west midlands police and crime commissioner

AGENDA ITEM 8

STRATEGIC POLICING AND CRIME BOARD
4th November 2014

Investigation into the death in police custody of Mr Lloyd Edward BUTLER

PURPOSE OF REPORT

1. The purpose of this report is to provide members of the Strategic Policing Crime Board with an overview of the Independent Police Complaints Commission's (IPCC) investigation into the death in police custody of Mr Lloyd Edward BUTLER and the subsequent response of West Midlands Police. The case was discussed as an agenda item at the force Command Team meeting on 9th September 2014.

BACKGROUND

2. On 4th August 2010, at approximately 12pm, Mr BUTLER was arrested, on the grounds of being drunk and incapable, following a call from his mother. He was conveyed to Stechford Police Station where his detention was authorised and he was placed into a camera monitored cell. Whilst in custody, he was placed on a care regime that required him to be constantly monitored via the CCTV system and to be roused at regular intervals, and a Health Care Professional was called.

3. At approximately 3.15pm, Mr BUTLER was visited in his cell by a nurse who, following an examination of him, called for an ambulance. Mr BUTLER received medical treatment and was transferred to Heartlands Hospital in Birmingham but was subsequently pronounced dead. In line with the IPCC's referral criteria, the matter was immediately referred to the IPCC, who decided to conduct an independent investigation.

4. The Birmingham Coroner opened the Inquest into Mr BUTLER's death on 17th August 2012. The Inquest was adjourned pending the outcome of the IPCC investigation. The Inquest reconvened on 16th June 2014 and concluded on 27th June 2014.

IPCC INVESTIGATION

5. The IPCC investigation concluded in December 2011, although the publication of its findings was withheld until the Inquest reconvened in June this year. The report is available at http://www.ipcc.gov.uk/investigations/west-midlands-lloyd-butler

6. The IPCC report highlighted a number of mistakes and unacceptable behaviour by officers on duty in the custody suite at the time of Mr BUTLER's detention, which meant that his deteriorating condition went unnoticed despite the observation plan that required him to be roused and his condition checked at regular intervals. The failings of two officers and a staff member were deemed to be the most serious:

    - The arresting officer, PC WOODCOCK, became distracted from the monitoring of CCTV footage of Mr BUTLER's cell by personal calls and use of the internet

    - PS ALBUTT, the custody sergeant, did not properly recognise the risk posed to Mr BUTLER and did not ensure that visits were conducted properly

    - PC WOODCOCK and Detention and Escort Officer (DEO) WALL made inappropriate remarks about Mr BUTLER's condition.

7. A review of the evidence from the IPCC concluded that there was a case to answer in relation to breaches of the standards of professional behaviour for PC WOODCOCK, PS ALBUTT and DEO WALL. It was also determined that the behaviour of three additional custody sergeants, all of whom had some degree of responsibility for Mr BUTLER's care whilst in custody, fell below the standard expected and they should receive 'management action'.

8. In the subsequent misconduct proceedings, PS ALBUTT was found guilty of gross misconduct and received a final written warning, PC WOODCOCK was found guilty of misconduct and subject of management advice requiring further training and development, and DEO Wall was also found guilty of misconduct and received a written warning and management advice.

9. On 25th June 2014 Guido Liguori, IPCC Associate Commissioner, wrote to the Chief Constable forwarding a copy of the IPCC's draft learning report, drawn from the findings of the independent investigation, which concerned the following:

    - *Dissemination of Detainee Prompt Cards to operational officers*

      'It is noted that since the incident the Detainee Prompt Cards have been brought to the attention of operational officers but it would be advisable that a record of receipt of such prompt cards is maintained and that all new officers are provided with any current prompt cards produced.'

      'The number of prompt cards issued to operational officers should not become so prolific that the significance of issuing the cards and their contents becomes diminished.'

    - *The wording of what constitutes 'drunk and incapable' within the prompt cards*

      'That the wording in the Detainee Prompt Card is amended to read 'walk or talk' as opposed to 'walk and talk' and the significance of this is effectively communicated.'

- *Constant observations on detainees in busy custody suites*

  'Constant observations of a detainee via CCTV should be conducted in as sterile an atmosphere as possible and clear arrangements should be implemented to ensure that there is sufficient cover for staff performing those functions to take breaks. If a separate room is available to perform constant observations it should be documented/policied and effectively communicated to staff likely to perform this function.'

  'Consideration be given to ensuring that one of the male cells at Stechford Custody Suite with a low bench is capable of being monitored from the room to the rear of the custody charge desk.'

- *Internet access within custody suite*

  'That personal use of the internet should be restricted to defined break periods and on terminals not within the custody charge desk environment to avoid distractions both direct and collateral.'

- *The availability of CPR masks within custody suites*

  'That vent-aids are kept in all custody suite first aid boxes which it is noted was immediately identified and rectified by West Midlands Police following this incident and that they also put in place a policy to ensure that all officers were issued with two vent–aids with one to be carried at all times and a spare to be kept secure in the event that the first is used.'

- *Rousing checks of detainees*

  'There should be a presumption that rousing checks are conducted by suitably trained officers such as Custody Sergeants or DEO's unless it is unavoidable when full detailed briefings should be provided to officers tasked with conducting rousing. It is noted that since the incident West Midlands Police have required that only custody trained staff now undertake observations.'

10. On 9th July 2014, ACC Cann wrote a detailed letter to Guido Liguori (Appendix A), setting out the force position with regard to the IPCC findings and proposed actions to address any shortcomings identified.

11. The force response to the learning report is summarised as follows:

- *Dissemination of Detainee Prompt Cards to operational officers*

  The force considers that prompt cards can be a useful tool to reinforce key points of learning and as a quick reference guide for officers but it is important that systems for ensuring that critical aspects of policy, such as the provision that drunk and incapable detainees should be conveyed to hospital, are robust in their own right. As such, the force has ensured that both control room and custody staff are fully aware of the policy regarding drunk and incapable persons; the control room to ensure that such detainees are transferred to hospital at the earliest opportunity and the custody staff when assessing detainees on their arrival in custody.

Between 2010 and 2012 the number of detainees brought into custody for being drunk and incapable fell significantly and since December 2012 no persons have been brought into custody for this offence.

In relation to the prompt cards themselves, it is not considered practicable to keep a record of all such documents that are given to staff as part of their training. A central training record is kept for each member of staff to ensure that they maintain all relevant qualifications for their role. In addition to this, staff can access policy guidance via the force intranet system and are also encouraged to refer to national guidance, such as Authorised Professional Practice, as part of their ongoing development. New officers will be provided with current prompt cards as part of their training.

- *The wording of what constitutes 'drunk and incapable' within the prompt cards*

The force has amended the wording on the 'Detainee Prompt Cards' in line with the IPCC advice, so that a person should not be taken to a custody facility if they are unable to 'walk or talk' owing to intoxication rather than 'walk and talk'. The change in wording has been highlighted to staff as a 'Message of the Day', via the force intranet system.

- *Constant observations on detainees in busy custody suites*

There is currently provision to conduct constant observations in a separate room in 10 of our 11 custody suites and staff have been reminded that CCTV monitoring equipment located in back offices should be utilised for constant observations, where available and appropriate in the circumstances. Brierley Hill custody block, the smallest site in the force area with 7 cells, does not have this facility owing to the physical lack of a separate room to site the monitor.

The force considers that the location of the individual carrying out the constant observations should be a risk based decision made by the custody officer for each detainee. Whilst it is important that officers conducting CCTV observations are not distracted by other activity around the custody desk, siting officers near to the custody sergeant does allow for closer supervision and makes the sergeant more accessible to the officer if queries arise.

Regarding refreshment breaks, all Criminal Justice inspectors and custody sergeants have been reminded of the need to ensure that staff conducting level 3 or 4 watches (constant observations) are allowed to take regular breaks, with cover being organised to ensure that the observation and care of detainees continues.

- *Internet access within custody suites*

It is clearly important that staff are not distracted from their duties by personal use of the internet. However, there is an operational need for internet access from custody charge desks in order to provide the best possible care and service to detainees and it is, therefore, not considered appropriate to restrict access in the manner suggested in the IPCC report.

The underlying issue appears to be one of individual professionalism and personal responsibility amongst staff. Staff can now easily access the internet from their personal mobile phones and other potential distractions will also

affect those who do not approach their duties with the correct attitude. As detailed below, the force is active in promoting a high level of professionalism and an appropriate culture within the organisation but is currently reviewing the force internet usage policy to ensure that it remains fit for purpose.

- *The availability of CPR masks within custody suites*

  All WMP officers are issued with a 'vent-aid' and operational officers carry these with them as part of their standard equipment. It was initially proposed that officers would be issued with a spare to hold in store in case they used their first one. However, following a review, a supply of vent aids has now been sent to all LPUs to be accessible on a 24/7 basis so that officers can obtain a replacement if necessary. All custody suites hold vent-aids as part of their first aid equipment, which is checked on a monthly basis.

- *Rousing checks of detainees*

  Since August 2010 the force primarily uses custody staff to conduct observations on detainees. The percentage of custody staff conducting constant watches compared to non-custody staff is monitored on a monthly basis to ensure our performance in this area is maintained, with figures showing that, on average, over 80% of watches were conducted by custody staff between January and June 2014. In our largest custody facility, Birmingham Central, Custody Officer Assistants (COAs) have been recruited to provide additional capacity in this regard.

  On the rare occasions that non custody staff conduct the observations, custody sergeants are required to fully brief the officer involved, utilising Observation Briefing Sheets (Appendix B), and an entry recording that the briefing has taken place is made on the custody record.

INQUEST

12. The Inquest re-convened on Monday 16th June, concluding on Friday 27th June. The jury, having heard all of the evidence, determined that Mr BUTLER died as a result of a cardiac arrest in the A and E Department of Heartlands Hospital at 16.10hrs on 4th August 2010. The jury also provided a narrative which recognised failings by staff in the custody suite, which reads as follows:

    'The jury find that taking into account all of the evidence presented at the inquest, on his arrival at custody Mr BUTLER was incapable and according to the policies in place, he should not have been detained in custody but should have been taken to A and E.

    An inadequate risk assessment led to discretion being applied to keep Mr BUTLER in custody and requirements put in place for regular observations and a Health Care Professional (HCP) called.

    - Rousings were not adequately carried out
    - Visits were not maintained on schedule
    - There was a delay in the arrival of the HCP to the custody block

It is the finding of the jury that had Mr BUTLER been on monitor in A and E at the time of his heart attack, the probability is he is more likely to have survived.'

13. On 25th June 2014 the Coroner for Birmingham and Solihull, Mrs Louise Hunt wrote to the Chief Constable under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 raising matters of concern that had been apparent from the evidence given at the Inquest. This legislation places a duty on the Chief Constable to respond to matters of concern raised within 56 days.

14. The matters of concern related to the apparent lack of leadership and professionalism in the custody suite, training and guidance and the general culture within the custody estate.

15. On 1st August 2014 CC Sims wrote to Mrs Hunt, formally responding to these matters of concern and setting out the action that the force has taken since 2010 to address them. Mrs Hunt acknowledged the force's response on 12th August 2014. Reports relating to Inquests are published by the Chief Coroner.

16. The Chief Constable was able to respond that, since 2010, management of custody facilities and staff has been brought under a central force department, Central Justice Services (CJS) and the number of custody suites reduced from 21 to 11. The creation of this department has allowed for greater accountability and clearer leadership.

17. The force has also prioritised work to ensure an appropriate culture of professionalism within the organisation. In June 2013, the force launched the 'Pride in our Police' campaign. This internal campaign aims to promote a culture of high professional standards and personal responsibility across the organisation. The campaign has already covered topics including uniform and appearance, personal standards and behaviour, and driving standards.

18. DCC Thompson has overseen the local implementation of the police service Code of Ethics, and the principles within the Code have been incorporated into all WMP training courses, including those relating to custody. A mandatory one day training course has been held for all first and second line supervisors, sergeants and inspectors, covering the Code and its requirements.

LIAISON AND SUPPORT OFFERED TO THE BUTLER FAMILY

19. The board has requested details of the liaison and support offered by WMP to the family of Mr Butler from the time of his death onwards.

20. Mr Butler's death was immediately referred to the IPCC who commenced an independent investigation on 5th August 2010 and took responsibility for providing updates and support to the Butler family.

21. The Butler family were present during the misconduct hearing of PS Albutt and PC Woodcock and, following the conclusion of that process, ACC Forsyth and C/Supt Foulkes (now ACC Foulkes) met with the Butler family to explain the outcome.

22. Following the conclusion of the Inquest and the IPCC process, ACC Cann has offered to meet with the Butler family and it is hoped that this can be arranged in due course.

FINANCIAL IMPLICATIONS

23. There are no financial implications to note at this time.

LEGAL IMPLICATIONS

24. There are no legal implications to note at this time.

RECOMMENDATIONS

25. The Board is asked to note the content of this report.

C. Sims
Chief Constable