the time.

[34] It is clear from later information that the three homicides had been committed by this time.

diagnosis of unspecified non-organic psychosis and appeared to be experiencing a relapse in his mental health.

4.55 It was agreed that Mr A had a mental disorder of a nature and degree that required a period of assessment in hospital in the interest of his health and safety and the protection of others. Due to his unpredictability, it was felt that he would require admission to a Psychiatric Intensive Care Unit (PICU). The AMHP has a duty to inform the nearest relative, and at that time his father would have been the nearest relative. Mr A's mother clarified that the functions of the nearest relative had been delegated to her after Mr A's last detention, and she was informed of his detention under Section 2 MHA.

4.56 Mr A was transferred to the Junipers PICU at Wonford Hospital, Exeter at 7.45pm on 11 February. He was admitted into seclusion because of his level of aggression in custody.

Tuesday 12 to Saturday 16 February 2019

4.57 Mr A's mother called the PICU at about 11.30 am on 12 February and was informed that he had been admitted, after establishing his consent to share the information. She was advised not to visit until he was more settled.

4.58 Mr A came out of seclusion later on 12 February; he was nursed on one-to-one observation but was able to stay in the ward area and interact safely with others. He accepted oral medication and there was no aggression.

4.59 On the evening of 12 February contact was made by police trying to ascertain Mr A's whereabouts. Senior Trust staff were informed that police wanted to arrest him on suspicion of murder. Given the seriousness of the charges, it was decided to rescind the Section 2 MHA, rather than agree Section 17 leave. A referral was made to the L&D team to help ensure that Mr A's mental health needs would be met as far as possible while in local custody and that clinical information would be communicated to any further establishment to which he might be transferred.

4.60 It was noted that a clinical plan would be needed if there were no plans to charge and remand Mr A. Police arrested him during the night of 12 February in the PICU and he was transferred to Exeter custody. No medication was supplied with him, and the PICU did not have a prescription pad on site to supply a prescription.

4.61 Mr A's mother was due to visit him in the PICU on 13 February; it was noted that staff believed that she could not be informed of recent events because staff did not have permission from Mr A. This was discussed with the Chief Operating Officer, to plan contact.

4.62 Mr A's mother phoned on 13 February 2019, and was told that no information could be shared, and the enquiry was passed to the Chief Operating Officer. Mrs A later called the L&D team, as she had been informed that he had been arrested. L&D staff requested that police contact her to share what information was appropriate. Mrs A said that when she called the ward, she spoke to a member of staff who then did not put the phone on mute, and she heard them say "it's his mother and she knows nothing". Mrs A told the investigation team that she was very distressed that she had no support from any organisation and, despite being Mr A's Nearest Relative and his next of kin, she was not given any information from mental health services.[35]

4.63 On the morning of 13 February 2019, the L&D team were informed that Mr A had been arrested and was in custody in Exeter, and likely to remain in custody for more than 24 hours. It was noted that there was a possibility that Mr A might not be charged with any offence if the threshold for charge was not met. The plan was that his mental health needs and vulnerabilities were to be monitored while the criminal justice process was completed.

4.64 If no charge was deemed likely, a clear plan to meet his mental health needs was needed to reduce risks to others as highlighted from the previous assessment in custody. If a charge was applied, Mr A would appear initially at the Magistrates Court and remand to prison might be requested. If he was remanded in custody the plan was for L&D to liaise with the mental health team at HMP Exeter to request an urgent assessment.

4.65 L&D arranged for Mr A to have a prescription written by the Consultant Psychiatrist at the PICU. There were delays in arranging this, because it was written on a prescription that required Mr A's consent to collect from a community pharmacy. He was unable to consent for a police officer to collect it on his behalf. L&D staff then arranged for a different kind of prescription and collected medication on his behalf.

4.66 L&D staff visited Mr A in custody at about 6pm on 13 February 2019. He was advised that medication was available to him and that L&D staff would continue to visit to offer support.

4.67 They visited again on 14 February 2019, and Mr A was able to converse but expressed some paranoia about food and refused any medication.

4.68 Police custody records for the 14 February 2019 note that he had been released from the Section to allow the criminal justice process to proceed. It was acknowledged that Mr A had mental health issues, but that he had been arrested for three murders, and the seriousness of the offences "overrides"

[35] The Mr A care and treatment investigation has made a recommendation about this aspect.

the MHA at that time, and that his mental health care would be “dealt with at a later date”.

4.69 A report to the Court was provided by L&D on 15 February 2019, advising that L&D staff could attend if needed. L&D staff visited Mr A on 15 February, and he stated that he had no issues at present. He appeared orientated and told L&D staff that he was likely to still be in custody the following day.

4.70 On 16 February 2019 Mr A appeared at Exeter Magistrates Court and was charged with murder and GBH. He was remanded in custody to HMP Exeter. L&D staff forwarded notes of his recent history to the healthcare team at HMP Exeter and arranged a handover call with the mental health team. They attended Court on 18 February 2019 to ensure that all relevant agencies had up-to-date health information. Shortly after this Mr A was moved to another prison and there was no further contact with the L&D service.

5 Critical decision-making points on 9/10 February 2019

5.1 We have identified care and service delivery problems at critical decision-making points for each agency. Care delivery problems (CDP) are problems that arise in the process of care, usually actions or omissions by staff (for example, care that deviates beyond safe limits of practice, or a failure to monitor, observe or act). Service delivery problems (SDP) are acts or omissions identified during analysis, but not associated with a direct care provision. These will be shown as e.g. 'L&DCDP' or 'DCCSDP' where care or service delivery problems are identified.

5.2 There were seven possible outcomes from custody after Mr A's arrest on 9 February 2019, under PACE regulations:

- extension of the custody time limit
- charge and remand in custody
- charge and bail to court
- Section 136 MHA
- a Mental Health Act assessment (MHAA) resulting in a detention under the MHA and transfer to hospital
- release under investigation or bail
- release with no further action.

Liaison and Diversion role

5.3 At the Liaison and Diversion (L&D) assessment of Mr A on 8 February 2019, the triage tool was completed. Although the records show that Mr A declined a full assessment, he was in fact seen by L&D1, who completed an assessment form. L&D1 was clear in their account that if there were any concerns about his mental health, they would have alerted the police. They were also clear that they could have requested a MHAA if they believed it was needed and could have talked this over with an Approved Mental Health Professional (AMHP) if there was uncertainty. If there was a need to discuss a decision such as this at a weekend, we were told that the practice in 2019 would usually have been to also talk it over with an AMHP from the Emergency Duty Service (EDS).

5.4 On 9 February 2019 L&D2 was covering Barnstaple and Exeter custody suites and was physically based in Exeter. The operational issues around contact and geographical base meant that when the request was made to assess Mr A, it was already afternoon. This meant that L&D2 was unable make an assessment in Barnstaple within their working hours. Because of

recruitment issues, across weekends there were times when there was only one L&D practitioner to work across two custody suites, as was the case in February 2019. There were no contingencies agreed for occasions when it would not be possible to visit a custody suite as usual. L&DCDP

5.5 They told us that they made efforts to discuss possible solutions with police. There was a discussion with police about applying Section 136 MHA, but according to L&D2[36] this was discounted by police for two reasons:

- He would need to be 'de-arrested' to apply the Section 136 MHA and there was a risk he could not be rearrested if he was not detained after the MHAA. This was a concern because of the seriousness of the alleged offence. Part of the rationale for not using the Section 136 option was also because they felt they were quite likely to secure charges and be able to charge with an offence overnight.

- The other concern was practical: police would have had to convey him to the Place of Safety which was at Exeter custody suite to apply Section 136 MHA. They were concerned about his presentation and the practical and operational challenges of conveying him safely to Exeter. While this is L&D2's recollection of the conversations, the police have assured this review that operational issues would not have influenced decision making about conveyance to Exeter.

5.6 The telephone consultation with Mr A at 14.40pm on 9 February raised the concern that an MHAA was indicated, but L&D2 was unable to attend in person due to their hours of work on the day. L&D2 discussed this with the EDS by phone.

5.7 The Devon L&D service specification (2019) and Operational Policy (2019) both indicate that:

"it is expected that L&D services will have screened anybody requiring a mental health act assessment and been the main referrer during operational hours."

5.8 The processes of case identification and assessment are detailed; however, it is not specified whether a face-to-face assessment is an expected requirement of the L&D assessment.

5.9 There is no protocol or standard operating practice guidance regarding how a referral for an MHAA should be carried out, either within or out of operational hours. L&DSDP

5.10 Clearly the usual practice is that the L&D practitioner is based in the custody suite and the assessment takes place face to face. This is not, however, a

[36] This is L&D2's recollection of events, and not a record of advice by police.

formal policy expectation (and may have varied since the beginning of the Covid-19 pandemic).

5.11 L&D2 phoned the EDS on 9 February 2019 at about 3.15pm to discuss possible solutions, considering they did not have time to assess face to face: the time of the referral and the geographical location precluded this. EDS1 believed they were talking theoretically about possible solutions and advised that a face-to-face assessment was expected. Although this is not a written policy, it was usual practice, and was a reasonable expectation.

5.12 At that time there was one L&D staff member on duty over the weekends to cover Barnstaple and Exeter custody suites.[37] This required the L&D practitioner on duty to monitor the police electronic 'white board' to pick up whether there were mental health concerns about any detained person. It had been communicated who was on duty and where they were, so police were aware that the L&D practitioner would not be in Barnstaple in person that day.

5.13 L&D2 had been informed by Street Triage that Mr A was in Barnstaple and might need assessment. L&D2 phoned Barnstaple custody at about 11.20am to ask if Mr A needed to be seen and was told there were no current concerns.

5.14 L&D2 would have been on duty the following day (Sunday 10 February) and planned to follow up to see if Mr A would agree to an L&D assessment if he was still in custody.

5.15 Following the discussion with EDS later that day, L&D2 suggested that if a face-to-face assessment was required, a medical assessment should be requested from the duty forensic medical examiner.

Emergency Duty Service role

5.16 The Emergency Duty Service (EDS) team were clear that normal practice, pre-Covid-19, was that there would be a face-to-face assessment before the decision to request an MHAA was made. A request by L&D to the AMHP team or EDS is not normally to discuss whether a MHAA is necessary, but to request that an MHAA take place, based on the practitioner's assessment.

5.17 EDS1 believed they were talking theoretically to L&D2 about possible solutions and advised that a face-to-face assessment was expected. Although this is not a written policy, it was usual practice. In our view this was a reasonable expectation. L&D2 did not have time to travel to Barnstaple, therefore requested that a forensic medical examiner (FME) be called to do a face-to-face assessment.

[37] This has since changed to provide two staff on duty over weekends.

5.18 EDS told us they would not normally have a discussion with an FME about whether an MHAA was indicated; they would expect the FME to have decided and make the request. If an MHAA was requested, the EDS AMHP would contact the Section 12 doctors to discuss the case and plan the assessment with the AMHP.

5.19 EDS expected that Dr1 could have contacted the single point of access (before the Access and First Response Service was in place) if they required background information, although they were not sure whether this was an agreed protocol. EDS staff told us that Dr1 did not request any background information about Mr A on 9 February 2019; the discussion concluded that Dr1 was satisfied that an MHAA was not needed at that time, based on their assessment. Evidence of mental health issues that would need some follow-up from a community service was described, and it was suggested that Dr1 speak to the L&D service, for them to be able to make the referral the next morning.

5.20 The role of the AMHP is to coordinate an assessment under the MHA, the assessment under the Act should be the most appropriate response to the circumstances of the situation. The outcome of admission under the MHA must be the last resort after all other least restrictive possibilities have been explored.[38]

5.21 The MHA Code of Practice states that "people who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as everyone else. Any person who is in prison or police custody or before the courts charged with a criminal offence and who is in need of medical treatment for mental disorder can be considered for admission to hospital where the criteria are met".[39]

5.22 The provision in Devon for mental health assessments in custody out of L&D service hours does not provide an equivalent level of service to the daytime provision. The only health assessments which are expected in custody out of hours are 'medically fit to detain', a specific assessment such as a post-taser review, or a request for an MHAA.

5.23 However, the Code also states that "if criminal proceedings are discontinued it may be appropriate for the relevant local authority to arrange for an approved

[38] Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Code of Practice Mental Health Act 1983 (2015). https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

[39] Chapter 22, Code of Practice Mental Health Act 1983 (2015). https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

mental health professional (AMHP) to consider making an application for admission to hospital under part 2 of the Act".

5.24 The Code offers guidance to professionals working at the interface of health and criminal justice processes. However, it is feasible that either process may carry primacy in relation to the nature and degree of the circumstances present. In practice, these decisions are made in conjunction with the agencies involved, and the MHAA is not dependent on a decision not to proceed with criminal proceedings. It is clear, however, that decisions about MHAA in custody need to consider the progress and limitations of the custody process (PACE) and should be planned in conjunction with the police. EDS,G4S,L&DSDP.

5.25 However, on 11 February 2019 it was deemed inappropriate for the L&D staff to enter the cell to assess Mr A because of his level of disturbance. There was no requirement for a face-to-face assessment prior to the request for an MHAA. The level of disturbance was not clearly articulated at this point as either severe mental disturbance or behaviours intended to confound the criminal justice processes.

5.26 In our view, this indicates that the decision-making about MHAA is premised (understandably) on a different set of priorities out of hours. EDS,G4S,L&DSDP.

G4S role

5.27 In February 2019, 'fitness to detain' medical assessment forms (MAF) were completed after each contact as expected. The MAFs completed on 8, 9 and 10 February all note that Mr A was fit to detain and interview. These were all completed within expected standards. All requests for G4S healthcare input were managed in a timely way by the call centre.

5.28 A healthcare professional (HCP) saw Mr A about 4.40pm on 9 February and suggested his behaviour "was not of clinical origin", although it was clarified to us that this was intended to convey that there was no medical reason for his presentation. The HCP commented that Mr A "appears to understand what is happening but is deliberately choosing to misinterpret any conversation". The HCP would not however had access to onsite specialist mental health support or advice.

5.29 The HCP did, however, convey to police that at that time Mr A was fit to detain and interview and did not require an appropriate adult. This suggests that Mr A's presentation was interpreted as deliberately difficult, rather than being linked to mental health issues.

5.30 In our view, this developed into a shared view among custody healthcare personnel that Mr A was a ‘nuisance’ and this became part of influencing factors in the decision-making about his management.

5.31 The G4S FME, Dr1, was called to see Mr A in the afternoon of 9 February 2019. Dr1 found that Mr A was expressing some delusional ideas but was not suicidal or overtly aggressive at that time. Dr1 found Mr A to be hostile to and about the police, with some paranoid ideas. He was not hostile or aggressive to Dr1. Dr1 believed the police intended to keep him in custody.

5.32 Dr1 decided to talk the situation over with the EDS team and spoke to a duty AMHP. Dr1 did not ask for any background information. The AMHP had access to Mr A’s DPT electronic clinical records, which could have been accessed if required.

5.33 The discussion was around Dr1’s view that an MHAA was not indicated based on the presentation that Dr1 described, which was that Mr A was not suicidal, not overtly aggressive, but expressing some paranoid beliefs. The duty AMHP realised that this was the same individual who had been the subject of discussion with L&D earlier in the day. Dr1 did not ask for advice about Mr A’s history. G4SCDP

5.34 Dr1 conveyed to EDS their belief that Mr A would be detained overnight, and that there was time for L&D to assess him in the morning, and there was no indication for an urgent MHAA. At interview EDS staff recalled this as Dr1 conveying his opinion; Dr1 recalls this as talking it over and coming to a mutual conclusion.

5.35 Dr1 recorded this as a plan, concluded Mr A was ‘fit to detain’ but advised that Mr A should have an appropriate adult to support him if he was interviewed.

5.36 The relevant sections in the police/G4S contract regarding mental health assessments are:

- “The Healthcare Professional will be required to assess whether the arrested person is ‘fit to be detained’ and/or ‘fit to be interviewed or charged’. If the arrested person is assessed to be mentally vulnerable the Healthcare Professional shall advise the custody officer that an appropriate adult will be necessary for any subsequent interview.

- If the Healthcare Professional has raised concerns about the person’s mental health, the Healthcare Professional must request that a full Mental Health Act assessment is completed. The Mental Health Act assessment will be completed by an approved mental health professional and a doctor approved under Section 12 of the Mental Health Act 1983.”

5.37 The contractual expectation on G4S therefore, is that an MHAA must be requested if there are concerns about an individual's mental health. G4S& Police SDP

5.38 In this case Mr A had been judged as 'fit to detain' and 'fit to interview'. This assessment should identify whether there is a mental health issue that requires further attention, in tandem with an L&D and/or FME assessment. It was explained that the medical assessment form used by the healthcare professional (HCP) concentrates on physical and medical health issues, with only a small section to comment on mental health. HCPs were clear they do not have mental health training and are not qualified to comment. Within L&D working hours the HCP would request an L&D assessment if there were concerns about mental health.

5.39 The contract does not make it clear how the assessment for fitness to detain impacts or relates to a need for an MHAA, as they appear to have very different thresholds. It is difficult to understand how both can be true. G4SSDP

5.40 Dr1 believed Mr A would remain in custody until the following day, based on the information that was shared.

5.41 However, decisions around fitness to detain or the requirement for an MHAA cannot legitimately be deferred for a period (in this case, to the following day) as there is no guarantee an individual will still be lawfully detained in police custody. The police are guided by PACE and the Human Rights Act 1998, and if there are no longer formal grounds to detain, they must release the individual, and there are no other legal options available to them

5.42 These issues were not discussed in detail by the parties concerned, and the various influencing factors and any contingency planning were not adequately considered. G4S CDP and Police CDP.

Police role

5.43 Taken on its own, Mr A's arrest and subsequent process through the custody system on 8 February 2019 was largely unremarkable. He was clearly aggressive and displayed some behaviour that caused concern, but the custody staff were reassured by assessments of both his physical and mental states that he was fit to be detained and fit to be interviewed.

5.44 We do not have access to the specifics of the call from his mother when she raised concerns prior to his release, but it does seem to be the case that the only way he could have been kept in custody is for bail to be refused (and the police explain why that was not appropriate) or for him to have been further detained for the purposes of a Mental Health Act Assessment. On that occasion, neither of those circumstances could reasonably have been

considered to have applied. The police IMR notes that this mother called and expressed concerns but does not discuss any police response to her concerns. He was released from custody, after being found a bed for the night by police at a local hostel, at just after 2:30 in the morning of 9 February 2019.

5.45 With the benefit of hindsight, it is easy to see that events of 9 February were a clear sign of a descent by Mr A into crisis. It was the first step in a pattern of behaviour that previously had escalated quickly (in June 2016 and August 2017) and included bizarre behaviour and associated aggression and criminality. While the police would have had access to his previous arrest/offending history which may have indicated some of this history, they would not have had access to his previous mental health history or necessarily any detention in hospital voluntarily or by virtue of a deprivation of his liberty under the Mental Health Act that resulted from those episodes. His mother undoubtedly raised her concerns in her telephone call prior to his release but neither the L&D staff nor the custody staff regarded any of his presenting behaviour as of a level that caused them concern enough to warrant an MHAA.

5.46 The mental health pathway for the South West Police Custody Contract states:

"The process for requesting a mental health assessment in the South West Police Custody contract is as follows: When the Liaison and Diversion mental health nurses are present in the police custody suite, they will assess all detainees with a mental health issue, or if concerns are raised by a G4S clinician or the police. Unlike G4S, the Liaison and Diversion mental health nurses have access to the detainee's past mental health medical records. If these nurses assess that the detainee requires a full Mental Health Act Assessment, they will directly contact the Approved Mental Health Professional (AMHP) who will coordinate a full assessment, undertaken by a Section 12 approved psychiatrist."

5.47 In our view, the police acted entirely in accordance with PACE and their own procedures for assessing detainees on this occasion.

5.48 Having been released from custody at just after 2:30am that morning, he was back in custody by just before 9am that same morning, 9 February for offences of assault and burglary.

5.49 It seems pertinent, at this juncture, to summarise the legislation that governs police detention, applicable timescales for that detention and any connection with powers to detain under the Mental Health Act.

5.50 It is important to note that Mr A had been arrested by police and not detained under the police emergency powers set out within Section 136 Mental Health Act. Those latter powers allowing the police to remove someone to a place of

safety (in certain circumstances, a police station) for the purposes of a mental health assessment.

5.51 His arrest meant that his time in police custody would be governed entirely by the Police and Criminal Evidence Act 1984. Code C of that Act provides the police with a set of rules that they must adhere to whilst that person is in their custody. Those rules include what must be put in place to deal with someone who they consider vulnerable; this includes those who may be vulnerable by means of mental ill-health.

5.52 The primary responsibility for decision making relating to a person's care and treatment in detention lies with the police custody officer. That custody officer must be an officer not below the rank of sergeant. Practically, in almost all circumstances, the police custody officer is a police sergeant.

5.53 Code C has been revised at various times since its introduction. However, main principles such as the duration that police can detain a person and what to do in terms of vulnerability remain long established, and largely without ambiguity.

5.54 Dealing first of all with custody time limits: In general terms the police can detain a person for a maximum of 24 hours from the point that detention is authorised before they must either charge that person with an offence (and then make a decision about bail), release the person under investigation, or release the person without charge. Once detention is authorised that period of time is known as the 'PACE clock'.

5.55 In certain circumstances that 24 hour period can be extended. Such extensions are subject to a set of legislative criteria which are also set out within Code C of PACE. The first level of extension is for a period not exceeding 12 hours. Such an extension must be authorised by a police superintendent. An extension under this authority is relevant in this case and will be discussed later. Any extension naturally extends the PACE clock.

5.56 Further extensions to detention are available to the police through the courts. They are not relevant in this case and thus we will not make further reference to them.

5.57 Under very limited circumstances the PACE clock can pause. The most common of these is if a person is taken to hospital for treatment. Such a pause is not relevant in this case. However, it is worthy of mention because the PACE clock does not pause when arrangements are made for a person's mental health assessment whilst they remain in custody at a police station. This can impact upon the time available for police to complete one of the central reasons for an arrest, that of 'obtaining evidence by way of questioning'. It would be unwise for police to interview a suspect about whom they have concerns regarding their vulnerability until such time as measures

have been put in place to assure the police that person is fit to be detained and interviewed and safeguard that person's rights whilst in custody. Any such interview prior to such safeguards would likely be ruled inadmissible in any future criminal proceedings. This point does feature within this case.

5.58 None of the above precludes the police from progressing other aspects of investigation whilst that person is in custody and those safeguards are in place.

5.59 In this case, shortly after his arrest and arrival at the police station on 9 February, Mr A had an initial assessment by a healthcare practitioner (HCP).

5.60 The records on the G4S system at 11.40am on 9 February show the following: "[Mr A] has been difficult and verbally abusive since arriving in custody. Sustained minor injuries to elbows and wrists." "Appears to understand what is happening but is deliberately choosing to misinterpret any conversation." "[Mr A] refused to be seated again and told me he refused consent to any obs (sic)." "Past Medical History was not disclosed by [Mr A]. Fit to detain. Plan: discussed with the Police Sargent (sic)."

5.61 In interview for this review, the HCP who undertook the assessment stressed that this was a medical (physical) assessment of his fitness to be detained. Further, that HCPs were not mental health practitioners, and that the assessment form has no mental health questions on it. The HCP's view was that it remained a police responsibility to action further in relation to any concerns about his mental ill-health. They went on to say that in their experience the custody staff at Barnstaple are extremely 'risk-averse' and would always err on the side of caution when dealing with detainees (with physical or mental health concerns) ordinarily always seeking further advice when they are unsure.

5.62 We have had sight of the redacted custody records for 8 and 9 February 2019. We have had sight of police statements that were provided to the coroner, made by custody sergeants and police officers who were on duty at Barnstaple on 8 and 9 February, and the police superintendent who was consulted in the early hours of the morning on 10 February. We have also seen the statement made by the custody sergeant on duty in Exeter police station when Mr A was arrested on 11 February 2019.

5.63 The HCP made an entry on the custody record to suggest that "he was fit to interview and did not require an appropriate adult", and it could be argued that they are in fact making comment about his mental health.

5.64 Section 1.4 Code C PACE states:

"If at any time an officer has any reason to suspect that a person of any age may be vulnerable (see paragraph 1.13(d)), in the absence of clear evidence to dispel that suspicion, that person shall be treated as such for the purposes

of this Code and to establish whether any such reason may exist in relation to a person suspected of committing an offence […], the custody officer in the case of a detained person […] shall take, or cause to be taken, (see paragraph 3.5 and Note 3F) the following action: (a) reasonable enquiries shall be made to ascertain what information is available that is relevant to any of the factors described in paragraph 1.13(d) as indicating that the person may be vulnerable might apply; (b) a record shall be made describing whether any of those factors appear to apply and provide any reason to suspect that the person may be vulnerable or (as the case may be) may not be vulnerable; and (c) the record mentioned in sub-paragraph (b) shall be made available to be taken into account by police officers, police staff and any others who, in accordance with the provisions of this or any other Code, are required or entitled to communicate with the person in question. This would include any solicitor, appropriate adult and health care professional and is particularly relevant to communication by telephone or by means of a live link (see paragraphs 12.9A (interviews), 13.12 (interpretation), and 15.3C, 15.11A, 15.11B, 15.11C and 15.11D (reviews and extension of detention)."

5.65 Section 3.5 mentioned above states:

"The custody officer or other custody staff as directed by the custody officer shall: (a) ask the detainee whether at this time, they: (i) would like legal advice, see paragraph 6.5; (ii) want someone informed of their detention, see section 5; (b) ask the detainee to sign the custody record to confirm their decisions in respect of (a); (c) determine whether the detainee: (i) is, or might be, in need of medical treatment or attention, see section 9; (ii) is a juvenile and/or vulnerable and therefore requires an appropriate adult".

5.66 It therefore is the case that the HCP in this instance, together with the custody officer, could conclude that he was fit to be detained, fit to be interviewed and did not require an appropriate adult. All of this of course has to be taken as a 'moment in time' i.e. at the time of that assessment.

5.67 What is clear is that despite this initial assessment, the custody officer remained concerned about Mr A's behaviour and vulnerability. They rightly sought to assure themselves of his mental health by instigating the procedures in place at the time for a mental health assessment.

5.68 The process undertaken followed the agreed procedure which states:

"When the Liaison and Diversion mental health nurses are not present in the police custody suite, custody police officers will contact G4S to assess the detainee. The G4S FME will carry out the initial mental health assessment and if the FME assesses the detainee to be an immediate risk to themselves or appears to be suffering with a significant mental health problem, the FME should request support from the AMHP. The G4S FME in this contract is not required to be a mental health specialist. G4S mental health assessments of detainees are therefore carried out by generalists and are not equivalent to

the Mental Health Act Assessment. The AMHP is the decision-maker on whether a Mental Health Act Assessment should be carried out."

5.69 It seems clear that the police felt an MHAA was required. PACE is clear that a mental health act assessment must be carried out by an Approved Mental Health Practitioner (the AMHP) and a registered medical professional (Code C 3.16).

5.70 There was no L&D staff member present in police custody suite at the time but as part of the process they were contacted by police and spoke with Mr A on the telephone during the early afternoon, at 14.40pm. The L&D staff member formed the view that he was showing signs of mental illness, to the extent that they spoke with the EDS about their concerns. Because Mr A had not been seen in person, the default position now meant that in order to the follow the practice in Devon at the time, he now had to be seen by the FME (as described by process) to determine his suitability for a full assessment. That FME had to be a trained doctor but was not required to be qualified specifically in relation to mental health.

5.71 The custody sergeant thus requested that the FME attend to help determine whether a full MHAA was required. This was entirely the correct course of action to take.

5.72 The records show that prior to Dr1 attending, Mr A was seen again by an HCP. This was a different HCP to the one who had completed the initial checks.

5.73 On this occasion the G4S records show the following: "[Mr A] believes he has low BM [blood sugar] – refused earlier assessment." "[Mr A] now declares he's diabetic and wants his blood sugar doing …" […] The records also state: "plus he was HCP assessed in a timely manner. Assessed Mr A's presenting symptoms. Documentation completed and legible and includes details, hypoxic due to an airtight cell". Mr A then withdrew his consent. The HCP concludes, "behaviour is ridiculous and bizarre. I feel this is however, premeditated and not of a clinical origin."

5.74 By now, two HCPs had seen Mr A, both coming to effectively the same conclusion, that while his behaviour was "bizarre", he was being deliberately difficult.

5.75 Dr1 attended the custody suite in the early evening and made an assessment of Mr A. In interview, for the purposes of this review, Dr1 recalled that on balance he did not feel that Mr A required a full MHAA at that time. He did not though have access to Mr A's mental health history and thus could only make an assessment on how he presented 'there and then' together with conversations with custody staff, the HCPs' assessments and subsequently the conversation with the AMHP.

5.76 While the integrity of the doctor is not in question, the factors that may have had an influence upon his assessment could include the documented HCPs' views that, effectively, Mr A was someone who was being deliberately difficult in custody. There is no record that Dr1 had the benefit of a similar conversation with L&D2 who spoke with Mr A on the telephone and who was concerned about his presentation.

5.77 An excerpt of wording from Mr A's custody record shows that he was seen by Dr1 at 7:05pm. At 7:12pm an entry is made on the custody record by Dr1 stating the following:

"Asked to see DP (detained person) for MH. DP not disclosing any suicidal ideation, not psichotic (sic). D/w (discussed with) duty AMHP and agreed that DP will not need a Mental Health Act assessment, but he will need to see L&D in the morning.

Treatment: FTD (Fit to detain), no acute medical conditions noted at the time of the examination, can eat and drink. For L&D in the a.m."

5.78 The actual custody record states that Dr1 was escorted to the cell at 6.30pm and left the cell at 6.49 pm. Dr1 told this review that in his view an MHAA was an emergency intervention and that the patient had to be "actively suicidal". He said that in his experience it is not unusual for prisoners to be aggressive, upset and angry and often they calmed down as their time in custody progressed. He recalled that he saw him alone and that in his view, Mr A's aggression was directed towards the police and not towards anyone else. The conclusion that he should be seen again by the L&D service in the morning was, he believed, a joint decision between him and the AMHP/EDS. He was not aware that Mr A could be released without a further visit by the L&D service.

5.79 There remains a level of uncertainty about the length of time Mr A was seen by Dr 1, but records suggest this was for no longer than 20 minutes. There is also some uncertainty about conversations that took place with police after this assessment. The police IMR does not reflect any additional entries on the custody record about the need for Mr A to seen again the following morning by the L&D service, and the police have told us they would not have supported this as a plan. It is reasonable to suggest that it is likely there would have been some level of conversation about the outcome of the assessment, especially as a written record of the assessment appears on the custody record but there is no record of that within the police IMR.

5.80 There is no record of any conversation between Dr1 and custody staff to suggest that Dr 1 was ever told that there was no guarantee that Mr A would remain in custody until the following morning. There remains only the record of the outcome of the assessment and a record that an appropriate adult was felt to be in Mr A's best interests.

5.81 We are unable to reconcile the differences between the G4S record and the police record on this aspect. We are therefore unable to say who was expected to have the responsibility for arranging any further assessment, assuming that Mr A was still in custody. The police say that it was not their responsibility, however it was noted in the custody release plan that both L&D and Dr1 requested that Mr A should be provided with contact details for L&D, which was done. Dr1 had clearly recorded "to be seen by L&D in the morning", not that he should be given the contact details. Dr1 was clearly under the impression that Mr A would not be released in the foreseeable future and that he would still be there in the morning for a further conversation with L&D staff.

5.82 This lack of clarity around this aspect is a learning point in itself.

5.83 As stated earlier, any interviews that may have been held with Mr A prior to the assessment by Dr1 were likely to have been ruled inadmissible in evidence thus the police were quite correct in not seeking to interview him until his 'fitness' was determined. Following his assessment, when police sought to interview him he refused to come out of his cell. Therefore, he was interviewed at the cell door.

5.84 Other enquiries into the offences for which he had been arrested had continued during the day. With the interview process being completed it was right that police sought charging advice from CPS in order that a decision could made about how to ensure Mr A's appropriate disposal from police custody.

5.85 At 11.40pm, officers sought such charging advice on the threshold test from the CPS. This related to three matters: An allegation of GBH (the assault), the burglary and an additional matter of damage to Mr A's cell whilst in custody.

5.86 This review has been provided with the police report requesting such advice. This is known as a form 'MG3'. In the report, the police set out the circumstances of Mr A's arrest, the evidence available and the fact that he was on bail having been charged the previous day with a burglary and damage to his cell. It is clearly shown that advice was required as a remand in custody was sought.

5.87 This last point, about remand in custody, is an important point to note as it is indicative of police thinking at that time and which may of course have been explicitly said to Dr1, or unintentionally implied to him by police staff leading to his view that Mr A was likely to have been in custody the following the morning.

5.88 The review has also been provided with the CPS response to the MG3. The CPS felt that there were evidential deficiencies relating to the identification of Mr A as a suspect for the assault, and that additional work was required in

order to progress the burglary offence before a charging decision in relation to either offence could be made.

5.89 There remains a difference of opinion between the police and the CPS as to the outcome of this charging advice. The police view, contained within their IMR, is that CPS said Mr A should be bailed for those further enquiries to be carried out. The CPS state they did not advise that he be bailed, their view is that they expected the police to carry out those further enquiries whilst he remained in custody under the PACE clock and then return to them for a charging decision.

5.90 The police also state that they went to CPS for a Threshold Test and not a Full Code Test. The CPS explain why the correct route was for a Full Code Test to be considered first and a Threshold Test is considered only in certain circumstances.

5.91 The differences between the Threshold Test and a Full Code Test will be explored further later within this report.

5.92 Whilst we are unable to place a time on the return of the CPS advice, it was certainly well after the request, which was sent at 1.40 am. The police were now faced with a position where further work was required before they could return to the CPS for a charging decision and that Mr A's PACE clock expired at around 9:30am the following morning. Completing both the identification procedure and the obtaining the statements to progress the burglary charge were difficult at that time of night. In addition, Mr A would be required to either comply or otherwise with the identification procedure and having been in custody since early that morning, he was in need of a PACE rest period.

5.93 PACE requires that a detained person have a period of rest during the 24 hours unless that would prevent his release from custody. Given that those further enquires were likely to take place the following morning, establishing that rest period during the night seems an appropriate course of action.

5.94 It was left, therefore, to the investigating officer to determine how best to progress the investigation in light of the fact that in order to progress the investigation prior to charge before the expiration of the 24 hour PACE clock would be almost impossible. Thus, the officer made the decision to seek an extension on detention by way of a superintendent's extension.

5.95 The officer telephoned the on-call superintendent to discuss the extension at around 2:15am.

5.96 This review is grateful to the police superintendent for disclosing the statement and a copy of the notes made at the time, in order to understand their decision making. The superintendent declined to authorise an extension to detention requesting that actions in relation to the identification procedure

be fast-tracked and that Mr A be bailed with conditions in order that were if the additional enquires came to proof then he could return to the police station for charging within his original 24 hour PACE clock.

5.97 Section 42 of PACE is lays out the requirements that have to be satisfied for a Superintendent's authorisation for further detention as such:

"Where a police officer of the rank of superintendent or above who is responsible for the police station at which a person is detained has reasonable grounds for believing that—

(a) the detention of that person without charge is necessary to secure or preserve evidence relating to an offence for which he is under arrest or to obtain such evidence by questioning him;

(b) an offence for which he is under arrest is an indictable offence; and

(c) the investigation is being conducted diligently and expeditiously,

he may authorise the keeping of that person in police detention for a period expiring at or before 36 hours after the relevant time."

5.98 The Superintendent set out their thinking in this case. We have chosen to include a summary of the issues outlined in their statement as it is important that the context to that decision making is considered and not just the outcome. It is as follows:

'A PACE Extension can be requested at any time after the second review of detention and it is usual as part of the criminal investigation oversight to give early notification after the 2nd review that a PACE Extension is anticipated. It is usual within the investigation of a Serious Crime and Indictable Offence for there to be a review of evidence gathered and any further evidence required to meet CPS Charging Standards, prior to progressing to a CPS Charging Decision. It would usually be in advance of any progression to CPS Charging Decision that a superintendent would expect to be approached for a PACE Extension'.

5.99 In this case however the investigating officer advised that the reason the PACE Extension was being requested was that having progressed to a CPS Charging Decision, the evidence presented was reviewed against national charging standards and the investigation had been directed to obtain further evidence before any charge could be laid against Mr A.

5.100 In requesting further detail about the CPS requirements, the superintendent was advised:

- for a charge of ABH, there was a requirement to conduct an ID procedure with the male victim and victim's wife.

- for the dwelling house burglary / criminal damage there was a requirement to photograph the key found in the possession of Mr A.

- for the dwelling house burglary / criminal damage there was a requirement to take a statement from the owner of the property who resided out of force to ID the key and prove ownership of the dwelling.

- for the dwelling house burglary / criminal damage there was a requirement to take a statement from the female looking after the house to outline the timeline of the burglary / damage caused.

5.101 As part of any PACE Extension request, the superintendent needs to seek to understand if the objectives of securing and preserving further evidence are achievable within the period of the PACE Extension. This is to understand the viability of the request against the PACE Clock and to consider the implications for the use for the said PACE Clock against the investigative plan.

5.102 In order to conduct CPS requirement 1) of the ID procedure - it was the intention of the investigating officer to request that an ID officer be called out by early turn investigators on Sunday 10th February 2019 to conduct this procedure. The officer was asked how achievable it would be to call a member of staff in, to conduct this procedure and to carry out the identification process for two witnesses. It advised that it would be tight but best efforts would be made to achieve. In order to conduct CPS requirements 2 / 3 / 4, the investigating officer felt that these objectives were achievable.

5.103 Further questions were:

5.104 Is the severity of the offence likely to secure a remand in custody?

If a remand in custody is not anticipated then it must be recognised that the subject would be given Court Bail, which brings into question the necessity and proportionality of continued detention through a PACE Extension as opposed to the use of police bail. The superintendent in this case did not hold reasonable grounds to believe that a remand in custody would be forthcoming in this instance.

5.105 Does the severity of the offence meet the legal requirement for a PACE Extension?

The offence committed was not ‘Indictable Only’ it was a ‘Triable Either Way Offence’. The superintendent therefore needed to hold reasonable grounds to believe the case would be indicted to Crown Court. From their professional experience of 27 years in policing they did not hold reasonable grounds to believe on the severity of this offence and offending history of Mr A that this case would be indicted to Crown Court.

5.106 Other factors which were considered were:

- Mr A's Mental Health had caused concern during this period of detention and that he had been seen by the Health Care Professional / Force Medical Examiner and Mental Health Liaison Officer but not deemed to be psychotic and would not require a full Mental Health Assessment. He was deemed fit to detain, fit to interview and fit to charge.

- Against the decision not to make Mr A subject of Section 2 of the Mental Health Act, there was no Mental Health legislative framework in place to detain him further. The purpose of any police power such as Section 136 of the Mental Health Act is detention for the purpose of assessment. As mental health practitioners had already made the decision that a mental health assessment was not required there was no legitimacy in utilising this legislation.

5.107 The superintendent took the fact that Mr A had not been made subject of Section 2 of the Mental Health Act to mean that from a Mental Health perspective a professional judgement had been applied that Mr A as not a significant risk to himself or the public.

5.108 The superintendent's overall assessment of the facts was that Mr A would not be subject of a PACE Extension as the case did not meet the legislative framework, but that Mr A would be released on Pre-Charge Police Bail with conditions in order to secure his return to Barnstaple Police Station at a later date and to prevent further crime or interference with victims or witnesses. The superintendent expressed the view that on the information they had reviewed, these measures were necessary and proportionate in the interests of public safety.

5.109 They spoke with the officer about addressing the potential causation factors behind Mr A's offending behaviour as they were presenting at that time, and it was requested that he be given direction on local accommodation, where he could seek help and support through local services.

5.110 The investigating officer was advised to progress 'fast track' actions in respect of the ID procedure and statements and arrest Mr A on fresh evidence, in order that he could be brought back and charged on the existing PACE Clock ahead of the bail date set. This would enable the case to line up with the existing Court date of 22 February 2019.

5.111 The superintendent asked the officer to endorse the custody record accordingly with the decision not to authorise a PACE Extension and to discuss bail conditions with the Duty Custody Sergeant for authorisation by the Duty Inspector.

5.112 At about 9.00 am the following morning, the superintendent made contact with the Duty Detective Inspector and highlighted the request to progress fast track actions in respect of Mr A as outlined above.

5.113 We are grateful for the superintendent setting out their thinking in such a comprehensive way. It does demonstrate the difficult balancing act that officers have to make and the complex considerations that are necessary. We would make the following observations:

5.114 The superintendent makes the point that ordinarily a request for an extension would be made before the matter had been progressed to CPS for a decision. We would endorse this as the preferable approach. The CPS should not need to concern themselves with PACE clock issues; the PACE clock is an issue for the police to manage.

5.115 The superintendent's considerations at this point should be confined to the three aspects set out within Section 42 PACE. None of the arguments they makes out are wrong in law, however, some superintendents may agree, while others may take a different view.

5.116 The forward thinking about the final disposal of the cases at either Crown Court or otherwise may be felt by some to be largely extraneous and an additional level of consideration that was not necessary. The legislation says that 'either way' offences should be treated as indictable for the purposes of the extension. Such a view would be equally valid.

5.117 The Police & Crime Act 2017 made changes to both PACE 1984 and the Bail Act 1976 in respect of pre-charge police bail. This, in effect, provided further emphasis on the need for the police to seek to finalise their investigations during the first period of a suspect's detention where at all possible, i.e. making maximum use of the PACE clock and any associated extensions. By looking to release Mr A prior to the completion of those investigations goes against this principle, countered however by the other considerations that the superintendent outlines.

5.118 Some superintendents may take the view that Mr A was arrested within eight hours of being released for a similar offence (the previous burglary), and that the circumstances were escalating (the attack on the farmer) and therefore he could reasonably have been considered to present a real risk of reoffending and thus charging followed by a decision about bail, not prejudging a decision about bail at this point, would have been considerations. Such a view would be equally valid.

5.119 The option of extending the detention for a shorter period than the full 12 hours does not appear to have been considered. For example, an extension of perhaps five hours (taking the PACE clock to around 2pm) may have

allowed time for the statement to be taken identifying the keys from the burglary and thus allowed a charging decision around that.

5.120 Some superintendents would not agree with the statement that because Mr A "had not been made subject of Section 2 of the Mental Health Act to mean that from a Mental Health perspective a professional judgement had been applied that Mr A as not a significant risk to himself or the public." The police also have to consider independently whether he presented a risk, certainly to the public, and his actions as outlined above would indicate that he did. Such a view would be equally valid.

5.121 The superintendent does discount use of mental health legislation to further detain him; that is absolutely right. There is no indication that they, or indeed perhaps the investigating officer, were aware of the FME's view that he should be seen the following morning, or that his behaviour had deteriorated to such an extent that a further assessment was necessary. They did suggest that the police place conditions around him to mitigate what they understood his risk to be, they also checked that these actions had been set in train the following morning.

5.122 It is a case, therefore, that some superintendents may have taken a different view and some may have agreed. Whatever the view of those considerations and that decision, the ultimate outcome could not, with the knowledge available to that officer at that time, have been something that they could reasonably have foreseen: a fact that must not be forgotten.

5.123 The fact that there is no written record of the application to the superintendent, nor of their decision, other than in the personal notes of the superintendent, is an issue recognised by Devon and Cornwall Police. A process for ensuring a record of such requests is recorded is a recommendation from this review.

5.124 PACE says that where a decision to extend a period of detention is made, then a written record must be made on the custody record to that effect. It does not say that a decision not to extend a period of detention is similarly recorded.

5.125 Had the police been able to charge for both of those offences then a decision about bail would have been necessary. The fact that he had been arrested and charged with burglary and damage only two days previously is likely to have led to an application for a remand in custody: he was offending on bail, he was of no fixed abode and was targeting similar properties – issues that could be taken into account if a decision about bail after charge was necessitated.

5.126 The additional time in custody could also have afforded the opportunity for him to be further assessed by the L&D team, as suggested by Dr1 the

previous day. However, it has to be made absolutely clear that this would have been an opportunity afforded by the extension, and that Mr A could not have been kept in custody because of his mental health, save for certain conditions as discussed below.

5.127 There were four custody officer shifts covering the 24 hour period that Mr A was in custody (early shift, late shift, night shift, early shift again). Thus, a minimum of three different custody officers were responsible for his detention. We are unable to say if there was any discussion between them about the Dr's request that he be seen again in the morning.

5.128 Mr A had been assessed during the evening of the previous day by Dr1, who, after talking to the AMHP, had not felt it necessary to request a full MHAA. Instead, Dr1 had suggested that he be seen again in the morning. It appears that there was no discussion with Dr1 about what would happen if the police got to a point where they had to release him because their reasons under PACE to hold him had ended. This has been identified as a procedural gap in understanding by the police.

5.129 In conversation for the purposes of this review, it is suggested that a revised procedure be developed. There were no grounds to hold Mr A for the purposes of a further mental health assessment that following morning. In order for there to be such grounds, his behaviour would have had to have deteriorated significantly from that which had been experienced at the time of his assessment the previous evening.

5.130 We had access to a redacted version of Mr A's custody record for 8 and 9 February 2019. Our views about any level of deterioration in his behaviour is gleaned from the custody record, the police individual management review, the G4S records, the appropriate adult contact form and statements provided to the coroner by police officers on duty.

5.131 There is no evidence in the information available to us of a significant deterioration in his behaviour. He remained aggressive and difficult, as had been previously assessed. It is not unusual for some detainees to act in such a way, it is not unusual for detainees to damage cells and 'dirty protests' are also not uncommon.

5.132 There were, therefore, simply no grounds to hold him further for assessment. Had they done so, in the absence of a significant change in his behaviour, the police would have been rightly criticised for having not undertaken an assessment in the 24 hours that he had been with them.

5.133 That was not communicated with the health teams and that is an area of learning. That aspect has been addressed within the new procedure for mental health assessments while in custody, and this change demonstrates immediate learning prompted by this case.

5.134 We have considered the possibility that the police wanted to have him out of the cell block because he was being too disruptive. The fact is, that even after the superintendent had declined to authorise a further period of detention, he remained in custody until the following morning. Had they wanted to release him, they could have done so after the officer had updated the custody record with the CPS advice and Superintendent's decision.

5.135 We have had sight of the custody pre-release plan. This notes that HCPs had not made any recommendations about the release plan. As discussed earlier, it was stated in the custody release plan that both L&D and Dr1 requested that Mr A should be provided with contact details for L&D, which was done. However, Dr1 had clearly recorded "to be seen by L&D in the morning", not that he should be given the contact details. The plan includes a question about whether there are "any concerns about physical or mental health issues that have not been addressed" and this section included that Mr A identified a number of minor injuries to his wrist and elbow of his left arm and was signposted to his GP and given the number of NHS Direct. The police also provided him with the contact details for the Freedom Centre because he was of no fixed abode. The plan notes that he is of no fixed abode but also contradicts this by stating he lives locally and does not require transport.

5.136 Mr A being released at 9.30 in the morning gave minimal opportunity for any further assessment by the L&D team. They were not made aware that the FME had requested that they see him.

5.137 It seems absolutely clear in hindsight, with the benefit of all that is now known about him, that by the time of Mr A's second arrest within two days, he was descending into a severe mental health crisis. It followed a pattern of behaviour previously seen in 2017 culminating in criminality and him being detained under the MHA.

5.138 The question here is, why was that not identified while he was in police custody?

5.139 We have considered whether confirmation bias[40] was an issue within custody. It may have been the case, but it would be easier to come to that conclusion had the L&D2 who spoke with Mr A on the telephone not assessed him as requiring an MHAA. Therefore, the FME was aware that different views were held. The FME simply did not consider that Mr A posed a great risk at that time.

5.140 The fact that the FME did not have access to his previous history, and thus the evidence of his aforementioned rapid descents into crisis, is hugely significant. The FME had to assess what was before him. The lack of access

[40] Confirmation bias is the tendency to search for, interpret, favour, and recall information in a way that confirms or supports one's prior beliefs or values.

to previous history seems to make protecting the public and caring for/treating a man such as Mr A incredibly difficult for those charged with that duty 'in the moment'.

5.141 The fact that Mr A was not seen again by mental health professionals prior to his release has been the focus of the debate within this report. There was certainly a breakdown of communication and a lack of understanding of what could and could not legally be achieved. This has been identified as a matter of urgency for local learning.

5.142 The custody sergeant on duty on 11 February 2019 arranged for Mr A to be seen by the FME, after he had seriously assaulted a HCP without warning. He was verbalising paranoid ideas, including having been bitten by a snake, stating he had razors in his throat and refused to use the toilet facilities provided.

5.143 Mr A asked to see a doctor because he said he had something stuck in his throat and was spitting and purging. The FME Dr1 was asked to see him and relayed his view that Mr A did not need an MHAA at that time. The custody sergeant recorded that he did not agree with Dr1's assessment and asked that this be discussed directly with the L&D team locally.

5.144 Given that there is an example (on 11 February 2019) of a custody sergeant stating they did not agree with an FME's decision not to request an MHAA, we have considered whether such a decision could reasonably have thought to have been applicable to the circumstances of Mr A's release from custody on 10 February.

5.145 We have not been able to interview any of the parties involved to gather any further understanding of the decisions made, so are reliant on our own analysis of the evidence supplied.

5.146 On 10 February 2019 Mr A is described as aggressive and difficult, and was restrained twice, once after arrest when he tried to grab an officer's taser, and the following morning he was physically taken back to his cell after his non-cooperation with the identification procedure. Before this he had been obstructive and bizarre in speech but had been described as not psychotic by the FME the previous evening. We have not seen evidence that his behaviour deteriorated markedly. The custody sergeant who released him made the point in his statement that it is not unusual for individuals to be aggressive with police even at the point of their release from custody, but there would have to be a legal framework for any new detention.

5.147 On 11 February 2019, at the point at which the custody sergeant questioned Dr1's view, Mr A had been arrested for a third time in a short period, for a second incident of violence. He resisted arrest, was described as 'running amok' and was tasered. In custody his behaviour was very disturbed, and he

talked of having been bitten by a black mamba snake, living in a castle, and fighting bears in a bear pit. He assaulted a HCP violently with no warning and accused staff of trying to poison him, asking them to eat some of the food he was given before he would agree try it, but even then refused to eat.

5.148 Although his behaviour and presentation were clearly of concern, in our view there is no evidence that his presentation deteriorated markedly on 9/10 February, in contrast to the degree of disturbance he presented with on 11 February 2019.

Crown Prosecution Service role

5.149 The Code for Crown Prosecutors is a public document, issued by the Director of Public Prosecutions, that sets out the general principles Crown Prosecutors should follow when they make decisions on cases. It specifies that it is the duty of prosecutors to make sure that the right person is prosecuted for the right offence and to bring offenders to justice wherever possible. Prosecutors must ensure that the law is properly applied, that relevant evidence is put before the court and that obligations of disclosure are complied with.

5.150 The Code sets out that the police and other investigators are responsible for conducting inquiries into any alleged crime and for deciding how to deploy their resources. This includes decisions to start or continue an investigation and on the scope of the investigation. Prosecutors should advise the police and other investigators about possible reasonable lines of inquiry, evidential requirements, pre-charge procedures, disclosure management and the overall investigation strategy. This can include decisions to refine or narrow the scope of the criminal conduct and the number of suspects under investigation. Such advice assists the police and other investigators to complete the investigation within a reasonable period of time, and to build the most effective prosecution case. Prosecutors should identify and, where possible, seek to rectify evidential weaknesses.

5.151 The Full Code Test: Prosecutors must only start or continue a prosecution when the case has passed both stages of the Full Code Test. The exception is when the Threshold Test may be applied (see section 5).

5.152 The Full Code Test has two stages: (i) the evidential stage; followed by (ii) the public interest stage.

5.153 The Full Code Test should be applied: when all outstanding reasonable lines of inquiry have been pursued; or prior to the investigation being completed, if the prosecutor is satisfied that any further evidence or material is unlikely to affect the application of the Full Code Test, whether in favour of or against a prosecution.

5.154 Prosecutors must always seek to apply the Full Code Test (see Code 4.1 and 5.1). In limited circumstances, where the Full Code Test is not met, the Threshold Test may be applied to charge a suspect. The seriousness or circumstances of the case must justify the making of an immediate charging decision, and there must be substantial grounds to object to bail.

5.155 There are five conditions to the Threshold Test:

First condition	There are reasonable grounds to suspect that the person to be charged has committed the offence.
Second condition	Further evidence can be obtained to provide a realistic prospect of conviction.
Third condition	The seriousness or the circumstances of the case justifies the making of an immediate charging decision.
Fourth condition	There are continuing substantial grounds to object to bail in accordance with the Bail Act 1976 and in all the circumstances of the case it is proper to do so.
Fifth condition	It is in the public interest to charge the suspect.

5.156 There must be a rigorous examination of the five conditions of the Threshold Test, to ensure that it is only applied when necessary and that cases are not charged prematurely. All five conditions must be met before the Threshold Test can be applied. Where any of the conditions are not met, there is no need to consider any of the other conditions, as the Threshold Test cannot be applied, and the suspect cannot be charged.

5.157 Further guidance on the joint working of police and prosecutors during the investigation and prosecution of criminal cases is contained in the Charging (The Director's Guidance) 2013. This Guidance is issued under the provisions of section 37A of the Police and Criminal Evidence Act 1984 (PACE). It also incorporates the National File Standard.

5.158 In particular, this Guidance sets out:

- how the police should deal with a person where there is sufficient evidence to charge or where a person has been arrested again having been released on bail awaiting a charging decision by a prosecutor,
- the offences that can be charged by the police and those where the decision must be made by prosecutors,
- how and when early investigative advice is to be sought from a prosecutor,

- the evidence and information needed for a charging decision to be made and for the prosecution of cases at court,

- the circumstances when a person may be given a simple caution for an indictable only offence, or a conditional caution.

5.159 It also states that police officers and prosecutors must comply with this Guidance to ensure that charging and other prosecution decisions are fair and consistent and fully comply with PACE, the PACE Codes of Practice and the Code for Crown Prosecutors.

5.160 This Review has had sight of the written charging advice and the CPS Direct response. It must be pointed out that CPS is responsible for issues related to evidence supporting a prosecution, while the wider remit of safeguarding remains the responsibility of the police.

5.161 The police sought advice on three potential charges: the burglary, the assault, and damage to the police cells. The CPS was also made aware that Mr A was on bail having been arrested two days previously for a similar burglary. The fact that he was on bail for burglary only two days previously only becomes a factor if it is deemed there is sufficient evidence to charge him in relation to any of these offences.

5.162 In relation to the burglary, Mr A had in his possession at the time of his arrest a key that had been identified as coming from inside the property. While there had been a verbal identification, there had been no formal statemented identification. The CPS felt it necessary to have this prior to charging. They also felt further work was required in relation to footwear marks left at the scene.

5.163 In relation to the assault, CPS felt that additional identification work was required before charge and did not feel they could rely solely upon Mr A's 'admission' that was made in interview of "yeah, I did it. He's a pervert."

5.164 In relation to the criminal damage to the cell, we can find no recorded reason for not progressing this to charge; however, it is often the case that an administrator has to provide a statement as to the costs of the damage. Under Paragraph 15 of the Director's Guidance on Charging[41] the police were able to charge this offence without CPS authority. However, the police contend that if he had been charged on this offence alone, it would be unlikely to have attracted a remand decision.

5.165 Given the time of day, it was deemed not possible to progress the evidential requests for the other offences until the following morning. The police were

[41] Charging (The Director's Guidance) 2013 - fifth edition, May 2013 (revised arrangements). https://www.cps.gov.uk/legal-guidance/charging-directors-guidance-2013-fifth-edition-may-2013-revised-arrangements

left thus in a position where a decision had to be made about how to progress the enquiries and whether it was appropriate to keep Mr A in custody while those enquiries were to take place. This consideration is solely related to the investigations into the crimes he was arrested for and not in relation to any mental health detention.

5.166 It should be pointed out that had CPS felt he could be charged at that time, then a decision would have had to have been made there and then about whether he was remanded in custody for court the following day or whether he was released after charge.

5.167 Given that he was on bail for a burglary and damage just two days previously and was of no fixed abode, then it is reasonable to consider that he might well have been refused bail and kept in custody for court the following morning. It is also likely that this would have reduced the opportunity for him to be seen by the L&D staff in the morning, as he would have been moved to court before they would have that opportunity. Coincidentally, as this was a Sunday morning, the following court would have been on the Monday morning giving a whole day for any further conversations between Mr A and L&D staff. This was a by-product of the weekend and could not have been used as part of the decision making process.

5.168 The police IMR comments that the Police Constable (PC) who requested charging advice was not happy with the advice given by the CPS but accepted it. The IMR noted that they did say they were not aware that they could have escalated their concerns to an Inspector.

5.169 While the explanation about challenging the CPS advice by the PC is understandable, it does beg the question as to whether that option is understood by more experienced and/or supervisory officers who could have assisted the PC on that day.

5.170 We can understand the police's questioning of the CPS advice; however, the CPS has a statutory function to consider whether there is, at that time, sufficient evidence to charge a suspect. In this case it would be reasonable for police to feel that Mr A has been caught 'red-handed', in that he had property from a burglary in his possession and was caught near the scene of the assault. The CPS however, noted significant evidential gaps, enough to say that at that stage there was insufficient evidence to charge Mr A on the Full Code Test and that at this stage, more work was required to strengthen the case, which should be carried out within the PACE clock. A challenge to the decision may have had a different outcome, or it may not; it is an individual reviewing lawyer's consideration made at that time.

5.171 While this is one of several individual decisions that cumulatively led to the tragic outcome in this case, it is not wrong in law.

5.172 The police have a 24-hour PACE 'clock' that runs from the time that a person is placed in detention. In this case, that was around 10:30am on 9 February 2019. Thus, a decision to either charge him or release him had to be made prior to 10.30am on 10 February 2019. The only exception to that is where a police superintendent authorises a further period of 12 hours in addition to that detention time.

5.173 In this case, the investigating officer sought a 12-hour extension and updated the custody record at 3.19am to explain that CPS had asked for further work to be completed before a further referral to CPS could be made. The IMR noted that the OIC stated at the time that he believed that the tasks could be completed if there was a full 12-hour Superintendent extension "although this may prove difficult".

5.174 When the officer became aware that the required work could not be completed within the PACE clock and the request for an extension had been refused, the officer should have returned to CPS for further advice. The prosecutor (which may or may not have been the same prosecutor depending on the time the case was re-presented) would have then had to consider whether to charge the suspect under the Threshold Test. Such a charge would have been immediate.

5.175 Paragraph 24 of the Director's Guidance on Charging (DG5)[42] sets out that where, in a case that has been referred to a prosecutor for a charging decision, the decision of the prosecutor is to charge, caution, obtain additional evidence, or take no action, the police will proceed in that way unless the case is escalated for management review (as set out in Paragraph 22 of DG5).

Learning points

5.176 A summary of contributory factors influencing the custody release is in Appendix E.

5.177 The police should have clarified with L&D and the forensic medical examiner (FME) about the PACE clock and time limits.

5.178 If clinical observations are made about mental health, objective language should be used.

5.179 The FME should have discussed forward plans and possibilities with the police.

5.180 The FME could have requested background information about Mr A from the Emergency Duty Service.

[42] Director's Guidance on Charging 2013 (DG5) Paragraphs 22 and 24.

5.181 Police could have used the established escalation process to discuss concerns about CPS advice.

5.182 The advice from the CPS was not supported by detail which explained the rationale for the decision making.

Findings

- There should be L&D cover in each custody suite in agreed daytime hours.
- Develop L&D guidance for the structure of mental health assessments to enable narrative description of a mental state examination.
- Clarity of process when making Mental Health Act assessment requests from custody, including with PACE expectations.
- G4S mental health knowledge/training should be enhanced (structured/accredited induction planned).
- G4S should provide clarity on threshold for fitness to detain/expectations of medical assessment forms.
- G4S/FME/HCP should have access to NHS records, risk history and clinical information.
- The Police healthcare contract should be aligned with NHS processes.
- HCP/FME assessments should include clarity on what mental health presentation changes would indicate that a new medical assessment was required and could be requested.
- DCC and DPT need to recognise the lack of equivalence and the system pressures that impact on decision-making regarding Mental Health Act assessments out of hours. AMHP/MHAA function to be disaggregated from EDS out of hours.
- CPS should provide detailed written explanation about charging advice provided.

6 Inter-agency communication and information sharing

6.1 There is an existing Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons (2017). The signatories of the protocol are: Devon and Cornwall Police, Cornwall Council, Cornwall Partnership NHS Foundation Trust, Devon County Council, Devon Partnership NHS Trust, Plymouth City Council and Livewell Southwest.

6.2 The protocol applies to people who "have not been convicted of, or cautioned for, any offence placing them in one of the three MAPPA categories, but whose behaviour gives reasonable grounds that there is a present likelihood of them committing an offence or offences that will cause serious harm."

6.3 This protocol covers requests to police to disclose offending history, and from police to disclose health information. Part of the aim is to allow the exchange of information which can assist if an individual who is deemed potentially dangerous or suffering from a mental disorder is taken into custody. There is a very clearly defined process for this, with the appropriate legal limitations.

6.4 It is not clear how this very positive information sharing process may be applied to assist with the management of someone who has been arrested and is in custody. In our view, it would be very helpful to have a clearer route to access historical risk information about a detainee (as in the case of Mr A in February 2019) which could then have been added to the information available on the day. G4S are not signatories to the protocol.

6.5 L&D (and Street Triage) staff have access to police electronic records (Unifi) and Devon Partnership NHS Trust (DPT) mental health care records (CareNotes). They can make entries into both systems.

6.6 L&D staff based in Plymouth have access to the records of the local mental health services provider, Livewell Southwest. L&D staff can also see basic GP records, including medication.

6.7 At the L&D assessment of Mr A on 8 February 2019 the triage tool was completed. This contains a long list of 'tick boxes' which include demographic and quantitative information. There are two free text spaces entitled "additional information from triage" and "part 2 – assessment".

6.8 There are no instructions to guide L&D assessing staff in completing a mental state assessment. The 8 February 2019 assessment gave a short summary of the interactions, but at interview for this review it was clear that at the time there had been observations made about Mr A's mental health and presentation. The 9 February 2019 assessment used a situation, background, assessment, recommendation (SBAR) structure, and the 11 February 2019 assessment used the SBAR structure but included additional headings for a

very detailed mental state examination (appearance and behaviour, mood and affect, sleep, appetite, speech and language, thought content and processes, drugs and alcohol, cognition, medication, social circumstances, insight and capacity). L&DSDP

6.9 L&D1 described him as “irritable”, which they felt could have been his response to being arrested. Because of this, a police officer was requested to be present during the interview. Mr A expressed his reluctance to be involved in mental health services but did not display any evidence that he might be mentally ill.

6.10 G4S healthcare staff can only see the basic GP electronic record which shows medication prescriptions, and at that time G4S made paper records which were later uploaded to a central system. A G4S worker such as an FME working remotely could not at that time access any G4S care records. G4SSDP

6.11 AMHP and EDS staff can read and make entries directly into the individual’s DPT mental health records. EDS use three separate electronic record systems: Eclipse for child protection, CareFirst for adult safeguarding, and CareNotes for DPT mental health issues.

6.12 If there is an EDS contact, an EDS contact form would be raised, on CareFirst (DCC Adult Database) and Eclipse (DCC Childcare database)[43] which details the enquiries, the referral, what happened, actions and whether the contact was ‘received actions’ or ‘information only’. The senior EDS worker then has the duty of signing these off to check accuracy, and all phone calls, incoming and outgoing, are recorded.

6.13 CareNotes does not have an EDS contact form. Instead AMHPs open and complete an Episode (referral) form. This is a basic form which states the EDS Team are involved. The AMHP then opens a Clinical Note Referral Template and enters the details of the referral. Clinical notes are then added for updates.

6.14 Having carried out a Mental Health Act assessment the AMHP completes an AMHP Assessment Form and then closes the referral on the Episode form. The AMHP also has the option to complete an AMHP Short report on a Clinical Note Short Report template if there is going to be a delay in completing a full (more detailed) AMHP Assessment Report.

6.15 EDS staff told us they are not all sufficiently familiar with the CareNotes system to confidently access past information about risk assessments, care plans, correspondence and previous MHA information. EDSSDP

[43] not Carenotes (DPT Mental Health database)

6.16 EDS staff told us they are not always confident in accessing historical risk information in CareNotes.

6.17 The police individual management review (IMR) identified that PACE Superintendent extension requests should be submitted in writing to avoid any ambiguity. Decisions for or against an extension should be recorded, preferably electronically to time and date-stamp the decision, in the electronic detention log on the custody record.

6.18 A decision to extend a PACE clock would generally be very well documented on the custody record and a video and audio recording is made of this.

6.19 A decision to not extend a PACE clock can be subject to exactly the same level of scrutiny as extending it and therefore should be recorded in sufficient detail that the thought process and rationale is clear. It should also, however, be shared with the other agencies involved so that all are aware of the limitations. PoliceSDP

6.20 The G4S IMR identified that while the process of communication with the police is robust and auditable, communication with L&D staff is less formalised. G4S believes this is an area where quality improvements could be made, subject to the Data Protection Act 2018[44] and/or the consent of the patient.

6.21 Currently, communication between G4S clinicians and L&D staff takes place through discussions on site, or via the police using the Unifi database and verbal messages. When L&D staff are at custody in person between 8am and 6pm, the quality and quantity of communication with G4S healthcare professionals (HCP) and FMEs is described as very good.

6.22 Access to mental health information becomes extremely difficult when the L&D staff are not on site, or out of hours. There is no written feedback from the Liaison and Diversion mental health nurses after a G4S clinician makes a referral, so there is no formal opportunity for G4S to learn from or reflect on the case. L&D/G4SSDP

6.23 G4S has recognised that a more formal approach to communication will improve care for detainees. A referral form has been developed for G4S clinicians to formally refer cases to the L&D service, incorporating a feedback section to ensure that the G4S clinician receives details of the referral outcome for reflective practice and to provide opportunities for further dialogue.

6.24 The G4S IMR noted that building a comprehensive profile of the detainee before assessment is important. However, since the clinical care provided by

[44] Data Protection Act 2018. https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

G4S is episodic, in other words, responsive to the arrest of a detainee, there is often little opportunity to build this profile. There are also barriers for G4S when attempting to access past medical and mental health history. The medical records that G4S produce are in paper format and any previous contact with the detainee is archived off site. G4S medical information is not shared with any other agency. G4S does not have access to detainees' mental health records. G4SSDP

Learning points

6.25 The G4S healthcare professionals or forensic medical examiners could have gathered current clinical information, requested previous risk information from L&D and EDS and obtained knowledge of previous Mental Health Act assessment outcomes.

6.26 EDS staff were not always confident in using CareNotes.

6.27 L&D could have shared their assessments on 8 and 9 February directly with G4S healthcare professionals.

6.28 The PACE clock extension outcome should have been recorded formally as part of the custody records, and contingencies discussed.

6.29 Police could have requested a further mental health assessment if concerns about his mental health continued to the following day.

Findings

- G4S should develop electronic clinical records.
- G4S should develop an auditable process for information requests and responses/outcomes.
- G4S should gather clinical information rather than reliance on ‘point in time’ assessment.
- L&D assessment forms should be restructured to focus on mental state examination.
- Emergency Duty Service should have access to relevant information about mental health, and DCC should ensure that staff are confident in the use of CareNotes to access risk information.
- Police should ensure that all agencies involved are aware of the individual PACE conditions and any changes.
- Revise the Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons, to include G4S and guidance for custody.

7 Protocols for mental health emergencies

Crisis Care Concordat

7.1 The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.[45]

7.2 In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. Since then, five more bodies have signed the Concordat, making a total of 27 national signatories.

7.3 The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure that people are referred to appropriate services.

7.4 The work of the Crisis Care Concordat in Devon was led by the Devon Emergency Mental Health Steering Group. This work is now held within the Integrated Care System (ICS)[46] Urgent & Crisis Mental Health workstream. This is led by NHS Devon Clinical Commissioning Group,[47] and is a partnership of NHS Commissioners, Police, Devon County Council, South Western Ambulance Service NHS Foundation Trust, Devon Partnership NHS Trust, Royal Devon and Exeter NHS Foundation Trust. The local programme included:

[45]The Mental Health Crisis Care Concordat. https://www.crisiscareconcordat.org.uk/about/

[46] Integrated Care System for Devon. https://www.icsdevon.co.uk/get-involved/better-for-you-better-for-devon/

[47] Previously NHS Northern Eastern and Western (NEW) Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group

- Investment in Street Triage which is provided in the Police Control Rooms in Exeter, Torbay and Plymouth, where the police receive calls.
- Liaison and Diversion teams of mental health professionals in custody centres and courts.
- Investment in psychiatric liaison teams in hospital A&Es to deliver 24-hour response.
- Investment in a 24-hour place of safety in Plymouth and Exeter and Torquay.
- A 24-hour place of safety for children in Plymouth, covering the whole of Devon.

7.5 The most recent Devon Emergency Mental Health Steering Group last update to the action plan is May 2017. The action plan provides an update on seven workstreams:

- Delivery of a 24/7 crisis response (including crisis resolution home treatment teams)
- Provision of a Devon wide single point of contact
- Increased focus on primary and secondary prevention of mental health crisis
- Improved processes and protocols for the use of Section 136
- Provision of safe environment/havens across Devon (including crisis cafes/excluding POS)
- Consistent approach to mental health triage (“street triage”)
- Improved approach to mental health conveyance
- Involvement and support for carers

7.6 Each of these actions has a lead, milestones, progress updates and a key performance indicator measure included. However, there have been several structural changes in health commissioning across Devon over the last two years: the Devon Clinical Commissioning Groups (CCGs) have amalgamated to form NHS Devon CCG, and the Integrated Care System was established.

7.7 Devon is now developing a local version of the national NHS Long Term Plan, called 'Better for you, Better for Devon'.[48]

7.8 Devon's Integrated Care System has an Urgent and Crisis Mental Health workstream, which involves all key stakeholders and has adult and young people's workstreams.

7.9 Recent work has focussed on a review of the access points for those needing urgent mental health care, such as Access and First Response Service (AFRS), Street Triage, the Joint Response Unit, NHS 111 and the ambulance service. This work is ongoing, focussing on what the needs of the different elements of the system are and then designing stems around this.

7.10 There has also been recognition that some of the adaptations to systems during Covid-19 have led to creative ways of problem solving.

Single agency protocols

7.11 In February 2019 the L&D service was provided between the hours of 8am and 5pm, with practitioners based at Exeter and Barnstaple. This equates to the national service specification for L&D services, which is seven days a week and was never intended to be a 24-hour service.

7.12 Because of recruitment issues, across weekends there were times when there was only one L&D practitioner to work across two custody suites, as was the case in February 2019. There were no contingencies agreed for occasions when it would not be possible to visit a custody suite as usual. This has now been addressed through recruitment and changes to shift patterns, providing an 8am to 6pm service across seven days, with the resource to cover all custody suites.

7.13 Street Triage staff in Devon routinely work remotely (from 10am to 2am) seven days a week. Street Triage routinely provide police with information regarding whether an individual is known to mental health services, information about their mental health history and potential risks. This supports effective risk management and early access to mental health assessments.

7.14 Street Triage may be requested to provide information about previous and current mental health services contact on request from the police. We were told that they do not provide any consultation about the care of the individual, or any direct input into the care of the individual, although they could do if required. While this provides useful information for the police on request, this appears to be a rich clinical resource that is used for information sharing only

[48] Better for You, Better for Devon – Engagement report. https://www.icsdevon.co.uk/download/better-for-you-better-for-devon-engagement-report/

rather than to assist with the care and management of the individual. DPT SDP

7.15 Mental health emergencies are only one element of the function of the Emergency Duty Service (EDS). Between 2010 and 2014, EDS carried out approximately 25 per cent of all arranged Mental Health Act assessments across the county. Out of hours, these requests can be made from across the county of Devon, and the prioritisation of responses will inevitable be affected by the statutory work which is the responsibility of EDS.

7.16 In 2019 the EDS team was based in County Hall in Exeter. The EDS Advanced Professional who coordinates the service is always also a qualified Approved Mental Health Professional (AMHP), and there are three or four team members out of hours, including an AMHP, a community care worker and a childcare worker. In February 2019 the staffing was a childcare worker, community care worker, AMHP and coordinator. This would allow five staff on a Saturday daytime, four on a Sunday daytime. This rota changed in April 2020 to increase resources in response to service demands.

7.17 There is an EDS Governance Board which oversees the work of the service, with input from local partner agencies. A review of the EDS service was being undertaken in 2021 in conjunction with the daytime AMHP service, in response to an increase in demand on the service. Discussions have focussed on identifying the best model of delivery, taking other service changes into consideration. As other services have changed and evolved, these have had an impact on EDS pressures, such as new referral streams from mental health liaison teams (MHLT) and the L&D service, and the need to assess people in custody.

7.18 The daytime AMHP service provides a responsive service for the provision of Mental Health Act assessments (MHAAs) on request. The AMHP service is provided by a ‘Hub and Spoke’ model which consists of a small central full-time AMHP team (‘Hub’) who receive and triage all requests for MHAAs (in office hours).

7.19 G4S protocols regarding mental health emergencies in custody are discussed above (from paragraph 5.27).

Multi-agency protocols

7.20 Liaison psychiatry is the subspecialty of psychiatry that provides specialist mental health assessment and treatment for patients attending general hospitals. This includes patients who attend Emergency Departments and who are admitted as inpatients. There are liaison psychiatry teams (provided by Devon Partnership NHS Trust/DPT) based at Torbay, Exeter and North Devon, with detailed operational policies and protocols. Livewell Southwest provide this service at Derriford Hospital in Plymouth.

7.21 Their remit is to respond to mental health emergencies but is limited to those individuals who either attend A&E or are inpatients in one of the acute hospitals. The interface tends to be with the acute providers. Any police involvement occurs either where people are brought to A&E by police or under Section 135/136 MHA before the centralised place of safety came into effect in 2020.

7.22 There is a DPT Section 136 and 135 MHA Policy, supported by a Peninsula-Wide Protocol. Attempts were made during this review process to ascertain which version of this Peninsula Wide Protocol was the current working document, but it was not clear.

7.23 The DPT Section 136 and 135 MHA Policies have multi-agency agreement through the Local Criminal Justice Board (LCJB) meeting.

7.24 There are two places of safety (POS)[49] in the county, with the DPT central POS at the Cedars, Wonford House, Exeter. This reflects the expectation that there are dedicated health-based places of safety and the 2017 changes to the Policing and Crime Act, which limit the use of police cells as places of safety for adults.

7.25 From 2017 a police station can only be used as a place of safety for adults in specific circumstances, set out in The Mental Health Act 1983 (Places of Safety) Regulations 2017:

- "the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person
- because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and
- so far as reasonably practicable, a healthcare professional will be present at the police station and available to them."
- The guidance envisages movement to a different place if the person's behaviour has moderated, however such a judgement should also include an assessment of whether a person's behaviour would pose the imminent risk were it not for the fact that they were in the police station. Moving a person multiple times is to be avoided.

7.26 The maximum detention period (for Section 135 and 136) will be 24 hours (reduced from 72 hours); it can be extended for a further 12 hours by the responsible medical practitioner if a Mental Health Act assessment cannot be completed within the permitted period due to the person's mental or physical condition.

[49] The POS in Plymouth is at the Glenbourne Unit and is provided by Livewell Southwest.

7.27 There is clarity within the Policy on the nature of police support within the POS after an individual is detained under Section 135/136 MHA. The Policy does not, however, guide the process for police officers if they wish to detain someone who is currently arrested, under Section 135/136 MHA.

7.28 A draft multi-agency protocol for Mental Health Act assessments in custody/under PACE (v10 2021) has been developed. The partner agencies to this protocol are Devon and Cornwall Police, Devon Partnership NHS Trust, G4S, and Devon County, Plymouth and Torbay Councils. It has had input from custody staff, Liaison and Diversion teams, Approved Mental Health Professional Services, forensic mental health services and forensic medical examiners. The aim of this protocol is to: "set out a clear multi-agency process that supports both the requirements of PACE and timely decision-making when considering the use of psychiatric admission or on-going mental health supports through the criminal justice process."

7.29 This protocol suggests an initial strategy call between the healthcare professional/mental health practitioner (usually L&D), police custody staff and the Emergency Duty Service/Approved Mental Health Professional, with a clear decision-making pathway to follow that takes account of PACE considerations.

7.30 This protocol would directly address some of the gaps in process between agencies that have been highlighted by the February 2019 issues involving Mr A. We note that this protocol has been in draft for some months, and it is not currently clear how it would be agreed across agencies.

7.31 DPT has a formal Clinical Strategy to reflect expectations of NHS England Five Year Forward View, NHS England Long-Term Plan and the new national Community Mental Health Framework.

7.32 Within this strategy is a commitment to the provision of immediate help – responding to crisis referrals within 24/48 hours and organising a network meeting with the important people around the person within the first few days.

7.33 The Access and First Response Service (AFRS) was launched in March 2020, and is accessible through a call centre, seven days a week, 365 days a year. The FRS takes calls from individuals, families/carers or professionals. Advice may be given over the phone or signposting to other services.

7.34 Devon Partnership NHS Trust and Devon and Cornwall Police work together on a number of multi-agency committees, many of which also have a number of sub-committees. The following list summarises the key committees where joint work was undertaken:

- Torbay and Devon Safeguarding Adults Partnership

- Devon Safeguarding Children Partnership
- Torbay Safeguarding Children Board
- Safer Devon Partnership (Domestic Abuse)
- Torbay Domestic Abuse/Sexual Violence Committee
- focussed safeguarding workstreams regarding such issues as modern slavery; county lines; substance misuse
- Prevent/Channel Panel
- Multi-Agency Risk Assessment Conference (MARAC) steering committee
- Multi-agency public protection arrangements (MAPPA) steering committee
- Mental Health Partnership Group
- Creative Solutions steering committee[50]

7.35 These committees are multi-agency and typically include (as a minimum) other health partners and social care. There are additional focussed workstreams regarding the Urgent Care Pathway, which are joint committees between mental health and police:

- Street Triage
- High Intensity Network pilot in North Devon steering committee
- Joint Response Unit (JRU)
- Liaison and Diversion Services – there is a national specification which outlines how services can provide a consistent and high quality approach
- Mental Health/Police Liaison Committee and locality sub-committees – includes work on Emergency Transfer from Custody Policy; providing flowcharts for police on pathways into mental health, for example; evaluating data regarding use of Section 135 and Section 136 (full terms of reference below).

7.36 The AMHP daytime and EDS Service Managers are invited to Mental Health/Police Liaison Committee meetings.

[50] This was stood down in March 2020

Learning points

7.37 Section 136 practice guidance is needed for police if a person is arrested and in custody.

7.38 Crisis Care Concordat plans should be updated, or clarity of the structure for urgent and crisis mental health, going forward.

7.39 A pathway for governance between structures and agencies should be developed.

7.40 A process and structure for decision-making between committee structures should be developed.

7.41 There is no single information sharing agreement.

Findings

- Update of Crisis Care Concordat actions and of urgent and crisis mental health workstream.
- Multi-agency protocol for Mental Health Act assessments in custody/under PACE should be agreed and implemented.
- Evaluate the outcomes of the Street Triage service.
- Set a timescale for the agreement and implementation of the Peninsula Wide Section 135/136 policy.
- Clarify process for Section 135/136 if a person is arrested and in custody.
- Pathway for governance and decision-making between agencies.
- One overarching information sharing agreement across agencies.

8 Out of hours mental health emergencies

8.1 The First Response Service (FRS) service specification includes referrals from “the individual in crisis; their referrer or other agencies (GP, Police, etc.) may refer to the service themselves via telephone”. The intention of this service is to provide advice to other agencies in the community, but it does not include any reference to advice to police or custody healthcare professionals who may have an individual in custody who has mental health issues.

8.2 There are three local centres which provide 24/7 out of hours mental health crisis support to anyone aged 16 or over, in the Devon area, from three locations in Barnstaple, Exeter, and Torquay. These support services are provided by a third sector provider[51] and can be accessed through self-referral or through signposting from the FRS. The service cannot take people who need urgent medical attention, for example after self-harm, or who may present a degree of challenging behaviour.

8.3 The provision in Devon for mental health assessments in custody out of L&D service hours is vastly different. The only health assessments which are expected in custody out of hours are either ‘medically fit to detain’, a specific assessment such as a post-taser review, or a request for a Mental Health Act assessment (MHAA). As described, there is no agreed protocol to access out of hours psychiatric or mental health advice or information in custody, in the absence of the L&D service.

8.4 There is a Mental Health Urgent Care programme led across Devon’s integrated Care System, with involvement from all key stakeholders.[52] This sets out a structured approach to the NHS England Long Term Plan ambitions:

- “By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis.
- Increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways.
- By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained

[51] Mental Health Matters Mental Health Matters (MHM) is a national charity delivering mental health and social care services. https://www.mhm.org.uk/the-moorings-devon

[52] We have been informed that this is the product of the ICS urgent and crisis mental health care workstream.

and equipped to respond effectively to people experiencing a mental health crisis.

- Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.

- Eliminate inappropriate out of area placements for non-specialist acute care by 2021."

8.5 The project workstreams include the FRS, Home Treatment Teams, interface with South Western Ambulance Service NHS Foundation Trust (SWASFT), emergency department interfaces, out-of-area treatments, and police interface.

8.6 The police interface workstream includes a Joint Response Unit, Street Triage and places of safety.

8.7 It is clear that the local health systems have already identified that there is a need to expand and develop the current out of hours mental health emergency access, and interface with the police is one of the five priorities.

8.8 The next steps, which are currently marked as "not funded", are a system model review of 2022 Street Triage, the Joint Response Unit, First Response Service, places of safety, and a review of delays in accessing MHAAs in hours and out of hours, in partnership with AMHP services.

8.9 These initiatives could address the gap in provision for MHAA in custody identified in this review.

8.10 In March 2020 the Coroner for Exeter and Greater Devon delivered a Regulation 28[53] ruling with respect to a death in custody that occurred in March 2017. The Coroner identified that there was no mechanism for the ready transfer of a person in police custody within the police areas of Devon and Cornwall, Avon and Somerset, Wiltshire, and Gloucestershire from police custody to a medium secure mental health facility for assessment and treatment under Sections 2 and 3 of the Mental Health Act 1983 where such a person is suspected of or charged with a serious crime.

8.11 The South West Provider Collaborative[54] has responsibility for the medium and low secure mental health care of adults originating from the south-west, since NHS England formally transferred its commissioning responsibilities. The new arrangements came into effect on 1 October 2020. The South West

[53] https://www.judiciary.uk/wp-content/uploads/2020/04/Lewis-Francis-2020-0074.pdf

[54] South West Provider Collaborative Group members are Devon Partnership NHS Trust, Cornwall Partnership NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, Somerset NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust, Livewell Southwest, Elysium Healthcare and Cygnet Health Care.

Provider Collaborative has eight partners, comprising five NHS organisations, one community interest organisation and two independent sector companies. Devon Partnership NHS Trust (DPT) is the Lead Provider for the Collaborative and holds the new contract with NHS England. In response to the Coroner's ruling, the South West Provider Collaborative Oversight Group developed a protocol for emergency access to a medium secure mental health bed.

8.12 A protocol and flowcharts were developed, for secure mental health services, police, CPS and HM Courts and Tribunals Service. This clearly describes the decision-making points and referral pathways for police, Liaison and Diversion, Approved Mental Health Professionals and acute mental health services, guiding the process of referral from police custody to secure services.

8.13 The guidance refers to arrest for serious offences, for example, murder, attempted murder, Section 18,[55] serious sexual offence (rape) and arson.

8.14 This is a very positive development that was implemented to help address a weakness in the system which was identified by the Coroner. It has been implemented across agencies, and staff we spoke to referred to using it in practice.

8.15 However, the key decision within this protocol is the agreement that there is evidence of a mental disorder. A very helpful step in the process is that if it is thought that a Mental Health Act assessment (MHAA) is likely, then there is expected to be liaison with the secure services Consultant Forensic Psychiatrist prior to and following the MHAA required, to discuss the appropriateness of possible admission to inpatient secure care.

8.16 This option is not open if there is a difference of opinion, or a decision that a MHAA is not necessary. The referral is closed if it is judged that there is no evidence of a mental disorder.

8.17 There is a decision-making flowchart which assumes that the nature of assessments made in and out of hours is comparative. However, our finding is that there is a lack of equivalence in the provision of mental health assessment out of hours after an arrest.

Escalation routes

8.18 In February 2019 the L&D service was managed within the Adult Mental Health Directorate, and there was a lack of expertise perceived by L&D staff in responses to out of hours concerns. From April 2019 the L&D service was brought under the management of the Secure Directorate. There is now an

[55] Section 18 Assault is an offence described as either "wounding with intent" or "causing grievous bodily harm with intent" and is the most serious form of assault (save for murder and manslaughter) that can be committed.

on-call manager for L&D to consult as needed. This was described to us as a very positive move, and there was better integration into an operational unit, with accessible management support and oversight.

8.19 As referred to in Section 5 of this report, there is no local escalation process or source of clinical mental health advice or information available to a G4S healthcare professional or forensic medical examiner out of hours. G4S have set up access to an informal internal network of mental health clinicians who may be available, but there is no formal structure.

8.20 If, as was the case in February 2019, the police had concerns about the mental health presentation of an individual who had been assessed as not requiring a MHAA, there is no obvious route to challenge this or request any further review. The police would then have to be guided by the expectations of PACE only.

8.21 There are DPT practice standards and principles in place to guide staff at the interface points between Access and First Response Service, Liaison Psychiatry, the Home Treatment Team, AMHPs and Bed Capacity, which guides staff through the steps in a referral and assessment pathway. This is an example of good practice.

8.22 There is no comparative guidance for the interface points between NHS services, the AMHP/EDS service, and forensic and custody health care.

Learning points

8.23 Coordination of services for out of hours mental health emergency responses is needed, with clarity on the interface between custody and NHS services, and custody and AMHP/EDS services.

8.24 The interface (if any) between police custody/HCP/FMEs and First Response Service is unclear.

Findings

- Coordination of services for out of hours mental health emergency response and custody interface.
- Evaluation of the Joint Response Unit and Street Triage.
- Clarify how police custody and healthcare professionals can interface with the First Response Service.
- Clinical advice and local mental health service advice available for forensic medical examiners.
- Escalation routes for police if mental health concerns.
- Practice standards and principles at the interface of NHS services/AMHPs/EDS and custody health.

9 Oversight structures

9.1 We have reviewed the various agency oversight structures relevant to the terms of reference.

NHS structures

NHS Devon Clinical Commissioning Group

9.2 NHS Devon Clinical Commissioning Group (CCG) is responsible for planning, commissioning (or buying) and developing local healthcare services.

9.3 The CCG is one of the three statutory partners of the Torbay and Devon Safeguarding Adults Partnership (TDSAP), and a member of a number of subgroups, including the Safeguarding Adult Review (SAR) Core Group (hereafter referred to as the Core Group). There is a Safeguarding Adults team led by a Designated Professional Lead for Safeguarding. When a concern is raised about the provision of healthcare by an organisation or to an individual, the CCG advises on actions.[56]

9.4 If a concern is raised that may require a Safeguarding Adult Review (SAR), or a referral is received for a SAR, the Core Group review the information and decide on next steps. This might be a request that the relevant agencies provide further information.[57]

9.5 The information is reviewed by the Core Group, who may make a recommendation for a SAR, which then goes to the TDSAP Board Chair for review and decision-making. The TDSAP SAR policy sets out how this should be progressed, and the Core Group advise on process such as methodology and recruitment of a SAR author. The role of the CCG is to provide oversight and challenge to health organisations (and others).

9.6 There have been a series of changes in structures in health commissioning in Devon, with the current combined CCG being in existence since 2019.

9.7 The CCG safeguarding team works across three local authorities and two Safeguarding Adults Boards (Plymouth and TDSAP). There is also CCG representation on the local providers' internal Safeguarding Adults committees to provide communication and oversight.

[56] Safeguarding Adult Policy, NHS Devon CCG, March 2020.

[57] Torbay and Devon Safeguarding Adults Partnership (TDSAP) Multi-Agency Safeguarding Adults Review (SAR) Policy. May 2021.

9.8 Where there is a safeguarding element of a health serious incident or of a Section 42 enquiry,[58] the CCG will advise on whether escalation to a SAR is indicated.

9.9 Assurance on the implementation of action plans from SARs was carried out by the Core Group. Following a review of the TDSAP structure the Learning and Improvement Subgroup, which the CCG will continue to attend as it no longer chairs this meeting, will have oversight of action plans going forward and draw out learning to be shared across the system. The CCG now chairs the newly formed Quality Assurance and Improvement Subgroup which will be responsible for monitoring the effectiveness of the action plans.

9.10 It would not be proportionate for the CCG to follow up on all action plans arising from the breadth of investigations undertaken by health providers, but systems are in place to request updates on any relevant safeguarding issues.

Devon Partnership NHS Trust

9.11 The Liaison and Diversion (L&D) service reports to the Devon Partnership NHS Trust (DPT) Secure Directorate and is commissioned by NHS England Health and Justice. A service specification is in place and is monitored by NHS England Health and Justice.

9.12 Street Triage was originally commissioned as a pilot within this service, which was co-located across the Plymouth and Exeter Police control rooms, with staff able to access the first point of contact, input directly onto Force information management systems in real time, and cover all clinical areas. On request, clinicians would access a person's mental health records and input that information directly onto the Police log and bring it to the attention of the relevant supervisor or dispatcher.

9.13 We have not seen the outcome of the pilot evaluation but note that within the Partnership Board papers it is stated that the pilot was due to end in March 2021. DPT have informed us that the evaluation has been completed, and a further time limited extension agreed. It is noted that the short term extensions perpetuate the necessity to employ temporary staff and limit the ability to embed the service alongside other initiatives such as the JRU.

9.14 Accepting that these are funded through a variety of different streams, we suggest it would be helpful if these were aligned.

[58] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

9.15 There is a Peninsula Liaison and Diversion Partnership Board which provides governance, strategic direction and leadership to oversee the delivery of the L&D service.

9.16 The members of the Peninsula Liaison and Diversion Partnership Board are NHS England Health and Justice commissioners, Devon and Cornwall Police, DPT, Cornwall Partnership Foundation Trust, HM Prison and Probation Service, HM Courts, G4S and probation services.

9.17 There is reference in April 2019 to a review of the Memorandum of Understanding. This was an agreement signed in January 2018 between NHS England, Devon and Cornwall Police, DPT, Cornwall Partnership Foundation Trust and Livewell Southwest. It clarified the roles of each agency in relation to the functions of the L&D service. We have not seen an updated MOU.

9.18 NHS England formally transferred its commissioning responsibilities for the medium and low secure mental health care of adults originating from the south west to the South West Provider Collaborative. The new arrangements came into effect on 1 October 2020. Devon Partnership NHS Trust is the Lead Provider and holds the new contract with NHS England.

9.19 The South West Provider Collaborative Oversight Group agreed the 'System Response to a Coroners Regulation 28 Ruling: Emergency access to a medium secure mental health bed' in November 2020. This is an example of excellent inter-agency practice in response to a systems issue. It did, however, require the development of another MOU with various stakeholders.

Other agency structures

9.20 G4S Health Services provides a multi-site service, with a Custody Leadership Team overseen by the Head of Custody Healthcare. There is a lead doctor for the FME provision, and a clinical lead for each of the areas where G4S provides custody health service (London; Avon and Somerset; Gloucestershire and Wiltshire; Cumbria; and Devon and Cornwall). This provides a management and quality assurance structure.

9.21 G4S has identified that there was a need for assurance about their healthcare professionals and forensic medical examiners' knowledge and awareness of mental health. A more comprehensive induction and continuing professional development programme was developed, and the programme was shared with us as part of this review. The aim is to have an induction and development programme which is accredited by the Faculty of Forensic and Legal Medicine.[59]

[59]The Faculty of Forensic and Legal Medicine is a charity set up to develop and maintain standards of competence and professional integrity in forensic and legal medicine. https://fflm.ac.uk/

9.22 We have found that while G4S provides an essential element of the pathway for detainees who may have mental health issues out of hours, the only route into local health systems out of hours is via the police, due the nature of the contract.

9.23 The Emergency Duty Service (EDS) is managed within the Child Services Directorate of Devon County Council. Pressure on the service to provide Mental Health Act assessments has been identified. A review of delivery models is currently underway through the EDS Governance Board in response to systems pressures and recruitment issues. Other models in use, in other rural settings and in Birmingham, are being examined.

9.24 Devon and Cornwall Police is a single organisation; however, across the South West Peninsula there are three NHS Provider Mental Health agencies: Devon Partnership, Cornwall Partnership and Livewell.

9.25 There is no clarity among police or mental health colleagues as to the overall governance structures and no single overarching governance committee monitoring the inter-relationship between mental health services and police, or between DPT and Devon and Cornwall Police.

9.26 The Mental Health/Police Liaison Committee provides an overarching forum for discussion of a number of topics. Both the Street Triage project and the High Intensity Network project have been presented to the Mental Health/Police Liaison Committee, and groups have been established to work on new policies. Fundamentally, however, decision-making and governance of many specific projects lies in separate discussions or conversations.

9.27 The Mental Health/Police Liaison Committee has evolved in the last two years with more focussed agendas. The locality mental health/police committees report into the over-arching committee which receives project reports and explores specific cases where the committee believe cross-agency working could be improved.

9.28 There are innumerable information sharing agreements, which at its best can be confusing for professionals. There is no single governance pathway nor any clear pathway between committee structures.

9.29 There are however multiple examples of professionals in both police and health working collaboratively together, seeking to find creative solutions and providing training. Many of the professionals from both police and mental health work with each other regularly on numerous multi-agency committees.

9.30 A revision of the terms of reference of the Mental Health/Police Liaison Committee is suggested, to ensure clearer reporting structures to the

respective Executive Boards in Health and to the office of the Chief Constable.

9.31 Concerns related to the quality of local care and support services are core to the working of Torbay and Devon Safeguarding Adults Partnership. The Partnership Board and its partners are covered under Section 45 of the Care Act 2014[60] and in our view is the appropriate body to develop an overarching information sharing agreement.

9.32 We were told that a review of the current (2015) information sharing agreement with the police is planned by the TDSAP, to ensure that it is compliant with new legislation.

Learning points

9.33 G4S health services are not linked into local health communication structures.

9.34 Emergency Duty Service resources for Mental Health Act assessments and Approved Mental Health Professionals are not based on flow and demand.

9.35 Various new protocols are still in draft.

9.36 Street Triage has only time limited funding and would ideally work in tandem with the JRU.

9.37 No overarching information sharing agreement.

Findings

- Revision of the terms of reference of the Mental Health/Police Liaison Committee.
- Develop a fully funded service that aligns the functions of Street Triage and the JRU.
- Include G4S as a partner in custody/health MOUs and information sharing agreements.
- Develop an overarching information sharing agreement under the Torbay and Devon Safeguarding Adults Partnership which incorporates health, social care and criminal justice partners.

[60] If a SAB requests a person to supply information to it, or to some other person specified in the request, the person to whom the request is made must comply with the request if: a) conditions 1 and 2 are met, and (b) condition 3 or 4 is met. (2) Condition 1 is that the request is made for the purpose of enabling or assisting the SAB to exercise its functions. (3) Condition 2 is that the request is made to a person whose functions or activities the SAB considers to be such that the person is likely to have information relevant to the exercise of a function by the SAB. (4) Condition 3 is that the information relates to— (a) the person to whom the request is made, (b) a function or activity of that person, or (c) a person in respect of whom that person exercises a function or engages in an activity. Condition 4 is that the information (a)is information requested by the SAB from a person to whom information was supplied in compliance with another request under this section, and (b)is the same as, or is derived from, information so supplied. https://www.legislation.gov.uk/ukpga/2014/23/section/45

10 Culture, leadership, capacity and resources

10.1 Services across Devon have to manage the geographical distances involved, as well as the range of needs of urban and rural populations.

10.2 Within the services reviewed in this report, issues of distance, travel and the breadth of areas covered were raised by most interviewees.

10.3 Services had to take account of, and be responsive to, the working environments of other agencies: for example, the Liaison and Diversion (L&D) team are based in custody suites, that are provided by the Police.

10.4 There have been challenges in recruitment for L&D staff in 2018 and 2019, which affected the ability of the service to provide consistent cover to each of the custody suites, particularly at weekends. These have been addressed through recruitment and adjusting shift patterns.

10.5 The L&D team were originally managed in Devon Partnership NHS Trust (DPT) through the community mental health services management structure, and staff told us this did not provide them with sufficient support and direction. From April 2019 the responsibility changed to the Forensic directorate, with more direct management oversight.

10.6 The detailed monitoring of L&D contracted activity between DPT and NHS England was paused during the Covid-19 pandemic, and as monitoring restarts it is hoped that there will be an opportunity to carry out a formal review of the L&D operating model. The perception is that there has been an increase in demand and dependency, but the current staffing model is weighted to a Monday to Friday service up to 6pm.

10.7 We suggest that a review of the L&D service should take place in tandem with a review of arrest and detention/custody patterns, looking at presentations of individuals with mental health issues across daytime and evening.

10.8 It was clear that the EDS service operates using an excellent teamwork approach, with very experienced practitioners. The functions of EDS are very disparate, and although for Mental Health Act issues there are good links professionally with the Approved Mental Health Professional (AMHP) team, there is a very separate management and policy focus. It is entirely to be expected that in any decision-making about prioritising resources, balancing statutory work and Mental Health Act assessments is very different at weekends and during the night.

10.9 We suggest that the model of delivery of out of hours MHAAs be revisited, assessing resources against capacity and demand.

10.10 Within G4S we found that the perspective and training of healthcare professionals (HCPs) and forensic medical examiners (FMEs) was primarily on medical care in custody, with less focus and awareness of mental health issues. This presents a potential gap in the skills and knowledge required to provide a quality service where an increasing number of detainees may be identified as having a mental illness (29% in 2021).[61]

10.11 We have not seen the outcomes of the Street Triage and Joint Response Unit service review, but questions were raised with us about the efficacy of the model, which in rural areas seems to have become more limited to information sharing between DPT and police.

10.12 There are obvious benefits of information sharing, but we suggest this rich resource of skilled staff may be more usefully focussed on service provision than information sharing.

Unintended barriers to effective multi-agency working

10.13 The assessment of risk is a fundamental element of clinical practice. With reference to the assessment of risk in mental health, according to the Royal College of Psychiatrists' practice guidance:[62]

- "all clinicians should carry out careful, curious and comprehensive history taking.
- preparation is crucial and clinicians should try to gather information from as many reliable sources as possible."

10.14 It is not clear whether the purpose of the G4S medical assessment form in use in custody is to assess risks or purely to identify the presence or absence of a medical disorder. There is also a lack of clarity regarding how G4S HCPs and FMEs access previous mental health history or advice on management. The routes for physical care are more straightforward: if there is a physical health emergency in custody, urgent intervention is provided, the person is transported to an A&E department, or an ambulance is called.

10.15 Systems are not set up to provide a corresponding emergency mental health response, particularly in custody.

10.16 As identified in Section 5 of this report, when an individual has a mental health and/or custodial history there is a mixture of paper records and standalone

[61] Figure based on a cohort of 134 people. Semele, C. et al. (2021). 'The prevalence of mental illness and unmet needs of police custody detainees', Criminal Behaviour and Mental Health, 31(2), pp. 80–95.

[62] Rethinking risk to others in mental health services. Assessment and management of risk to others: good practice guide. Royal College of Psychiatrists CR201, 2016.

electronic systems. These cannot be easily accessed to give a rounded picture of the person's presentation and risks.

10.17 There is a lack of agreement about what information may be accessed as part of an emergency out of hours mental health assessment, and a lack of clarity about which NHS or local authority structures can be accessed for advice or information.

10.18 The National Health and Social Care South West Strategic Information Governance Network (SIGN) has produced a Peninsula wide information sharing agreement (Tier 1).[63]

10.19 This agreement aims to "provide partner agencies with a robust foundation for the lawful, secure and confidential sharing of personal data (information) between themselves and other public, private or voluntary sector organisations that they currently work with or would wish to work with across the evolving healthcare, social care and local authority environments". This agreement does not include the police or G4S.

Recent developments

10.20 There have been a number of local developments since 2019, some linked to learning from these tragic events.

10.21 G4S have developed a structured induction and professional development programme for all their healthcare professionals, with external accreditation.

10.22 The DPT single point of access was replaced in March 2020 by the Access and First Response Service, providing a service seven days a week, 365 days a year. The service is an urgent mental health service for people with mental health and learning disability needs. Contact can be made by professionals, or directly by an individual or family member.

10.23 The new 'emergency access to secure bed' protocol has been agreed across agencies and has been applied in real situations.

10.24 We have had sight of proposals by South Western Ambulance Service NHS Foundation Trust for a model for an Ambulance Service Mental Health Response service. The figures for demands on ambulances to respond to mental health emergencies show a steady rise in the South West, with escalating Devon figures.

[63] V5.2-Peninsula-Information-Sharing-Agreement1.May 2019. There are regional information governance networks across England, which provide a network of local and regional groups that are part of the National Health and Social Care Strategic Information Governance Network (National SIGN). https://www.nhsx.nhs.uk/information-governance/strategic-information-governance-networks-signs/

10.25 The proposals include a ‘mental health desk’, with a qualified mental health practitioner providing support to the ambulance dispatch desk. The intention is to integrate resources so that responses to any emergency which involves both mental and physical health issues have appropriate resources. We understand that discussions are in progress about funding and commissioning.

Learning points

10.26 The police custody/G4S healthcare model is focussed on assessment of medical conditions. Systems are not set up to provide an emergency mental health response, particularly in custody.

10.27 There is a clear lack of an overarching information sharing agreement or a memorandum of understanding across agencies, and multiple paper and electronic record systems.

10.28 The Liaison and Diversion service staffing is weighted to a Monday to Friday service.

10.29 The Emergency Duty Service focusses on statutory work across the county out of hours.

10.30 Current models of emergency response are separated into physical and mental health issues, with varying resources.

Learning from previous review

10.31 A thematic review of Vulnerable Adults Mental Health Crisis Care was commissioned by Devon Safeguarding Adults Board in 2015. Although this predated the work of the Crisis Care Concordat, themes were identified which resonate with this review. One of the recommendations was about inter-agency communication, recommending that a process should be devised and staff should be trained to allow and encourage the transfer of risk information between two key agencies (at that time, between GPs and the Crisis Resolution and Home Treatment teams).

10.32 The report also noted that a Multi-Agency Safeguarding Hub structure had been set up for information sharing regarding children, and it was suggested that it might be possible to develop corresponding services for adults.

Findings

- IT platform that allows access across health and other agency records.
- Information sharing agreement/memorandum of understanding that includes all partner agencies including police and G4S.
- Analysis of flow and dependencies to inform a review of the L&D and Joint Response Unit operating model.
- The Emergency Duty Service model of delivery of out of hours Mental Health Act assessments to be assessed against capacity and demand.
- Systems for responding to emergency physical health and mental health issues should be integrated where possible.
- Development of multi-agency risk evaluation structures.

11 Family concerns

11.1 Although we do not have direct questions from all families, we are aware from our conversations with them that a central issue in the review is the question of how Mr A was managed after his arrest on 9 February 2019, and how the various agency policies, procedures and statutory obligations impacted on decisions to release him on 10 February 2019. These are addressed in the body of the report, and the analysis of the decisions made is at Section 5.

We have been provided with a list of questions from the family of one of the Exeter victims, and these are given below, with our brief comments in response:

11.2 "When [Mr A] was in custody in Barnstaple Police Station his mother contacted the Police and told them about his declining mental health and his behaviour was in response to this and this had happened on previous occasions, when his medical health was in decline. Why wasn't his mother's opinion/concerns about this decline taken into account by Police, mental health professionals or doctors who saw him prior to his release from custody and the appropriate action taken?"

Mr A's mother's concerns on 8 February 2019 were logged by police and he was helped to find a bed at the safe sleep centre. He had been seen by the L&D that day and no mental health concerns were noted. Mr A's mother's concerns that Mr A may be relapsing were not shared by police, but these had come after L&D staff assessed him.

Mr A's mother called police again on 10 February 2019, and police made enquiries about his whereabouts with mental health staff (Street Triage Team). Mr A was identified as a medium risk missing person.

11.3 "[Mr A] had previously been admitted to mental health hospitals after suffering a deterioration in his mental health. This would appear due to his own failure to take his prescribed medication, which made his mental health decline. Why on his release from the last hospital he was admitted to was nothing put in place by the mental health professionals/GP to support him taking the medication or make him take his medication? Why was there no follow up by any mental health professionals/GP?"

This question has been discussed in the Mr A care and treatment Report. Please refer to that report for further detail of our response.

We have discussed how the use of a Community Treatment Order may have been of benefit (Use of a Community Treatment Order (CTO)) and the limitations of this section of the Mental Health Act given that Mr A went to France within three weeks of being discharged from hospital in November 2017.

11.4 “We as a family would like to know what happened in the months and weeks prior to the incidents in [Mr A’s] life before he came to Devon? And whether any family or friends of [Mr A] contacted the mental health professionals or discussed among themselves seeing a decline in [Mr A’s] mental health.”

This question has been discussed in the Mr A care and treatment Report. Please refer to that report for further detail of our response.

We know that he consulted his GP in Wiltshire in late October 2018 January 2019, and attended A&E in London in December 2018.

In January 2019, the GP did not identify any mental health concerns.

11.5 “Why was [Mr A] released from Police Custody on two occasions having not received the appropriate level of mental health assessment by the mental health professionals?”

Our report discusses this in detail in Section 5. On 8 February 2019 Mr A was assessed by L&D staff as not needing mental health intervention. On 9 February 2019 Mr A was assessed by the FME who determined that Mr A did not require an MHA assessment.

11.6 “Before his release from Police Custody how much information was gathered from the various other agencies or other sources to complete an appropriate assessment of his mental health? other sources include mental health establishments outside Devon and Cornwall, his mother, GP records and mental health services in Devon and Cornwall.”

As we discuss in Section 5, there was insufficient information available. No background information was available to the FME who assessed him. It would not be usual practice for an FME to source information about a detained person from other agencies.

11.7 “If these incidents happened between Monday to Friday would there have been a different outcome to [Mr A’s] assessment and treatment in Custody i.e. a better outcome? Therefore, as a family we are asking if there is adequate Mental health staffing at weekends and access to mental health records to fully assess someone like [Mr A] if they are in custody over a weekend compared to a week day?”

We cannot speculate on the potential outcome of an assessment. However, in our view, there would be better access to information and resources on a weekday. There were system pressures that impacted on decision-making regarding Mental Health Act assessments out of hours.

12 Learning from NHS England independent investigations

12.1 The three separate NHS England independent investigations are:

- Care and treatment of Mr A prior to the homicides of three elderly men in Exeter in February 2019.
- Care and treatment of Patient A prior to the homicide of a man in Barnstaple in August 2018.
- Care and treatment of Mr S prior to the homicide of a man in Newton Abbot, and the subsequent suicide of Mr S in June 2019.

12.2 The findings and recommendations of these investigations have been reviewed for cross-cutting themes, and we have included here those that applied to at least two of the investigations. These do not all relate directly to emergency mental health services and systems but are included here for completeness.

12.3 We have summarised the themes under the headings of risk assessment, consistency, listening to families, the discharge process and the serious incident investigation process. We have not repeated the individual recommendations made in the investigation reports.

Risk assessment

12.4 Within clinical records, it was not always possible to readily access historical risk information. Some historical risk issues such as past harm to others were not in the awareness of the current clinical team.

12.5 Risk assessment and management plans did not include reference to dynamic risk issues and were not always updated by all professionals involved, and as expected by policy.

12.6 Potential harm to self or others was not assessed in a structured way.

Consistency

12.7 Care coordination was not handed over smoothly, with gaps in provision due to resources.

12.8 A consequence of handing over of care from one care coordinator to another in a different Trust meant that the last period of care was provided by a team new to the patient.

Listening to families

12.9 There were instances when a family member called to express concerns to a CMHT, but these were not always followed up. Records showed that assumptions were made that a lack of subsequent contact meant there were no concerns.

12.10 A structure or process for CMHTs to make and maintain contact with families or check collateral information would be helpful.

12.11 No contact was made with the family of one individual despite there being allegations which could have triggered safeguarding alerts.

Discharge process

12.12 Discharges lacked structure, and communication with the GP was incomplete.

12.13 Discharge from a Section of the MHA was managed directly from an independent placement.

Serious incident investigation process

12.14 Terms of reference were generic in nature and did not provide sufficient guidance for the investigation. There was a lack of expert clinical support in investigations.

12.15 There are many complexities regarding communication and making contact with families after a homicide committed by a mental health service user. There are particular issues in relation to contact with the families of victims, perpetrators and with the perpetrator themselves.

12.16 DPT had made contact with some members of the affected families but there were issues of confidentiality and police processes that prevented contact with some families. They have undertaken to establish a more structured process in the future, should such a tragic incident happen again.

12.17 There were no details in either of the three reports about support for staff during the investigation process.

12.18 Quality assurance processes in Devon Partnership NHS Trust and NHS Devon Clinical Commissioning Group did not identify these issues.

13 Findings and recommendations

13.1 One of the priorities in the NHS Mental Health Implementation Plan 2019/20 – 2023/24[64] is Mental Health Crisis Care and Liaison. The workstreams are: Liaison Mental Health, Crisis Resolution and Home Treatment teams, Crisis Alternatives and Ambulance Mental Health Response.

13.2 Comprehensive crisis pathways are likely to include jointly commissioned and/or delivered services with non-NHS partners such as local authorities, police, and voluntary community and social enterprises.

13.3 However, there is a gap in provision where criminal justice and/or custody structures become part of an individual's pathway through mental health services.

13.4 The recent thematic report[65] on individuals with mental health needs in criminal justice systems has made a range of findings about joint working, training, cross-system management and communication, and lack of consistency of services links, many of which resonate with the findings of this review.

13.5 A central issue in the review is the question of how Mr A was managed after his arrest on 9 February 2019, and how the various agency policies, procedures and statutory obligations impacted on the decisions to release him on 10 February 2019. It was after this release that the three homicides occurred.

13.6 We are aware that this a key question for the families involved, and the intention is to draw out the issues that guided and influenced decision-making. Serious incident reviews should draw out system learning to minimise the risk of a reoccurrence and are not intended to apportion blame.

13.7 Niche cannot provide definitive statements on acts of law as this is a matter for the judiciary. However, through our review we did not find evidence of obvious breaches - by any of the agencies involved- of the Mental Health Act, the Police and Criminal Evidence Act or of individual agency policies, in relation to Mr A's release on that day. We did, however, find that there were visible gaps in the way the system worked in a joined-up way that allowed Mr A to be released when his mental state was relapsing.

[64] NHS Mental Health Implementation Plan 2019/20 – 2023/24. https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

[65] A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders. November 2021. CQC, Criminal Justice Joint Inspection and Health Inspectorate Wales.

13.8 Mr A and his family have cooperated in the publication of this report. They welcome any recommendation which brings about an improvement in practices, procedures and conduct but cannot agree with nor accept the findings of the report.

13.9 We have analysed the contributory factors that influenced the decisions to release Mr A (Appendix F).

13.10 In our view the primary root causes of his release are as detailed below:

Primary root cause
Mr A's clinical history was not available to G4S on the evening of 9 February.
There was a perception that Mr A's detention would continue through the following day, to allow further health assessment on the morning of 10 February.
There was a separation of PACE process and healthcare perspectives, with no communication about the various limits and timelines.

Aggregate root cause
Custody healthcare is not commissioned by the NHS, with no information sharing system in place.

Care and service delivery problems

13.11 We have summarised the care and service delivery factors which influenced Mr A's release from custody. We found three care delivery factors and 9 service delivery factors.

13.12 This reflects our findings that the ways in which services were configured, the guidelines that were in place and the communication issues identified had a direct bearing on the decisions made, rather than there being individual practice issues.

Agency	Care delivery problems	Agency	Service delivery problems
DPT	L&D were unable to make an assessment in Barnstaple within their working hours.	DPT	The triage tool focusses on demographic information, with no guidance or structure for the mental health assessment.
G4S	The FME did not gather information about history and risk.	G4S	No historical information about an individual is available to HCP/FMEs.

Police/G4S/ DPT	PACE conditions were not discussed in detail and the various influencing factors, and any contingency planning were not adequately considered.	DCC/EDS	EDS have access to a range of electronic records systems, with varying degrees of user confidence.
		Police	The decision not to extend a PACE clock should be documented and shared with other agencies involved.
		DPT/G4S	There is no output or feedback for G4S after a referral is made to the L&D service.
		G4S	Medical records are in paper format and not accessible for reference in new assessments.
		DPT	Street Triage staff are contacted for information sharing only.
		All services	Access to information across agencies is limited.
		Police/G4S	Healthcare contract is separate to NHS systems and contains specific limitations regarding mental health assessments.

Recommendations

13.13 The Multi-Agency Incident Panel had oversight of the development of a set of outcome focussed recommendations and an action plan.

Recommendation 1: Devon ICB/DPT/NHSE

There should be appropraite available L&D cover in each custody suite in agreed daytime hours.

The L&D service should be designed and delivered in a way that meets contractual expectations.

Recommendation 2: DPT

Mental health assessments carried out by L&D should include a narrative description of the mental state examination.

L&D assessment forms should be restructured to provide more guidance in the mental health section of the form, ensuring it encompasses mental state examination.

Recommendation 3: DPT/DCC/Police/Police Healthcare Provider

There should be an agreed and implemented multi-agency protocol for Mental Health Act assessments in custody/under PACE.

There should be clear processes in place for making requests for MHA assessments in custody, aligning with NHS processes.

This should incorporate:

• access to L&D, AMHPs, First Response Service and taking PACE expectations into consideration

• escalation routes for police/custody healthcare personnel if there are mental health concerns about individuals detained in custody, including warning signs in a mental health state indicating deterioration

• Clinical advice and local mental health service advice available for forensic medical examiners

• actions when a mental health bed is required but not available.

Recommendation 4: Police Healthcare Provider/Police

Healthcare professionals providing police custody healthcare should have the skills and knowledge to make effective mental state examinations.

The Police Healthcare Provider should ensure mental health knowledge and training is enhanced to include:
• how to gather background information, mental state examination, risk assessment and decision making about requesting an MHA assessment.
• assessing clinical information rather than reliance on ‘point in time’ assessment.

Recommendation 5: Police Healthcare Provider/Police

HCP assessments should include clarity on the threshold for fitness to detain regarding mental health, and what mental health presentation changes would indicate that a new medical assessment was required and could be requested.

Police Healthcare Provider should provide clarity on threshold for fitness to detain and be evident in the medical assessment form including signs of deteriorating mental health.

Recommendation 6: ICB/DPT/Police Healthcare Provider

There should be an IT solution which allows access to health and other agency records.

The Police Healthcare Provider Healthcare Professional (HCP) should have multiagency agreement for access to NHS records, risk history and clinical information.

Recommendation 7: DCC/DPT

There will be sufficient capacity within the out of hours Mental Health Service to undertake Mental Health Act Assessments.

Devon County Council (DCC) and DPT need to recognise the lack of equivalence and the system pressures that impact on decision-making regarding Mental Health Act assessments out of hours.

Emergency Duty Service model of delivery of out of hours Mental Health Act assessments to be assessed against capacity and demand.

Recommendation 8: Police Healthcare Provider/Police

Clinical records should be available to custody healthcare professionals, which includes information about previous contacts, and tracks information requests and responses/outcomes.

The Police Healthcare Provider should develop:
• electronic clinical records
• an auditable process for information requests and responses / outcomes.

Recommendation 9: DCC/DPT

EDS staff should have access to and be trained in the use of relevant clinical information, when making decisions about out of hours MHAA.

Emergency Duty Service staff who have access to relevant clinical information about mental health should be confident in the use of CareNotes and how to navigate the system to access risk information.

Recommendation 10: Police

All agencies involved are aware of the individual PACE conditions and any changes of a detained person in custody.

Police should ensure that when there is a need for multi-agency healthcare input, all agencies involved are aware of the individual PACE conditions and any changes.

Recommendation 11: Police/Police Healthcare Provider

The overall sharing of information with the Police Healthcare Provider will be sufficient to ensure they can provide the best service possible with the maximum amount of information available.

Develop a Protocol between Devon and Cornwall Police in relation to Potentially Dangerous or Mentally Disordered Persons, which includes the Police Healthcare Provider and guidance for custody.

Recommendation 12: DPT/Police/ICB

Revised Peninsula Wide Section 136 policy in place and operational.

Set a timescale for the agreement and implementation of the Peninsula Wide Section 136 policy. This should include clarity on the process for using Section 136 if the person is already in custody.

Recommendation 13: DPT/Police

Mental Health/Police Liaison Committee should include clear reporting structures to the respective Executive Boards in Health and to the office of the Chief Constable.

Revision of the terms of reference of the Mental Health/Police Liaison Committee.

Recommendation 14: Police/Police Healthcare Provider

There should be structures in place to include the Police Healthcare Provider in local Memoranda of Understanding and information sharing agreements.

The Police Healthcare Provider should be included as a partner in custody/health Memoranda of Understanding and information sharing agreements related to custody settings.

Recommendation 15: TDSAP/DPT/Police/DCC/ICS

Local multi-agency risk evaluation processes should be in place for high risk individuals.

Development of multi-agency risk evaluation processes for high risk individuals.

Recommendation 16: DPT

There should be cohesive out of hours mental health service support for multi-agency partners.

Evaluation of the Street Triage and Joint Response Unit structures.

Recommendation 17: DPT/Devon ICS/DCC

The ICS Crisis and Mental Health Commissioning Group and TDSAP receive an updated system and oversight assurance report from the Urgent & Crisis Mental Health workstream. The report will seek to provide assurance that there is a coordinated responsive mental health service for the management of urgent mental health care in Devon.

There should be assurance that Crisis Care Concordat actions have been incorporated into urgent and crisis mental health workstreams.

Good practice

13.14 We found the following examples of good practice:

13.15 Liaison and Diversion services (L&D) had been informed by Street Triage that Mr A was in Barnstaple custody suite and might need assessment. L&D phoned Barnstaple custody suite at about 11.20am on 9 February to ask whether Mr A needed to be seen.

13.16 After Mr A was remanded in custody to HMP Exeter, L&D staff forwarded notes of his recent history to the healthcare team at HMP Exeter and arranged a handover call with the mental health team. They also attended Court to ensure that all relevant agencies had up-to-date health information.

13.17 The Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons (2017) applies to people who "have not been convicted of, or cautioned for, any offence placing them in one of the three MAPPA categories, but whose behaviour gives reasonable grounds that there is a present likelihood of them committing an offence or offences that will cause serious harm". Part of the aim is to allow the exchange of information which can assist if an individual who is deemed potentially dangerous or suffering from a mental disorder is taken into custody. There is a very clearly defined process for this, with the appropriate legal limitations.

13.18 The protocol for emergency access to a medium-secure mental health bed was developed and implemented with multi-agency commitment, in direct response to an identified systems issue.

13.19 In Devon Partnership NHS Trust, there are practice standards and principles in place to guide staff at the interface points between First Response Service, Liaison Psychiatry, the Home Treatment Team, Approved Mental Health Professionals and Bed Capacity. These standards and principles guide staff through the steps in a referral and assessment pathway.

13.20 There are multiple examples of professionals in both police and NHS health services working collaboratively together, seeking to find creative solutions and providing training. Many of the professionals from both police and mental health work with each other on numerous multi-agency committees.

Appendix A – Terms of reference

The following terms of reference are for an independent, multi-agency review of the safety and quality of mental health care provision across the county of Devon and have been drafted by NHS England and NHS Improvement in collaboration with Devon Safeguarding Adults Board members.

The terms of reference will be developed further with the investigative supplier and affected families.

Purpose of the review

An overarching independent review led by recognised subject matter experts to scrutinise and assess areas of concern identified as a result of the homicides committed in February 2019.

The investigation will include and draw upon, two reviews of homicides committed by two individuals who had a history of mental illness[66] and will incorporate elements of a Safeguarding Adults Review where appropriate.

The review is undertaken into the care given to the perpetrator and will therefore not include elements of a Safeguarding Adults review in respect of the victims of the homicides.

It is expected that affected family members of perpetrators and victims and staff are fully informed of the investigation and the investigative process, and are supported to engage with and contribute to the process.

Investigation

1. Determine a comprehensive, multi-agency chronology of events leading up to the incident in February 2019.

2. Identify critical decision-making points and whether those decisions were taken in line with local protocols/policy, national guidance and best practice for each agency.

3. Analyse the chronology for any areas of potential learning, service development or provision for each agency involved or for the systems supporting mental health emergencies across the county.

4. Review all multi-agency protocols (relating to the incidents), identifying areas of good practice and any areas for further development.

[66] Changed from: 'who were in receipt of mental health services at the time of the incidents' with the agreement of NHSE in July 2022

5. Review communication/information sharing processes (including recording of interventions) to identify any future developments.

6. Review single agency policy/protocols in relation to managing mental health emergencies.

7. Review the provision of out of hours mental health emergency services against national policy guidance and local commissioning strategies.

8. Consider whether there were effective and appropriate arrangements in place for the escalation of concerns for frontline staff/practitioners.

9. Provide an analysis of whether there were appropriate single and multi-agency arrangements, protocols and policies in place at the time and whether they were followed.

10. Taking into account the size and geographical spread of the county's services, review and assess the efficacy of agencies' governance arrangements and processes, the reporting of the same to the relevant Boards/executive management structures, including whether those Boards/Executives had a 'clear line of sight' of individual service areas/departments and any presenting issues.

11. Test the robustness of governance, review and assurance processes of the Trust, Commissioner (CCG) and onward referrals to the Safeguarding Adults Board.

12. Identify any issues in relation to culture, leadership, capacity or resources that impacted on the relevant services' ability to provide safe services.

13. Identify any unintended barriers to effective multi-agency working.

14. Make recommendations for quality improvement at all levels of the relevant organisations (i.e. governance, quality, commissioning and frontline services).

15. Determine any further lines of enquiry.

Deliverables

Provide a final written report to NHS England and NHS Improvement, Devon Safeguarding Adults Board and families that identifies areas of learning and provides measurable, sustainable and outcome-focussed recommendations.

Provide an executive summary and a learning case study referring to the three homicide incidents.

Provide an opportunity for the families to receive supported feedback related to findings.

Based on investigative findings, make organisational specific outcome-focussed recommendations, with a priority rating and expected timescale for completion.

Deliver an action planning event for the Trust and other key Stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.

Contribute towards a multi-agency media/publication strategy.

Support the commissioners and Safeguarding Board in developing a structured plan for review of implementation of recommendations.

Conduct an assurance follow-up visit with key stakeholders, 12 months after publication of the report, to assess implementation and monitoring of associated action plans. Provide a short written report for NHS England and NHS Improvement that will be shared with stakeholders and which will be made public.

Appendix B – Delivery of the terms of reference

The following table maps relevant sections of our report to the key lines of enquiry required by the terms of reference.

Requirement	Report reference
1. Determine a comprehensive, multi-agency chronology of events leading up to the incident in February 2019.	Section 4
2. Identify critical decision-making points and whether those decisions were taken in line with local protocols/policy, national guidance and best practice for each agency.	Section 5
3. Analyse the chronology for any areas of potential learning, service development or provision for each agency involved or for the systems supporting mental health emergencies across the county.	Learning points referenced in all sections
4. Review all multi-agency protocols (relating to the incidents), identifying areas of good practice and any areas for further development	Section 6/7/8
5. Review communication/information sharing processes (including recording of interventions) to identify any future developments	Section 6/7/8
6. Review single agency policy/protocols in relation to managing mental health emergencies.	Section 7/8/9
7. Review the provision of out of hours mental health emergency services against national policy guidance and local commissioning strategies.	Section 8
8. Consider whether there were effective and appropriate arrangements in place for the escalation of concerns for frontline staff/practitioners.	Section 8
9. Provide an analysis of whether there were appropriate single- and multi-agency arrangements, protocols and policies in place at the time and whether they were followed.	Sections 7/8/9
10. Taking into account the size and geographical spread of the county's services, review and assess the efficacy of agencies' governance arrangements and processes, the reporting of the same to the relevant Boards/executive management structures, including whether those Boards/Executives had a 'clear line of sight' of individual service areas/departments and any presenting issues.	Section 9
11. Test the robustness of governance, review and assurance processes of the Trust, Commissioner (CCG) and onward referrals to the Safeguarding Adults Board.	Section 9/10
12. Identify any issues in relation to culture, leadership, capacity or resources that impacted on the relevant services' ability to provide safe services.	Sections
13. Identify any unintended barriers to effective multi-agency working.	Section 10
14. Make recommendations for quality improvement at all levels of the relevant organisations (i.e. governance, quality, commissioning and frontline services).	Learning points referenced in all sections
15. Determine any further lines of enquiry.	Learning points referenced in all sections

Appendix C – Summary of Mr A's background

Contact with mental health services, June 2016 – January 2018

At the time of the three homicides Mr A was a 28-year-old, unemployed man with no fixed abode.

Mr A has an established diagnosis of schizoaffective disorder, which is a mental disorder within the meaning of the Mental Health Act. There is also history of poly-substance misuse.

His first contact with Psychiatric services took place in June 2016 when he was detained under Section 2 of the Mental Health Act following threats to kill his father. He presented as thought-disordered, believing he could talk to animals, particularly horses and monkeys. He was admitted to North Devon District Hospital.

There was a serious incident of arson and hostage taking, which led to his transfer to a Psychiatric Intensive Care Unit in Cygnet Kewstoke. He was prescribed antipsychotic medication, olanzapine 20mg once a day. Mr A was referred to DPT Forensic Secure Services due to his risk of harm to others because of the incident of arson and hostage taking. Following an assessment on 25 July 2016 it was decided that he did not meet the criteria for admission to a secure hospital. Mr A was discharged from Kewstoke on 12 September 2016 into the care of a community mental health team in Devon.

In April 2017 Mr A's Care Coordinator contacted Mr A's former partner. She reported that she did not know where Mr A was and that she had not had any contact with him. The decision was made to discharge Mr A back into the care of his GP with a rapid re-access plan should he require further mental health assessment.

There was no further contact with DPT services until August 2017 when Mr A's mother (Mrs A) contacted the Devon crisis team expressing concern about Mr A's mental state. There were a number of contacts between Devon and Cornwall Police and DPT Street Triage team during the period 1 to 4 August 2017 when information about Mr A's mental health risk information was requested.

On 17 August 2017 Mr A was arrested by police in London for dangerous driving. He was assessed by mental health services in London, and they sought information from DPT to inform their assessment. The plan was to admit Mr A to a PICU placement at Cygnet Hospital Kewstoke. Mr A's admission was delayed due to administrative processes and Mr A was initially remanded to HMP Brixton.

Mr A was admitted to Cygnet Hospital Kewstoke on 22 August 2017 under Section 2 MHA. His detention was converted to Section 3 MHA on 14 September 2017.

On 14 November 2017 a discharge planning and Section 117 aftercare meeting was held. Mr A's diagnosis was recorded as drug induced psychosis and his medication

had been reduced to olanzapine 10mg. It was documented that Mr A had been encouraged to remain compliant with this dose for at least six to 12 months. Staff documented that Mr A had plans to work in France from December 2017 and the plan was to discharge Mr A two to four weeks later to his mother's address in Wiltshire.

On 27 November 2017 Mr A was discharged from Cygnet Hospital Kewstoke into the care of community mental health services in Wiltshire where he was planning to stay with his mother. Mr A's discharge summary completed by Cygnet Hospital Kewstoke documented Mr A's diagnoses as drug induced psychosis, mental and behavioural disorder due to the use of cannabis and a provisional diagnosis of antisocial personality disorder.

Medication on discharge was olanzapine 10mg. Community staff in Wiltshire had a number of contacts with Mr A and his mother over the following two weeks.

On 12 December 2017 Mr A advised his Care Coordinator that he intended to go to France to work for several months. He left the UK on 15 December 2017 and was subsequently discharged from the community team caseloads in both Wiltshire and Devon (where responsibility for monitoring his aftercare requirements remained).

There was no further contact with mental health services until 8 February 2019 when Mr A was referred to the Devon Liaison and Diversion (L&D) service after being arrested for burglary.

Contact with Devon and Cornwall Police, January 2016 – August 2017

Mr A has been known on the Devon and Cornwall Police Unifi system since 2016.

In January 2016, Mr A first came to police attention for having an argument with his father. This stemmed from him wanting to keep his girlfriend's horses on the family's land, but his father was refusing to allow him to do this. Police were called but he left prior to their arrival.

Mr A next came to police attention in February 2016, following an argument that he had with the owner of the stables where he was keeping his horses. It was explained to police that he had agreed with the owner to keep his horses on her land for a fixed period of time and that this period had now lapsed. When she had asked him to remove them from her land, he became aggressive and waved a stick in her face.

As a result of the argument, Mr A did eventually move his horses and because of this, the victim declined to further support any criminal investigation.

In March 2016, Mr A's father reported that he lent his car to Mr A who had failed to return it to him. He explained to police that he had significant concerns for his son's mental health.

A further report was then received from Mr A's stepmother, his father's partner, to state that he had turned up at their address and was arguing with his father. She reported that he was very angry and was making threats to kill them both and their dog.

Police attended but Mr A had already left the location, again in his father's car. Numerous sightings were made of the vehicle by police, but he persistently failed to stop for the police and made off at speed each time he saw a police car.

He was eventually located at a nearby farm and arrested. A search of the car found numerous weapons hidden inside, including a bat and a knife.

In June 2016, police received a report of an arson at that location. Mr A had set fire to a rubbish bin full of rolled newspapers and then put that bin inside his wardrobe. This caused smoke damage to his room and put people in danger.

In August 2016, an unsuccessful attempt was made to seize the shotgun certificate belonging to Mr A. This was done because of his mental health detention on 10 June. The property was found to be vacant and looked unlived in. Despite the failed attempt to seize this, it was documented that Mr A no longer had a shotgun and that his certificate later lapsed without any request to extend.

There was then no contact between Mr A and the police for almost exactly a year.

In July 2017, a call was made to police regarding a male acting strangely in the street with a knife on his belt. It transpired that this was Mr A. Efforts to locate Mr A proved negative and he was eventually raised to missing person status and assessed as medium risk. His mother also called in to police and expressed concern for Mr A.

No crime was raised for the possession of the knife in a public place, and he was not considered for any criminal offences. He was dealt with purely as a concern for his welfare and was assessed by ambulance staff.

In August 2017, Mr A's mother reported him missing. She stated that he had run away from her and was suffering from deteriorating mental health.

Mr A was classified as a medium risk missing person but was located a short time later by his mother who had managed to persuade him into her car, only for him to jump out again. When he was eventually located by police, they described him as amiable and found that they had no concerns for him. They took him to a police station where he was collected by his ex-partner who had agreed to let him stay at her house.

Later in August 2017, Mr A's mother again reported concerns for his deteriorating mental health and again reported him as missing. Mr A attended a police station front office and spoken with staff there, asking why his mother was not arrested for the theft of his dog.

In August 2017 there were several public order offences, he was accused of stealing his partner's dogs and resisted arrest and assaulted a police officer. Mr A was bailed to court with no conditions. He was found guilty at court at a later date and sentenced to a 12-month conditional discharge and ordered to pay compensation. Later in August 2017, it seems that Mr A again attended his ex-partner's address and took her dogs to London with him. They were rescued in London and returned to her and she decided against making a formal complaint against him.

As a result of this and there being no complaint from the victim, this crime was filed as undetected with no further police action being taken.

In August 2017, Mr A was arrested with by the Metropolitan Police for dangerous driving, failing to stop, driving while unfit through drink/drugs, and failing to provide a specimen for analysis. Mr A was found guilty at Harrow Crown Court. He was given a suspended prison sentence of four months, wholly suspended for 12 months. He was disqualified from driving for 18 months and fined accordingly.

There was no contact between Mr A and Devon and Cornwall Police in 2018.

Appendix D – Table of abbreviations

AMHP	Approved Mental Health Professional
CCG	Clinical Commissioning Group
CDP	Care Delivery Problem
COO	Chief Operating Officer
CPS	Crown Prosecution Service
DCC	Devon County Council
DPT	Devon Partnership NHS Trust
EDS	Emergency Duty Service
FME	Forensic medical examiner
FRS	First Response Service
GBH	Grievous bodily harm
HCP	Healthcare professional
HMP	Her Majesty's Prison
IMR	Individual management review
ISA	Information sharing agreement
JRU	Joint Response Unit
L&D	Liaison and Diversion
LCJB	Local Criminal Justice Board
MAF	Medical assessment form
MAPPA	Multi-agency public protection arrangements
MHA	Mental Health Act
MHAA	Mental Health Act assessment
MHLT	Mental Health Liaison Team
MOU	Memorandum of Understanding
NHS	National Health Service
OIC	Officer in charge
PACE	Police and Criminal Evidence Act
PC	Police Constable
PICU	Psychiatric Intensive Care Unit
POS	places of safety
RCA	Root Cause Analysis
SAR	Safeguarding Adult Review
SBAR	Situation, background, assessment, recommendation
SDP	Service Delivery Problem
SIGN	Strategic Information Governance Network
SWASFT	South Western Ambulance Service NHS Foundation Trust
TDSAP	Torbay and Devon Safeguarding Adults Partnership

Appendix E – Documents reviewed

Documents Reviewed – Devon Partnerships NHS Foundation Trust	
Electronic clinical records for Mr A	Psychiatric reports for Court
Root Cause Analysis Investigation Report March 2020	CareNotes Standard Operating Procedures (SOPs) For CareNotes Version 5.7
Devon & Cornwall Liaison and Diversion Standard Service Specification 2018	Peninsula Liaison & Diversion Service Operational Policy June 2019
North Devon Liaison Service Specialist Services Directorate Liaison Psychiatry Team v2.0	Exeter Liaison Psychiatry Service Specialist Services Directorate v1.0
Torbay Liaison Psychiatry Team Liaison Psychiatry Service Specialist Services Directorate v6.0	The Single Point of Access and First Response Service SOP v3.0
Peninsula Liaison and Diversion Partnership Board terms of reference, minutes 2019 and 2020.	Mental Health Urgent Care Programme (undated)
Place of Safety Policy & Procedures M18	Devon Partnership Trust CQC Inspection – Improvement Plan. November 2020.
Clinical Strategy Draft 1	System Response to a Coroners Regulation 28 Ruling–Emergency access to a medium secure mental health bed. November 2020
Section 135 (1)(2) Mental Health Act Operational Procedure M06	First Response Service (FRS) specification V3 Updated November 2020

Documents reviewed – G4S	
G4S IMR	T50 Contract for healthcare and forensic examination services – Devon and Cornwall Police and G4S. April 2015
Safeguarding Policy and Procedures. September 2019	Standards for Record Keeping Policy. July 2019
Page 1 of 7Standard Operating Procedure For Safe Management of Section 136 Detainee's For Custody HCP's. v1.0	Section 136 Continuous Welfare Assessment Form
Custody Leadership Team chart	Call centre process
Job descriptions for FME and HCP	A&E referral form
Mental Capacity Act Policy. April 2019	Clinical Supervision G4S Health Services Policy. March 2019
Outline G4S induction	Faculty of Forensic & Legal Medicine Recommendations for Introductory Training Courses in General Forensic Medicine (GFM

Medical Assessment form audit tool	

Documents Reviewed – NHSE Devon Clinical Commissioning Group	
Serious Incident Requiring Investigation Policy v1.10	Safeguarding Adult Policy v2.2
GP service IMR and clinical records from 2018	EDS staffing
Update on the delivery of the Devon Crisis Care Concordat Action Plan. May 2017	Devon Street Triage Pilot Progress Report. April 2014
The 2014 Peninsula Declaration on improving outcomes for people experiencing mental health crisis - made in December 2014	EDS MHAA statistics 2020
Best Interests Meeting Guidance. v3.0	Multi-Agency Mental Capacity Act 2005 Policy. July 2020

Documents Reviewed – South Western Ambulance Service	
SWASFT IMR	Capacity, Consent, De-escalation and Safe Holding Policy. v1.0 December 2018
Risk assessment Policy. v3.0 November 2018	Mental Health Desk review v1.0
Mental Health Response to Ambulance Review of Mental Health Specialist Desk, Long Term Plan Funding	

Documents Reviewed – Devon and Cornwall Police	
Agreement for the exchange of information, in relation to safeguarding adults in Devon, Cornwall and the Isles of Scilly. V2.0 July 2015	Protocol for the Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons. v2.0 November 2017
Police IMR	MG03 report
Report on an unannounced inspection visit to police custody suites in Devon and Cornwall. May 2019	Police bail form 11/2/19 Police custody release plan 10/2/19 Redacted custody records for 8 and 9 February 2019 Police officers' statements to the coroner relating to 8, 9 and 11 February 2019

Documents Reviewed – Devon County Council	
Approved Mental Health Professionals	DCC IMR

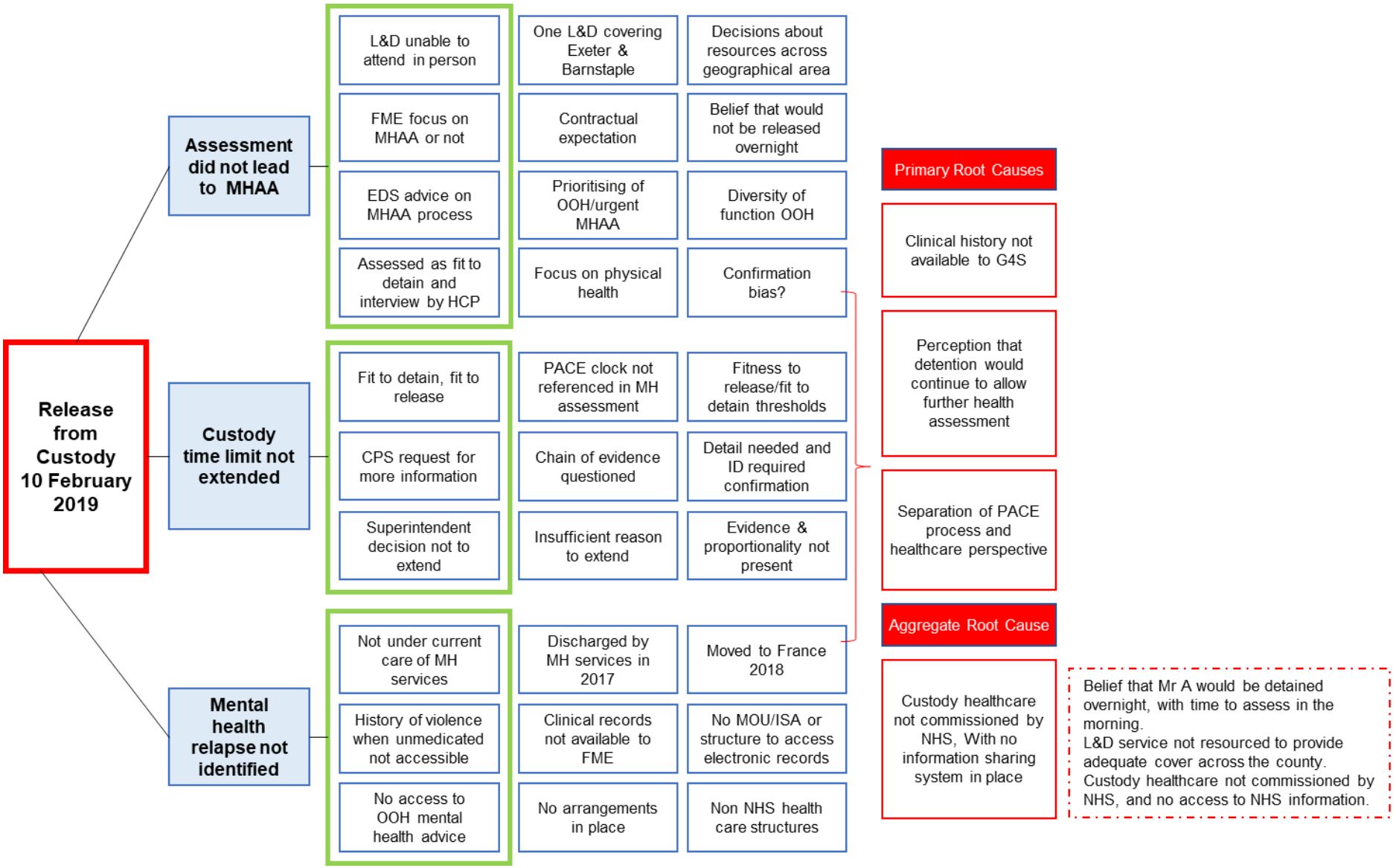
Borders Protocol for Cornwall, Devon, Plymouth and Torbay. July 2016	
Considering and arranging Mental Health Act assessments for those detained under PACE – Multi-agency protocol. v10	AMHP managers forum & Advisory Committee. Minutes 3rd February 2021
Review of Approved Mental Health Practitioner Service. September 2020	Organisational Structure 2020
Devon Children's Services: Supervision Policy and Procedure (undated).	Guidance note: record retention & management Adult Social Care. v4.0 June 2011
AMHP training and induction plans	EDT induction sample

Documents Reviewed – NHS England Health and Justice Commissioners	
Devon & Cornwall L&D Mobilisation Working Group Minutes	NHS Liaison and Diversion Standard Service Specification 2019
Liaison and Diversion agreement between NHS England, Devon and Cornwall Police, DPT, Cornwall partnership Foundation NHS Trust and Livewell Southwest	

Documents Reviewed – Crown Prosecution Service	
Written response to Niche prepared questions October 2021	Decision making notes February 2019

Documents Reviewed – other agencies	
South West Strategic Information Governance Network (SIGN) Information Sharing Agreement (Tier 1) v5.2 May 2019	Police powers: detention and custody, August 2021, House of Commons.
A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders November 2021	NHS Mental Health Implementation Plan 2019/20 – 2023/24
Torbay & Devon Safeguarding Adults Partnership (TDSAP). Multi-Agency Safeguarding Adults Review (SAR) Policy v1.3	Devon Safeguarding Adults Board Vulnerable Adults Mental Health Crisis Care: Thematic Review. January 2015
Reports for Court [Mr A] 2019 and 2020.	Safeguarding Adults Escalation Protocol. Devon Safeguarding Adults Partnership. February 2020

Appendix F – Contributory factors



Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk**

niche
HEALTH & SOCIAL CARE CONSULTING