Case 3 | Issue 35 – Custody	LEARNING THE LESSONS
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Vulnerable woman in custody

Detention of a vulnerable woman in police custody, raising issues about:

- *Retention of person escort record (PER) forms*
- *Equipment used to convey detainees of various sizes into the custody unit*
- *Availability of anti-rip clothing in various sizes*
- *NICHE risk assessment process when booking detainees into custody*
- *Keeping audio records for radio and telephone*
- *Keeping audio and CCTV footage*
- *Briefing health care professionals (HCPs) on force specific working practices*

This case is relevant if you work in:

Custody and detention

Overview of incident

Around 10pm Ms A went to the police station “semi-drunk”. She said that she was going to buy a bottle of vodka and walk into the river so that she could be with her dead grandmother.

Ms B, a station enquiry officer, created an incident log and recorded Ms A’s threat to self-harm. The log was routed to the control room. Ms B made contact with PC C and PC D as she thought they might have caught up with Ms A while she was buying vodka.

Both officers had dealt with Ms A before in alcohol-related incidents. They both knew that she would drink to excess on weekends.

PC C and PC D made a number of enquiries to find Ms A including checking local shops, searching the local area and going to Ms A’s home address. Ms A’s partner told the officers she was not at home, that she had been drinking and was upset about the death of her grandmother.

Around 11pm an incident log was created after a security officer at the local hospital called police to report that a woman was causing problems.

Security officers told the IOPC that Ms A was unsteady on her feet, had shouted and been abusive to staff, had a bottle of alcohol with her, and had urinated on the hospital floor. They also explained that Ms A told them that her grandmother had died at the hospital.

The control room operator who dealt with the call linked it to the log created when Ms A went to the police station. She updated PC C and PC D with Ms A's location and they confirmed that they would go to the hospital.

Around 11.05pm PC D told the control room that a search for Ms A was negative and requested that she should be treated as missing.

PC C and PC D arrived at the hospital around 11pm. On arrival PC C recognised Ms A. Both officers describe that on their arrival Ms A was sprawled on the floor and was shouting and swearing at two security guards.

PC D arrested Ms A for drunk and disorderly behaviour and called for the assistance of PC E and PS F as a van was needed to take her to custody. He updated the control room and asked for the two logs to be linked.

Around 11.06pm it was recorded on the log that PC E, PS F and PC G had been sent to the incident.

PC C and PC D got Ms A to her feet and walked her out of the hospital.

PC C and PC D told the IOPC that PS F then offered to take Ms A into custody.

Both PC C and PC D told the IOPC that they did not explicitly tell PC E and PS F of the concern for safety incident because the officers had been present when the initial report was made; numerous updates had been given to the control room over the previous hour while they were looking for Ms A; and there had been a lengthy radio conversation while PC D had been trying to find Ms A.

PS F told the IOPC that there had been no discussion between her and her colleagues about what options had been available to them when dealing with Ms A. She said on reflection they could have considered taking Ms A to the hospital's accident and emergency department as she was so drunk.

On arrival at the custody suite PC E, PS F and PC G had difficulty helping Ms A from the back of the police van into the custody suite because she was unable to walk unaided. They were assisted by PC H and PC J who were sitting in the front office when they arrived.

Officers tried to place Ms A in an EVAC chair, but this was unsuitable due to her size. EVAC chairs are typically used to move people in an emergency.

CCTV footage of Ms A entering the custody suite shows that she walked to the custody desk with PC G supporting her under her right arm. She leant on the custody desk and PC E, PC G and PC H helped to steady her on her feet.

Ms A removed her trousers while stood at the custody desk. She then sat on the floor.

PS K, the custody sergeant, allocated Ms A to a life sign cell with a camera and a low bed. A life sign cell is also equipped with a motion sensor which triggers an alarm if a detainee appears to stop breathing.

CCTV footage shows that PC E, PS F, PC G, PC H and PC J pulled Ms A to her feet and guided her towards the cell. PS F stood behind Ms A with her arms under Ms A's arms. PC J supported her left arm and PC E supported her right arm.

Ms A sat down on the floor again before reaching the cell.

CDO L told the IOPC that Ms A had told her that she had been to a funeral and that she could not get up because her knees and ankles were hurting her. When asked how she would get to her cell, Ms A said that she would crawl.

PS K told the IOPC that he only received limited information that Ms A had been arrested at the hospital for being drunk and disorderly. He stated she was obviously drunk as her speech was slurred, she was not able to listen, and her hair was dishevelled. He stated she lay down as officers tried to move her, and it was clear that she would not have been able to listen to the questions he needed to ask her as part of the booking-in process. He noted that she was apologetic and upset, although he could not recall anything she said specifically. He added that he did not think Ms A was incapable, and if he thought she was, he would have told the officers to take her back to the hospital.

PS K noted on the custody record that Ms A was unfit to complete the risk assessment.

PC H encouraged Ms A to go into her cell. She recalled that Ms A crawled on her hands and knees. Once Ms A was in her cell, PC H left the custody suite and returned to her duties.

PS F stated that when Ms A was in her cell she helped to remove her jewellery. She said that she recalled that CDO L had also been there and placed Ms A in the recovery position. PS F stated she did not know what custody markers were recorded for Ms A.

PS F told the IOPC there had been discussion regarding an anti-rip suit but there had not been one big enough for Ms A.

PS K told the IOPC that he was confident Ms A did not require anti-rip clothing and he felt that this could have made the situation worse. He explained he considered removing Ms A's clothing and providing her with an anti-rip blanket but considered that this could have compromised her dignity. He also stated that on one occasion, approximately six months before, Ms A had tied a blanket around her neck to try to self-harm.

Around 12am PS K recorded on the custody record that:

- a risk assessment was not completed as "DP [detained person] is extremely intoxicated and unable to understand at this time"
- Ms A needed to see a health care professional (HCP) for "obs/alcohol/withdrawal"
- Ms A was to be searched and placed on level two observations in an observation and life sign cell with mattress moved to the floor

PS K also added that Ms A should remain on her side to make sure her airway was open. He was aware of a previous occasion in custody where Ms A had rolled over and had breathing difficulties due to her size.

Ms M, the custody nurse, told the IOPC that because Ms A was so intoxicated she was unable to carry out any observations in line with PS K's request in the custody record. She went on to

say she was not allowed to assess a detainee in their cell unless it was an urgent case, and a detainee would not normally be assessed if they were very intoxicated.

During the night PS K received no information that caused him concern or made him think that he needed to call an ambulance for Ms A, send her to hospital or increase the level of observation.

Around 4.40am Inspector N recorded on the custody record that Ms A's continued detention was necessary until she was sober and a charging decision could be made. He recorded he had been advised that Ms A was extremely difficult to deal with.

Inspector N told the IOPC that when he conducted his review Ms A had been in custody for just over four hours. He did not wake her as she was drunk and resting. He explained there was sometimes no benefit in giving a detainee their rights and entitlements while drunk as they would be unlikely to understand or remember.

Around 6.45am at the end of his shift PS K updated the custody record to reflect that PS O and PS P had taken over responsibility for Ms A.

PS K told the IOPC that he noted that Ms A was "needy" and that he had most likely received that information from the CDOs. He stated he had meant that she needed a lot of care and that if she pressed her cell buzzer she should be treated more promptly and a relevant care plan should be implemented.

PS Q worked the same shift as PS K and also attended the handover meeting.

Ms A was checked around 6.30am.

PS K told the IOPC that while the handover had been ongoing, the buzzer in Ms A's cell sounded and someone had gone to her cell to take her to the toilet.

CCTV footage from inside Ms A's cell indicates that shortly after she returned from the toilet she knelt against the cell wall and appeared to strike her head against the wall several times. The footage shows that around 6.50am Ms A removed her bra and tied it around her neck. For the following 20 minutes Ms A moved around the cell, sitting up, kicking her legs and moving her arms before becoming still.

PS P, PS O and PS R found Ms A unresponsive in her cell around 7.10am.

PS O told the IOPC that when they found her Ms A was lying on her back, beginning to turn blue in the face, and her breathing was raspy. He stated he immediately placed her in the recovery position. PS P removed the ligature from her neck. Ms A's breathing then became easier, colour returned to her face and she became fully conscious.

PS P noted on the custody record that when Ms A started to breathe normally she disclosed that she wanted to kill herself. Around 7.25am he updated the custody record to reflect Ms A had been put on level four observations under constant supervision.

An ambulance was called and PC S accompanied Ms A to hospital.

PS O noted on the custody record that a PER form, care plan and risk assessment were given to PC S.

When a copy of the PER form was requested at the beginning of the investigation, the IOPC was told that it had not been kept.

Type of investigation

IOPC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. When a copy of the PER form was requested at the beginning of the investigation, the IOPC was told it had not been kept.

2. Two of the custody sergeants spoken to as part of the investigation were unaware of the requirement to keep a copy.

Local recommendation 1

3. To help prevent the loss of any PER forms, the force should make sure that the PER forms are completed and kept in accordance with APP. APP states that "The escorting officers should return the PER form to the custody officer and inform them of any additional risks identified."

Finding 2

4. Officers tried to place Ms A in an EVAC chair to take her into the custody suite but this was unsuitable due to her size.

5. Officers also considered placing Ms A in an anti-rip suit. However, none were available in a suitable size.

Local recommendation 2

6. The force should review the anti-rip clothing and equipment used to convey detainees through the force custody unit(s) to make sure it is sufficient for people of various sizes. This should include the EVAC chair and any other equipment used to move detainees throughout the unit.

Finding 3

7. During interview PS K highlighted an anomaly with the NICHE risk assessment process when booking detainees into custody. He explained that one of the questions on the risk assessment screen updated automatically once an answer had been selected.

8. The specific question reads: "Is the DP drunk or does the DP appear drunk?" PS K stated that he selected "yes" for Ms A. Subsequently, on the completed, printed version

of the custody record, the question appeared as “Is the DP drunk or does the DP appear drunk and there is sufficient concern that medical assistance is required?”

9. If the answer “yes” is picked, a comments box becomes active for additional information to be recorded. There is a help box alongside the question. If opened, it reads: “Is the detainee drunk or appear drunk and is there sufficient concern that medical assistance is required?”

10. Once the custody officer has completed their observations, they electronically sign that section of the risk assessment on the detention log. On doing so, a summary of the questions and answers appears and the question concerned reads: “Is the detainee drunk or appear drunk and there is sufficient concern that medical assistance is required?”

11. In cases where the answer is “no”, the full wording, including the query regarding medical assistance, is populated in the summary box for the custody officer to sign.

12. There are two separate questions asked but only one response is required. This could cause inaccurate information being recorded regarding the risk assessment, as it is possible that a custody officer would wish to record different answers to each part of the question.

Local recommendation 3

13. The force may wish to tell all their police officers and staff responsible for booking detainees into custody of an anomaly in the NICHE risk assessment. Specifically in relation to the question “Is the DP drunk or does the DP appear drunk?” In answering this question, an additional question is attached on the custody record - “Is the DP drunk or does the DP appear drunk and there is sufficient concern that medical assistance is required?” The force may wish to highlight to their custody staff that the question has two parts, which may impact on the medical requirements for the detainee.

Finding 4

14. When radio and telephone recordings were first requested for this investigation, the force explained that the contact centre had been temporarily relocated which had resulted in the loss of audio recordings.

Local recommendation 4

15. The force may wish to review how they store and keep audio recordings in all locations throughout the force to make sure that data is being kept correctly and in accordance with legislative responsibilities.

Finding 5

16. Audio and visual footage was requested at the beginning of this investigation from the custody suite covering 14 – 15 November. When further audio footage was requested, the operator explained that the audio material had not been kept on the system as there had been a fault on the server.

Local recommendation 5

17. The force should review the storage facilities used for custody footage, both audio and visual, to make sure that the material is kept in accordance with their expectations and procedures and to prevent loss of any footage in future.

Finding 6

18. Both PC C and PC D, the officers who responded to the initial call from Ms A, told the IOPC they did not explicitly tell PC E and PS F of the concern for safety incident. This was because the officers had been present when the initial report was made; numerous updates had been given to the control room over the previous hour while they were looking for Ms A; and there had been a lengthy radio conversation while PC D had been trying to find Ms A.

Local recommendation 6

19. To help prevent loss of information from the arresting officer when someone else transports the detainee to custody, the force should review their working practices when booking detainees into custody in these circumstances. It may be helpful for custody officers to review the details on the occurrence log to make sure they know the full circumstances about the detainee in police custody.

Finding 7

20. Ms M, the custody nurse, told the IOPC that because Ms A was so intoxicated she was unable to carry out any observations in line with PS K's request in the custody record. She said that she was not allowed to assess a detainee in their cell unless it was an urgent case, and a detainee would not normally be assessed if they were very intoxicated. She referred to training she had received while working with a neighbouring force. She explained that the force strongly objected to a nurse examining a detainee in a cell, particularly if a risk assessment had not been completed, as the risks were too great. She stated that she would attend to a detainee in a cell in an emergency, provided there were officers present.

Local recommendation 7

21. The force may wish to review the working practices in place when using agency nursing staff. The healthcare practitioner (HCP) in this case relied heavily on the working practices of another police force in her written response.

22. The force should consider how it makes nursing staff, particularly those working for agencies, who may also work (or have worked) in other force areas, aware of the processes in place within force custody units. This may include how the HCP would be notified that a detainee needed to be seen.

Response to the recommendations

Local recommendations

Local recommendation 1

1. The PER forms part of the presentation provided to custody staff and delivered to all officers as part of mandatory force training days.

Local recommendation 2

2. Anti-rip suits have been ordered to accommodate 4XL sizes and are available within the custody suite.

3. In regards to the wheelchair in custody, its location is centrally placed behind the custody desk next to all the emergency equipment. All staff are familiar with its use and location. The wheelchair is able to hold a weight of 17 stone 9 pounds. The wheelchair is only to be used for detainees who have mobility problems and are unable to move independently around the custody suite.

Local recommendation 3

4. A meeting was held on 9 January 2018. Attendees included the head of the criminal justice department (CJD), custody inspectors, a health and safety manager, a lead custody nurse and professional standards. The anomaly within the NICHE risk assessment is being explored by the Head of the CJD to establish if this is a viable option to amend the risk assessment. The NICHE record management system is shared with neighbouring forces and any changes will need to be agreed and ratified. Interim measures are being put into place for inclusion within custody staff training.

Local recommendation 4

5. The force use a system called redbox to access telephone recordings made to the force communications suite. The system is relatively new to the force and coincided with the review of the communications suite. A review is currently underway to make sure that the recordings are being captured accurately. Once captured, they can be accessed from any location given the appropriate access across the force. A previous problem has been found with the system where either the call is not stored on the system, or is stored but there are in the information captured. The issue with the system is there is no alert to indicate when the system does not work – this is only known at a later stage when the audio is requested. To relieve this, quality checks are required by supervisors every day to find any issues with recordings. The service level agreement is being reviewed with SRS, Unify (the providers) and the procurement team. Following a review undertaken by engineers in January 2018, the secondary server is now robust in its recording and the same processes are being applied to the primary server. This is an on-going piece of work that will continue to be tested and reviewed.

Local recommendation 5

6. Custody footage is kept for 28 days. This is in line with the majority of other forces. The server failure was beyond their control and could not have been predicted. The custody unit has recently been extensively refurbished, including an upgrade to the CCTV system. Body worn cameras have been ordered for custody. Following on from a number of incidents in custody where staff have been assaulted, they decided to introduce body worn video (BWV) cameras for all staff in the unit. The cameras have been ordered and they are currently working with staff to find out how best to carry the cameras. Staff will wear the cameras and switch them on when they are dealing with an incident. The cameras will not be personal issue, which is in line with force policy for front line officers. It was anticipated they would be in place by April 2018. These cameras are in addition to the full coverage in the unit via CCTV.

Local recommendation 6

7. The recommendation is partially accepted. The force training day presentation (recommendation 7) covers booking-in and presenting all circumstances about the detainee (action taken to address the recommendation). However, custody officers reviewing details on occurrence logs has been discussed with the head of the CJD and custody inspectors. It will be a difficult process due to the volume and time demand on custody sergeants within the unit and will cause delays for the booking-in process. It should be the responsibility of the officer presenting (whether arresting or transporting) to give full details to the custody sergeant.

Local recommendation 7

8. The working practices and training for all agency staff has been reviewed. A robust induction process is in place for full time health care staff and nurses when joining the force. The following are covered:

    - welcome to the custody environment – an overview of the role and responsibilities and legislation
    - management of drugs and alcohol, including intoxication and withdrawal
    - management of detainees concealing drugs
    - management of medical conditions and introduction of medical assessment forms including diabetes; cardiac; epilepsy; respiratory conditions; medical emergencies; medicines management; mental health; the *Road Traffic Act*; forensic sampling; documentation of injuries; and attendance at sudden death

9. Following induction, nurses are given a portfolio of evidence and competencies and they are signed off by an experienced healthcare professional. This is overseen by the lead custody nurse.

Outcomes for officers and staff

PC C

1. PC C, one of the two officers who responded to the initial call about the woman, was found to have a case to answer for misconduct. This was in respect of the allegation that he failed to make sure that the escorting officers were told about Ms A's threat to self-harm.

2. The appropriate authority (AA) informed the IOPC that PC C did not have a case to answer for misconduct. Unsatisfactory performance procedures (UPP) were not implemented for PC C. The IOPC accepted this and the AA's proposal that the officer receive management action.

3. PC C was reminded of the specifics of authorised professional practice (APP). This was around making sure that arresting officers pass relevant information, such as risk factors, to any escorting officers. Details should be passed to the custody officer when authorising detention. A copy of the investigation report was also shared with PC C.

PC D

4. PC D, one of the two officers who responded to the initial call about the woman, was found to have a case to answer for misconduct. This was in respect of the allegation that he failed to make sure that the escorting officers were notified of Ms A's threat to self-harm.

5. The AA informed the IOPC that PC D did not have a case to answer for misconduct. UPP was not implemented for PC D. The IOPC accepted this and the AA's proposal that the officer receive management action.

6. PC D was reminded of the specifics of APP around making sure that arresting officers pass relevant information, such as risk factors, to any escorting officers. Deatails should be passed to the custody officer when authorising detention. A copy of the investigation report was shared with PC D.

PS K

7. PS K, the custody sergeant who dealt with Ms A when she was brought into custody, was found to have a case to answer for misconduct. This was in respect of the allegations that he:

   - failed to carry out a review of the risk assessment
   - failed to make sure that Ms A received sufficient medical care

8. PS K received management action.

9. PS K was reminded of his responsibilities to observe APP guidance and comply with Code C of PACE. PS K received a copy of the investigation report.

MS M

10. Ms M, the nurse who was working in custody when Ms A was brought into the custody suite, was found to have a case to answer for misconduct. This was in respect of the allegation that she failed to assess Ms A when she arrived in the custody unit in an intoxicated state.

11. No further action was taken with Ms M as she was no longer employed by the police.

Questions to consider

Questions for policy makers and managers

1. How does your force make sure that person escort record (PER) forms can be stored and retrieved effectively?

2. Do staff working in your custody suites have easy access to wheelchairs that can be used by detainees of all shapes and sizes?

3. Do your force custody suites stock anti-rip clothing in a variety of sizes, including larger sizes?

4. How does your force make sure that radio and telephone recordings are kept, particularly when upgrade work takes place?

5. Does your force regularly check audio and video recording systems to make sure that footage is kept in accordance with force policy?

6. How does your force make sure that any contracted medical staff working in custody are aware of any force specific practices which might differ to those within other force areas where they operate?

7. Does your force set out expectations for when medical staff should visit people who are drunk and incapable?

Questions for police officers and police staff

8. As a custody officer would you routinely review the occurrence log when transporting officers are not the ones who initially dealt with the detainee?