***“These people are vulnerable, they aren’t criminals”: mental health, the use of force and deaths after police contact in England.***

***Abstract***

This paper considers deaths after police contact[[1]](#footnote-1) in England of people experiencing mental health issues. It uses rich qualitative data from interviews with the families of nine people who died after police contact to examine how they died. The paper aims to assess the police role in providing a de facto service for people undergoing mental health crises and how the use of force might affect the outcomes of such encounters. The paper aims to examine the manifest tensions when an enforcement agency is tasked with providing a duty of care to vulnerable people in society. Key findings are that force is disproportionately more likely to be used on people with mental health issues, and also disproportionately more likely to be used on people from Black and Minority Ethnic communities. Further findings provide insight on the use of mechanical restraint and the way in which inappropriate transportation can exacerbate the effects of restraint.

**Key words**: Deaths after police contact, police accountability, mental health issues, use of force, street triage.

***Final Word Count:*** *7975*

***Introduction***

The number of deaths after police contact (DAPC) in England and Wales is at the highest level in a decade, rising from 241 in 2016/17 to 283 in 2017/18[[2]](#footnote-2) (Independent Office for Police Conduct 2018). More than half of those who died in or following police custody had mental health issues (IOPC 2018). This paper aims to examine how people with mental health issues (PMHI) die after police contact, in particular by focusing on how force is used on them. A further aim is to consider how this relates to the police role in providing a duty of care for vulnerable groups in society. It represents the first known piece of academic research to explore this issue by using rich qualitative data gathered from the loved ones of those who died after police contact in England. It aims to examine this data within the context of existing academic literature on policing, mental health, and the use force. Further consideration will be given to policy reports on these issues in relation to their findings and recommendations, to determine whether lessons can be learned to improve practice and reduce the number of people who die after police contact in England and Wales.

DAPC highlight a number of issues that encapsulate concerns about policing in the 21st century (Savage, 2008). Deaths disproportionately affect those from marginalised groups in society: if you are from a Black and Minority Ethnic (BAME) group, are a PMHI, or have dependency issues, then you are disproportionately more likely to die after police contact than other groups in society (Angiolini, 2017; Xxxxx 2016a). Due to precedents driven largely by article 2 (the right to life) of the European Convention on Human Rights, police are required to provide a duty of care to those they encounter and have a procedural obligation to demonstrate that each individual’s right to life has been enabled in encounters with police (Angiolini, 2017; Xxxxx, 2016b; Her Majesty’s Inspectorate of Constabulary [HMIC], 2015). Research consistently states that restraint is more likely to be used on PMHIs, or those from BAME groups than any other group in society (see, for example College of Policing, 2017; IPCC, 2016; Leigh et al. 1998). Given these findings, police use of force is increasingly scrutinised as it brings into question their commitment to providing a duty of care to marginalised groups in society, and to respecting their right to life (Adebowale, 2013; Angiolini 2017).

Cases of DAPC, then, occur at the intersection of a number of charged issues in policing: the tensions involved in police being both an enforcement agency and an agency of care; the use of force; and the disproportionate number of deaths of people from marginalised groups within society. These issues are exacerbated by the apparent inability of police and regulators to learn lessons that prevent future deaths (Xxxxx, 2016a; Casale et al. 2013; Coles and Shaw, 2012). This paper investigates the factors influencing these fatal outcomes, it begins by examining how police have effectively become a de facto provision for PMHIs.

***Policing and the provision of mental health care***

The lack of mental health care provision stems largely from the move to a community-based model of care from the 1960s onwards which was seen to be under-resourced from the outset (Perkins et al. 1999; Ruiz and Miller, 2004). In England and Wales, the National Health Service (2016) notes that mental health issues account for 23% of its demand, but less than 11% of its total budget. There are considerable inconsistences in provision nationally, and where services do exist, they are often unable to cope with demand (Adebowale, 2013; Bradley, 2009). Without adequate support for PMHI, mental health crises within the community have become more common, effectively forcing police to become a de facto mental health service adopting the twin roles of law enforcement and healthcare provision (HMIC, 2015; Reiner, 2010). In England and Wales, the College of Policing is the principal producer of policy and training guidance for police forces, it states (2017: 4) that: ‘Ensuring effective and appropriate responses to mental health related incidents is “core police business.”’

The statutory power used by officers to detain PMHI is Section 136 of the Mental Health Act 1983. After detention, the PMHI should then be taken to a ‘place of safety’ which is broadly defined under Section 135 (6) of the same act as being any healthcare or custodial facility (Mental Health Act, 1983). Whilst police custody is intended to be used as a place of safety only in ‘exceptional circumstances’ (Department of Health, 2008), research demonstrates it is commonly used due to lack of alternate provision (see, for example Adebowale, 2013; HMIC, 2013). The use of police custody as a place of safety is considered to contribute to the criminalisation of PMHI (see, for example, Apakama, 2012; Markowitz, 2011) and the stressful environment of police custody can serve to increase anxiety, fear and further exacerbate PMHI’s mental state in some cases leading to DAPC (Angiolini, 2017; Apakama, 2012).

When encountering PMHI, the standard procedure is for police to refer them to crisis resolution home treatment teams for assessment and referral to support services (Onyett et al. 2006). However, the service provided varies according to locality and, in most cases, is inadequately staffed or has insufficient funding to operate during restricted hours. Outside of these hours, when the majority of incidents occur, police have little choice but to transport PMHI to alternative places of safety, such as police custody (HAC, 2015; HMIC 2013; Home Office, 2014). The lack of appropriate mental health care provision coupled with limited training on how police should respond in encounters with PMHI, can heighten the potential for force to be used (Kane and Evans, 2018).

PMHIs detained under Section 136 are not under arrest, but held in order to facilitate assessment of their health and ensure the safety of others (Kane and Evans, 2018). Consequently, officers without medical qualifications or training have the capacity to withdraw the liberty of PMHI, making officers not only gatekeepers to the criminal justice system, but also the healthcare system (Borschmann et al. 2010; HMIC, 2015). Police are not required to complete a statutory form when detaining an individual under Section 136, instead officers use their discretion to decide if an individual requires immediate care or control based on their perceived mental state (Borschmann et al. 2010; HMIC, 2015).

PMHI generate a significant amount of work for the police. In 2016, the Metropolitan police handled over 300 calls a day involving PMHI (Dodd, 2017). An HMIC[[3]](#footnote-3) (2015: 122) review found that custody heads believed PMHIs represented the: ‘biggest source of pressure on the custody service.’ Despite this demand, officers receive little or no training for their role as “street corner psychiatrists”, leaving them lacking the specialised skills and knowledge to effectively manage encounters involving PMHI (Bradley, 2009; Chappell and O’Brien, 2014; MacLean and Marshall, 2010). Cummins and Jones (2010) found certain groups within police culture viewed PMHIs as not ‘real’ police work, whilst Docking et al. (2008: 12) found that some officers believed PMHIs to be a ‘waste of police time.’ Other research suggests officers are likely to have misconceptions about PMHIs based on stereotypes (Angiolini, 2017; Lamb et al. 2002; Ruiz and Miller, 2004) and that this can lead to officers being more likely to use force on PMHI (Johnson, 2011).

Terrill (2005) noted it was not uncommon for officers to use force as a first rather than a last resort in encounters with PMHI. The use of force on PMHIs may exacerbate the distress of the individual, who often cannot understand why they are being restrained (Hannan et al. 2010). This could lead to increased resistance and consequently more force being used (Mulvey and White 2014; Lamb et al. 2002). A number of policy reports in England and Wales have noted the importance of multi-agency working in providing effective mental healthcare due to the complex needs of many PMHI (see, for example Angiolini, 2017; Adebowale, 2013; Bradley, 2009).

***Multi-agency working***

In light of inadequate service provision, concerns about the increasing use of Section 136 and the criminalisation of mental illness, efforts have been made to provide training for officers, improve access to community mental health facilities and implement alternative community treatments (Cummings & Jones, 2010; Dodd, 2017; Lancaster, 2016). It should, however, be noted that there is no legal obligation to make these changes rather it is left to individual forces to decide if they take action, and this varies according to local need, resources and funding (Horspool et al. 2016). In an attempt to improve standards of care for PMHI in England and Wales the Crisis Care Concordat (2014) was signed by 22 policing and healthcare organisations but appears to have made limited improvements to, for example, the use of force by police, or of PMHIs disproportionate representation in cases of DAPC (HMICFRS 2018). It has, though, encouraged initiatives that foster multi-agency working which might, in time, improve the provision of care to PMHIs.

One example of a multi-agency initiative is the liaison and diversion scheme which places psychiatric nurses in custody suites in order to assess, divert or support PMHI through liaison with appropriate agencies (James, 2000). Although liaison and diversion programmes are seen to have a positive impact in reducing the use of Section 136, facilitating information sharing and fostering effective multi-agency working (James, 2000) their success is limited by regional variations in implementation, with only 63% coverage in England as of April 2017 (Kane and Evans, 2018). Street triage is another intervention whereby mental health professionals support police on calls involving PMHI to ensure people are not unnecessarily detained and receive timely and appropriate needs based support and care (Cummins and Edmondson 2016; Kane and Evans, 2018). Unlike the liaison and diversion programme there is no specific model for street triage and schemes tend to vary locally according to need and resources (Horspool et al. 2016). There is a variety of street triage provision, but none of it is 24/7. Findings indicate that the use of Section 136 has decreased between 30-50% in areas where street triage is deployed, similar to findings on liaison and diversion schemes (HMICFRS, 2018; HAC, 2015).

***Methods***

The paper uses qualitative data gathered from semi-structured interviews with families of loved ones who died after police contact in England in the period 2003-2015. A total of nine deaths were examined, for which twelve participants in five English counties were interviewed between February and August 2017. Interviews typically lasted one hour and were either conducted with individual family members, or in pairs; the interviews were transcribed and analysed using Nvivo software. The interviews focused principally on how the deceased met their death, and how families attempted to secure justice for their loved one in the aftermath of that death. All nine of the deceased were male, four were Black, three were White, and two were of Mixed Heritage. The youngest was aged seventeen, the oldest forty-three.

The authors are not aware of comparable research into the issue of DAPC in the UK from the perspective of families affected by it. Writing about miscarriages of justice, Charman and Savage (2009) note that families of the deceased have special knowledge about these deaths, whilst Scraton (2002, p.112) notes that there is a ‘yawning gap’ between official discourse about controversial deaths and what families say. Recent official discourse on the issue of DAPC has noted the increasing relevance of input from the deceased’s families in learning lessons that might prevent future deaths (see, for example HMICFRS 2018, Angiolini, 2017; Casale et al. 2013; HM Government, 2017; IPCC, 2016).

Numerous academic authors (Liebling, 2001; Snell and Tombs, 2011; Westmarland, 2011) note that research into sensitive subjects in the criminal justice system often depends on small sample sizes, but that the importance of the findings outweighs the relative limitations of the sample size. The sample for this paper was gathered by what Bryman (2012, p.201-2) terms “convenience sampling” and Lee (1993, p.65) calls “network sampling”. This type of sampling is typical when dealing with sensitive subjects and special populations (Bryman, 2012; Lee, 1993). Lee (1993) notes that network sampling often represents the only way of obtaining a sample on some issues. The majority of participants were recruited as a result of charities and activist groups[[4]](#footnote-4) referring the authors to families who had experiences of DAPC. Personnel within these organisations identified relevant participants based on criteria supplied by the researchers. The key criterion of the research project was that participants should be family members of a citizen who died after police contact in the UK. In addition, these organisations made their own assessment about the suitability of the participant to undergo the interview process.

The project received ethical approval from Xxxxxxx University’s Ethics Committee (Reference P40350). In advance of the interviews, participants were made aware of the aims of the project by email via a participant information sheet, and spoke with the Principal Investigator by phone. The Principal Investigator used these calls as a way of informally assessing the participant’s emotional state and their suitability to be interviewed. Participants signed informed consent forms prior to conducting the interview. Before each interview, participants were made aware of the availability of counselling in the event of any distress they might feel during or after the interview process. Participants were made fully aware they could withdraw from the interview process at any time.

The data was analysed interpretatively, using framework analysis, with the aim of uncovering subjective meanings and interpreting them within a variety of contexts. In this sense, a specific version of reality is revealed by the process of research as distinct to any definitive statement of such a reality (Bryman, 2012). Applying framework analysis, (Ritchie and Spencer, 1994) first, the authors became familiar with the corpus of data in order to gain an overview of the nature of its contents. Secondly, familiarisation enabled a thematic framework to be constructed using NVivo software; this identified the key theme of mental health examined in this paper. Thirdly, a process of indexing took place, in the form of sub-nodes in NVivo to break down themes into case numbers and key issues or terms. Fourthly, charting enabled indexing to be used to make associations within and between issues and terms. For example, the link between use of force and the duty of care to vulnerable people in this paper. Finally, charting led to a process of mapping and interpretation. Maps emerged in the form of typologies such as the use of force and lack of police training, and the relationship between de-escalation and a duty of care.

***Research findings:***

***Use of force***

In all nine cases police used force on the deceased. Bartlett (2016) notes that in deaths in or following police custody in the period 2010-13 where restraint was a factor, approximately half involved PMHI (see also IOPC, 2018; IPCC, 2016). Lindon and Roe (2017) note that restraint related deaths after police contact are disproportionately more likely to affect people from BAME groups and/or PMHIs (see also Angiolini, 2017; IPCC, 2016); six of the nine deceased in this dataset are people of BAME or Mixed Heritage. The findings from this project clearly support the view from the extant literature that you are more likely to be restrained if you are a PMHI, and/or are from a BAME or Mixed Heritage group, and that you are consequently disproportionately more likely to die than those from other societal groups as a result.

In all cases physical force was used, and in several cases restraint implements were deployed. In the following two examples, parents describe how the physical force used on their sons is a precursor to restraint firstly by leg-stirrups and secondly by ankle and thigh restraints; in the second, the parent questions the efficacy of using restrictive force against someone undergoing a mental health crisis:

**Case 12**: *‘He was sat on [by police] and they put stirrups around the back of him, and that still wasn’t enough…they didn’t think he was restrained enough.’*

**Case 8**: *‘He didn’t look right at all. His arms were behind his back. I didn’t know at the time he also had restraints round his ankles and thighs. These people are vulnerable, they aren’t criminals.’*

The latter point is emphasised in the following two comments; in both cases the individual was known to police as a PMHI. Family members note the police duty of care, reflecting that the deceased was a vulnerable person in need of support, rather than a threat:

**Case 14**: *‘They used pain restraint, they took him down very quickly. They just went straight in there and over-reacted. It was just a catalogue of errors from start to finish.’*

**Case 1**: *‘They restrained [the deceased] after repeatedly hitting him and CS gassing him and knocking him to the floor. At some point more officers arrived and were pinning him by his arms and legs to the ground…his mum was screaming “what are you doing? He needs help!”’*

Prone restraint was used in four out of nine cases in the dataset, despite a number of recent policy reports cautioning against its use (see, for example Angiolini, 2017; HMIC, 2015; IPCC, 2016). All four of these deaths were people of BAME or Mixed Heritage further underlining issues of intersectionality within the aggregate number of DAPC and emphasising that specific types of force are disproportionately used by police on specific groups within society. In the following example a mother comments on the effect that prone restraint had on her son:

**Case 6**: *‘The inquest found that one of the things [that caused his death] was prolonged restraint…literally he was face down.’*

Since 2012 a number of policy documents have outlined the need for de-escalation when dealing with PMHIs (Adebowale, 2013; Angiolini, 2017; HMIC, 2015 and 2013; IPCC, 2016). College of Policing (2017: 12) guidelines on the use of restraint on PMHIs state: ‘The importance of de-escalation and other verbal skills in managing violence and aggression by **all** agencies cannot be overstated’ (bold as in original). However, until 2017 there was no requirement for police in England and Wales to record the use of force, either in instance, type or duration (Angiolini, 2017). Thus police regulators have speculated that police probably use force more commonly than was previously considered likely, whilst ultimately conceding this was unknowable due to the lack of data (HMIC, 2015; IPCC 2016).

Police regulators have long examined the use of restraint; both the IPCC and its predecessor, the Police Complaints Authority (PCA) published reports recommending (without apparent success) that clear policies on restraint should be formulated (see, respectively Hannan et al. 2010 and Leigh et al. 1998). Despite these recommendations the number of DAPC involving PMHI and restraint have increased, indicating that while there is sufficient official knowledge about these issues, there is insufficient ability to learn lessons that prevent future deaths.

The data in this paper reveals a variety of implements used to restrain PMHIs: spit hoods, emergency restraint belts, leg braces, ankle restraints, stirrups, Velcro straps and cable-ties; sometimes referred to as ‘mechanical restraint devices’ (Hannan et al. 2010). There are apparently no national police guidelines for the use of these devices, but the National Institute for Clinical Excellence[[5]](#footnote-5) (NICE) guidelines on mechanical restraint note it should only be used as ‘a last resort’ for the purpose of ‘managing extreme violence directed at other people’ (NICE, 2015). The Angiolini (2017) review into DAPC in England and Wales observed there was a perception that mechanical restraint was commonly used by police (see also HMIC, 2015). It might be the case, pace the earlier discussion (see, for example Johnson, 2011; Ruiz and Miller, 2004) that officers fall back on stereotypes in the absence of adequate training, and are consequently more likely to use whatever type of force is available to them. However, in the absence of any data on the use of restraint by police, and of the types of mechanical restraint used by each police force, it is not possible to accurately assess how and why restraint is used.

***Positioning***

The positioning of the detained person in police vehicles was highlighted by family members in more than half of the cases examined; this chimes with the limited literature on this issue (see for example Cummins and Jones, 2010; Riley et al. 2011). Recent policy reviews have noted that PMHI should be transported by ambulance where practicable (see, for example Angiolini, 2017; HMIC, 2015). The most recent review into policing and mental health issues found that in 50% of cases, PMHIs were transported to hospital by a police vehicle rather than an ambulance (HMRCFRS 2018). In the two cases below, family members state their loved one was crammed into a ‘V’ position in the footwell of a small police van, and in the aftermath of prolonged physical restraint this would have been stressful and traumatic:

**Case 14**: *‘They cable-tied his wrists behind his back, they put Velcro straps around his upper legs and Velcro again around his ankles and then they bundled him into the back of a very small van which is not fit for purpose. They put him in the foot-well of it, it is not meant for someone who is that heavily restrained…then you see them [on the recording], standing around laughing, swapping notes for another 5 minutes, whilst he is heavily restrained in a van that is too small for him.’*

**Case 4**: *‘The [inquest] jury found that he would be in the V position all the time that he was in the back of the van, and that he would have been in and out of consciousness.’*

In the following two examples, mothers talk about how their sons were mechanically restrained and then placed into the rear of a police vehicle without an escort:

**Case 12**: *‘They left him [in the van] with his legs behind his back with his stirrups on and nowhere to put his head.’*

**Case 8**: *‘The handcuffs had been moved to behind his back, he had restraints around his ankles and thighs, and all whilst he was wearing a winter coat [on a hot day] in this space that was ridiculously small for him.’*

The final example details the family protesting that, having called the police for support in caring for their loved one who was experiencing a mental health crisis, the police placed him under restraint into a police van to be transported to the custody suite rather than a healthcare facility:

**Case 1**: *‘[The deceased] was face down and carried to the seats where the officers continued to restrain him, feet in his back. The family were protesting: “where are you taking him, he needs to go to hospital”, and then they drive off with [the deceased] in the van to the police station.’*

It is not only the type or duration of restraint used; or the use of mechanical restraints that can affect the police duty of care to an individual undergoing a mental health crisis; it is also the manner in which they are transported after being detained by police. In combination, these issues raise significant questions about the capacity of police to provide a duty of care for PMHIs.

***Training and de-escalation***

The training of mental health awareness to officers is commonly identified as one way of providing an improved duty of care to vulnerable individuals (Bartlett, 2016; Chappell and O’Brien, 2014; Cummins and Edmondson, 2016). The type of training per force is variable, as is the length, duration and availability of refresher training (Lamb et al. 2002; Morabito, 2007). An HAC[[6]](#footnote-6) (2015) study into policing and mental health revealed that 76% of officers surveyed had had no training on working with PMHIs in custody. An HMICFRS (2018: 20) review found that 21 out of 43 forces in England and Wales followed the College of Policing’s guidance on policing and PMHIs, and that ‘only a handful’ of forces used the specialised two-day training programme on this issue produced by the same organisation. In the two examples below, participants talk about how police failing to recognise their brothers’ mental health crises led to a misunderstanding of their needs, and a consequent failure to use de-escalation techniques, instead using restraint:

**Case 4**: *‘Anyone could see he was suffering with mental health. A member of the public called the police and eventually [he] was restrained by four police officers in what is called the prone position. [The jury] found that the officers should have been aware of his mental health but the officers claim they were not aware of [it]; they just saw him as someone who was violent but the jury found that he hadn't been violent at any stage.’*

**Case 14**: *‘I think that [the officer] didn't try and talk to my brother. It was very, very obvious he was having a mental health issue. Members of the public were phoning in saying “he isn't well, he isn't all there”; things like that.’*

In the following two examples, police are made aware of the person’s condition, but it does not affect the way in which they subsequently treat them. In the first example, a mother recalls confronting an officer who restrained her son and is about to drive him to a custody suite. In the second, the sister of the deceased recounts watching CCTV footage of her brother in the custody suite being berated by officers because he was considered to be deliberately uncommunicative.

**Case 8**: *‘[I said]: ‘“Don’t hurt him, he’s ill, he needs to go to the hospital”; and the response I got [from the officer] is “he will only be seen when he has calmed down.”’*

**Case 11**: *‘One of the police [officers] was heard to be in the cell and they were being really horrible…you could hear them saying “we will beat your dog with a stick unless you talk.”’*

The final example sums up the views of many of the participants by explicitly questioning the capacity of police officers to provide a duty of care to those undergoing a mental health crisis:

**Case 15**: *‘I know they have to deal with a lot of mental health issues but maybe they have to be led by a mental health person or retrained.’*

Given the apparent propensity of officers to use force in encounters with PMHIs one is bound to question how the ongoing use of physical and mechanical restraint persists in the face of a raft of policy reports stating that it should be avoided wherever possible. A possible explanation lies in the use of causal narratives justifying the use of restraint on PMHIs.

***Causal narratives***

In order for the use of force to be perceived as necessary, proportionate and reasonable, it appears the actions of the deceased are constructed in such a way as to require the police to use force on them (see, for example Xxxxx, 2019, Hirschfield and Simon 2010). Families typically commented on how their loved one was portrayed by police as being violent, dangerous, unpredictable, or any combination of the three; but that this did not accord with evidence heard at their inquest:

**Case 14**: *‘They said he was threatening to bite, and spit throughout this time, he certainly didn't in the police station [which we could see from the CCTV footage], so then they got him to the floor and put the ankle restraints on him and put an emergency belt around his entire face. [The police] were not reporting he had been killed by the police, they were reporting that he was this mentally unstable guy.’*

**Case 12**: *‘They said he was struggling, but how the hell can he struggle with all those restraints on him?’* Before commenting: *‘So the victims have become the criminals.’*

The concept of victim blaming appeared in most families’ accounts of the events leading to their loved one’s death. In the comments below, two different types of conditions are noted as being causal in relation to the death. The first is ‘excited delirium’ which is perhaps better described as a ‘constellation of symptoms’ than a condition (see, for example Xxxxx, 2017). It encompasses possible drug use, mental health crisis, and unpredictable behaviour. Excited delirium has been used to explain police use of force in cases of DAPC, leading Brodeur (2010: 286) to note it is a ‘convenient illness’. The second quotation touches on alcohol in combination with mental health issues - the deceased is taunted by custody staff for being unresponsive and uncommunicative. Participants believed the deaths to be depicted in a way that explained how these individuals died, rather than focusing on the inability of police to provide a duty of care enabling them to live.

**Case 8**: *‘The Home Office pathologist said “this is a classic case of excited delirium.” So, from then onwards that was the narrative and [the deceased] was portrayed as being violently out of control before being restrained, and that just wasn't so. When you read the witness statements, that isn't what the witness statements were saying.’*

**Case 11**: *‘If you look at the media there was stuff regarding [the deceased’s] mental health. Derogatory comments about drunkenness and a really horrible comment by an inspector who came into view [on the CCTV] near the end of [the deceased’s] time - he was recorded as saying “is he dead and dying?” And they all laughed.’*

In this sense, causal narratives can be used by police to explain how the deceased met their death. The use of force by police is portrayed as being necessary, reasonable and proportionate, either to protect themselves, and/or the public (Xxxxx, 2016a, Hirschfield and Simon 2010). Consequently, the actions of the deceased are highlighted as in some way causing their own death, rather than the actions or omissions of police in the encounter with a vulnerable individual (Xxxxx, 2019; Razack, 2015).

***Learning lessons***

The tensions and challenges facing police in delivering a duty of care to PMHIs are not new. As the issues involved in police encounters with PMHIs also remain relatively unchanged, and the number of DAPC increases, this raises the issue of whether the role of police can be re-imagined to better adopt a care-based approach which focuses on an individual’s right to life and provides a duty of care to vulnerable people (Angiolini, 2017). The great majority of participants were sceptical about the capacity of police to learn lessons in the aftermath of these deaths, a view encapsulated by the following participant:

**Case 4**: *‘There have been a number of deaths since [my brother] died. Prone restraint related deaths, which is a pattern in mental health and nothing has changed. We have more reports and more reviews saying officers will be trained. Does someone really need to be trained and told that if you suffocate someone face down they will die?’*

There was, though, one dissenting view within the dataset. The final quotation talks about the pressure he was able to exert on police and healthcare organisations, and the positive effects this and the implementation of street triage had on policing:

**Case 1**: *‘I met with people for years, pushing for these recommendations. The mental health trust initiated places of safety which are within hospitals so that people experiencing what [the deceased] did don't get inexperienced officers, they get officers that have completed mental health first aid training. [Police] used to use unmarked police cars but now they use ambulances - not the big ones - the cars, in the car is a police officer that has gone through the [mental health first aid] training, a paramedic and either a mental health worker or a drug and alcohol worker and they all attend that incident to make sure that the person is looked after.’*

This progress, to some extent, underlines the piecemeal approach to policing PMHIs. The use of restraint, de-escalation techniques, training on mental health, and the deployment of multi-agency initiatives all occur within the domain of the particular police force, meaning that there is a structural impediment to implementing changes in practice due to the existence of 43 forces in England and Wales.

***Discussion and conclusion***

This paper clearly finds that restraint remains a significant factor in cases of DAPC involving PMHIs, and that such deaths are disproportionately more likely to affect people from BAME communities. A further finding is that restraint appears to be justified on a number of bases: first, it is used by police as a way of controlling an encounter in the absence of other options available to them; second, it is used because police are insufficiently trained in identifying mental health issues and consequently do not always use appropriate de-escalation techniques; and, third, when it is used, it is socially constructed as being necessary and proportionate due to the perceived behaviour of the person experiencing the mental health crisis. Thus, although the use of restraint is not recommended in policy, it appears to be tacitly accepted when dealing with PMHIs. An additional finding is that the lack of national data on the use of physical and mechanical restraint could be seen to be reflective of this tacit approval. Combined with the lack of statutory recording of incidents involving Section 136 (see HMIC 2013), this emphasises concerns about the capacity of police and justice organisations to learn lessons that prevent future deaths in these encounters, another finding emphasised by the participants in this research (see also, Angiolini, 2017).

Police have become a de facto mental health service by default rather than design; they have a statutory obligation to provide a duty of care to PHMIs that enables their right to life. Policies and protocols reflect this obligation, and police practice should in turn reflect this by providing a service to PMHIs in line with their healthcare needs rather than approaching them as an agency of enforcement. The finding that transportation of detainees is inappropriate and potentially unsafe in the aftermath of restraint being used underlines the tension between policy and practice in relation to police interactions with PMHIs. With little training on what is, after all, a healthcare issue, officers have limited options when assessing encounters with PMHI and may resort to using force to gain control of a situation they might not fully understand. Whilst multi-agency initiatives such as liaison and diversion and street triage appear to improve the provision of care for PMHIs, their deployment is piecemeal and does not offer 24-hour coverage (HMICFRS 2018). The findings in this paper are important because they underline that policies on police interactions with PMHIs are not consistently reflected in practice, and that this affects the numbers of people who die after police contact. Thus, although there is an increased awareness about the disproportionate use of force on both PMHIs and people from BAME communities, there is limited evidence that lessons are being learned that can minimise the number of fatal encounters.

Angiolini’s (2017: 37) policy review into DAPC noted that in police encounters with vulnerable people: ‘Effective training is crucial but a transformation in culture away from physical intervention as the default position to one of de-escalation will require strong leadership and recognition of the wider skills set required of our police officers in the 21st century.’ The findings from this paper suggest that there is a need to re-imagine the police role in relation to vulnerable individuals. As society becomes increasingly plural, the number of vulnerable people increases, and this affects the procedural obligation of police to provide a duty of care (Xxxxx, 2016a; Reiner, 2010). Officers need to be better equipped to deal with PMHIs, and the provision of mental healthcare needs to be better integrated to encompass a multi-agency network of service providers (see, for example HMICFRS 2018, Wood et al. 2011: 35).

The authors acknowledge the limited sample size for this research but argue that the findings should be understood in the context of a research project into the sensitive and contested topic of DAPC. Similarly, the issue of bias must also be acknowledged. As noted previously, participants for this project were recruited with the assistance of two activist groups and a national charity. The authors are not beholden to publish any research on behalf of these organisations or to support or endorse any of their research. Liebling (2001) notes that it is better to undertake certain types of sensitive criminological research even if bias is present, i.e; it is better to shed light on sensitive issues than not, a view shared by the authors of this paper. Evidently empirical research on this issue is limited, suggesting that further research could be undertaken. Future qualitative research might consider this issue from the perspective of police responders or mental health practitioners. Similarly, a mixed-methods review of street triage across a number of forces could shed more light on its efficacy with regards to providing an appropriate response to PMHIs (see comments by, for example Angiolini 2017, Cummins and Edmondson 2016, Horspool et al. 2016).

There are tentative signs of change with the commitment to record the use of police restraint and make the data publicly available per force, and an increasing commitment to phase out police custody as a ‘place of safety’ (Angiolini, 2017). Gradually, there is an increasing use of multi-agency initiatives to improve provision for PMHIs reflecting a care-based rather than an enforcement-based response. What is less clear is how the data on restraint will be evaluated once it is recorded, and how forces might be held accountable for its use once this data has been analysed by police regulators. Given the inability of police to learn lessons that prevent DAPC despite the increasing volume of official knowledge and guidelines on this issue, clearly this is not an idle concern. Similarly, it is unclear how the use of multi-agency approaches in a more systematic and planned manner might be achieved, or by what measure, or by which regulator/s their use might be evaluated. It might perhaps be more cogent to consider how police have become a de facto healthcare provision, what this says about public services in England and why we consider mental healthcare provision to be ‘core police business.’

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Xxxxx, X (2016b) Xxxxxxx

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Xxxxx, X (2019) Xxxxxx

1. The term ‘death after police contact’ is used in England and Wales by the Independent Office for Police Conduct (IOPC). The IOPC is the principal police regulator in England and Wales, it investigates and reports on every case of DAPC. The authors use the term DAPC throughout this article - it broadly denotes any citizen who dies after being in contact with police in a place which is public, private, or custodial (IOPC 2018). [↑](#footnote-ref-1)
2. The IOPC makes a distinction between the total number of DAPC (all deaths) and those who die in or after police custody. In the latest available data, both numbers increased. It is not the intention of the authors to examine how these statistics are collated, other than to note that the issue of collation is worthy of a piece of research in its own right (see, for example Phillips et al. 2017). [↑](#footnote-ref-2)
3. Her Majesty’s Inspectorate of Constabulary is a police regulator that assesses and evaluates a broad range of areas of police practice in England and Wales. It attempts to promote best practice and learn lessons from previous errors. It expanded its role in 2017 and was renamed Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). [↑](#footnote-ref-3)
4. The authors would particularly like to thank 4WardEver, the United Families and Friends Campaign, and INQUEST. Without their assistance this research project would not have been possible. [↑](#footnote-ref-4)
5. NICE is the healthcare body in England and Wales that dictates clinical practice for the National Health Service. [↑](#footnote-ref-5)
6. The House of Commons Home Affairs Select Committee (HAC) is a cross-party group of Members of Parliament that produces research papers on issues related to crime and justice in the UK. [↑](#footnote-ref-6)