Case 4 | Issue 35 – Custody	LEARNING THE LESSONS
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Self-harm with a razor blade

Self-harm of a man in custody, raising issues about:

- *Searches carried out on arrival into custody*
- *Risk assessment and care plan completed by the custody sergeant*
- *Adequacy of the cell checks conducted*

This case is relevant if you work in:

Custody and detention 	**Mental health** 
Personal safety 	

Overview of incident

Mr A was arrested on suspicion of common assault and was taken to custody. He was booked in by police sergeant (PS) B, the custody sergeant who had dealt with him before. The booking-in process was recorded by CCTV.

PS B recalled the shift in question being particularly busy with detainees arriving. The one other custody sergeant on-duty was involved in a matter which took a significant amount of time to resolve. As a result, PS B dealt with all detainees entering custody. When Mr A was booked into custody, there were fewer custody sergeants on-duty than the minimum staffing level of three custody sergeants and four detention officers. Booking-in Mr A was therefore described by PS B as pressurised and difficult.

During the risk assessment there was some discussion about the potential for self-harm.

A risk assessment was recorded on the custody record which showed that Mr A:

- did not have any illness or injury
- was not taking, or supposed to be taking, any tablets or medication
- had unknown mental ill-health
- refused to answer whether he had previously tried to harm himself
- had drunk two glasses of wine
- had no drug or alcohol dependencies

- did not require police help and support with reading/writing or have any learning disabilities
- refused to answer whether there was anything else regarding his welfare that he wished to make the custody sergeant aware of during his detention
- was feeling “very nice”
- did not want to speak to the custody nurse
- was not in contact with any medical or support services

The Standard Operating Procedure (SOP) for custody state that both the Police National Computer (PNC) and NICHE must be checked during a risk assessment. PS B checked the PNC (which showed markers from two years ago about self-harm and thoughts of suicide) but did not check NICHE (which showed a more recent suicide marker not contained on the PNC). PS B requested an assessment by a healthcare professional (HCP) for Mr A to determine his fitness for detention (due to the possibility of diabetes, but not about his mental health). PS B recorded a care plan for Mr A and placed him on level one observations with an enhanced frequency of visits every 30 minutes until the HCP assessment could take place.

College of Policing Authorised Professional Practice (APP) – Levels of observation

Level 1 general observation

Following full risk assessment, this is the minimum acceptable level of observation required for any detainee. It includes the following actions:

- the detainee is checked at least every hour (the risk assessment is updated where necessary)
- checks are carried out sensitively in order to cause as little intrusion as possible
- if no reasonable foreseeable risk is identified, staff need not wake a sleeping detainee (checks of the sleeping detainee must, however, continue and if any change in the detainee’s condition presents a new risk, the detainee should be roused)
- if the detainee is awake, staff should communicate with them.

Find out more online:
https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/?highlight=observations?s=observations#levels-of-observation

PS B had dealt with Mr A on a separate occasion two months earlier when Mr A said that he had taken 20 tablets and had tried to self-harm a week before coming into custody. He indicated that he wanted to die when he left custody. No warning marker was created on either the PNC or NICHE about this.

Mr A was searched by police constable (PC) C. During this he was asked to take off his shoes. His jeans and coat pockets were searched but his socks were not removed. PC C did not use the hand-held metal detector to carry out the search, despite the custody SOP stating that it must be used to assist in the search of a detained person on all occasions. The search was also not endorsed on the custody record, despite it being a SOP requirement. PC C told PS B that there was a rip inside the coat belonging to Mr A but that nothing could be felt inside. PS B confirmed that Mr A could keep his coat with him inside the cell, as Mr A had requested. Mr A was put in a cell.

When questioned PS B said that the rip in the coat did not concern him as a previous briefing to officers had said that leaving a detainee in their own clothing and increasing the observation levels may be more appropriate than seizing Mr A's coat.

Detention officer (DO) D entered the cell and placed toilet paper and a blanket on the bed. DO D had also dealt with Mr A before and voiced some concern to PS B about his demeanour inside the cell. It is not known if DO D raised any specific concern with PS B about Mr A being allowed to keep his coat with him in the cell. In light of PS B's previous experience of dealing with Mr A, no action was taken about the concerns raised by DO D.

The HCP attended and recorded that Mr A was emotional and refusing assessment. He said that he wanted to be left alone. No concerns were noted by the HCP about Mr A's fitness for detention. It was decided that he should remain on the same observations as decided by PS B. No risks of self-harm were identified by the HCP but it was suggested that consideration be given to a Liaison and Diversion System (LADS) assessment if there was no change in Mr A's emotional state.

Shortly after the HCP spoke to Mr A, CCTV footage showed him moving the cell blanket from over his head and sitting up. He held his left arm out in front of him (with the sleeve pulled up to his elbow) and moved it up to the left side of his head. His right forearm was placed on his right thigh. He then lay back down on his left side and pulled the blanket over his upper body. A minute later, Mr A sat up and walked to the toilet. Blood staining could be seen on the mattress. He stood over the toilet and pressed the flush button before returning to lie on the bed, holding his left arm over the side. Blood is seen to drip from his left arm onto the floor of the cell. Some minutes later, he stood up and walked to the toilet again. After bending over the toilet, he pressed the flush button and washed his hands before returning to lie on the bed and pulling the blanket over his upper body. The exact actions of Mr A at the toilet were obscured by a privacy panel on the CCTV footage.

While Mr A was lying on the bed, detention officer E heard voices coming from Mr A's cell. DO E opened the vertical louvered cell door viewer and closed it again within less than two seconds. DO E did not drop the cell hatch. The College of Policing APP (detention and custody) states that checking through a cell spyhole is not an acceptable welfare check under any circumstances. DO E recorded on the custody record that a welfare visit to Mr A had been made: "Cell visit DP awake, no concerns at this time". The CCTV footage showed that when the louvered viewer was opened briefly by DO E, there was bloodstaining on the cell floor below the left arm of Mr A. DDO E told the IOPC that she saw no visible signs of cuts on Mr A's wrist or hands, or blood on the floor. She therefore did not raise any alarm or seek medical assistance as she had no concerns regarding his welfare at that time. Minutes later, the CCTV showed Mr A moving his right hand and making a number of slash movements across his left forearm.

The CCTV showed Mr A leaning towards the toilet before lying down on the floor. The viewer and cell hatch were fully opened and other staff, including an Arrest Intervention Referral Service (AIRS) worker, entered the cell and attended to Mr A in the presence of the HCP. An ambulance was called and Mr A was taken to hospital. He received treatment for his injuries and a mental health assessment before later being returned to police custody.

After Mr A was taken to hospital, PS B spoke with Inspector F about the next steps required in relation to an adverse incident. Inspector F questioned whether the matter constituted an adverse incident but PS B completed the relevant form and submitted it to the appropriate unit. PS B also reported seeing a small blade at the bottom of the toilet pan in the cell that had been occupied by Mr A. The blade was recovered by Inspector F and measured approximately 21 millimetres by eight millimetres. The recovered blade had likely been used by Mr A to self-harm

while in the cell, although it was not known where Mr A had concealed it. PS B added warning markers for 'conceals' and 'self-harm' to the NICHE record for Mr A for subsequent uploading onto the PNC.

The incident was initially dealt with informally by Inspector F before a DSI referral was made by the force's Professional Standards Department (PSD).

Type of investigation

IPCC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The force's 'Standard Operating Procedures (SOP)' for custody refer to the Safer Detention and Handling of Persons in Police Custody.

Recommendation 1

2. The force's custody SOP should refer to the APP. This superseded Safer Detention and Handling of Persons in Police Custody in 2012.

Finding 2

3. Inspector F advised PS B that the incident involving Mr A was not an adverse incident.

Recommendation 2

4. The force should make sure that there is an increased awareness with custody staff of the definition of an adverse incident, and that the correct reporting procedure to the PSD is followed.

Finding 3

5. PS B told the IOPC that he believed that the PNC and NICHE mirrored each other, so he only checked the PNC.

Recommendation 3

6. Custody staff should be reminded that information held on NICHE is not always replicated on the PNC, and that both systems should be checked when making risk assessments as set out in force custody policy.

Response to the recommendations

Local recommendations

Local recommendation 1

1. Custody SOP has been reviewed by the force. Reference to Safer Detention and Handling of Persons in Police Custody has been removed and replaced by reference to the APP. The revised version will be published online as soon as possible.

Local recommendation 2

2. A definition of 'adverse incident' was also added to make sure that all staff are aware. This was disseminated to staff via heads of custody and a weekly bulletin circulated to all operational custody staff.

Local recommendation 3

3. A reminder has also been shared to staff via the same methods that information held on NICHE does not always replicate information held on the PNC, and that officers should therefore review both systems.

Outcomes for officers and staff

Police Sergeant B

1. PS B was found to have no case to answer for failing to make sure that the risk Mr A posed to himself was sufficiently reduced.

2. It was alleged that he failed to:

    - place Mr A on a higher level of observation
    - explore and consider that Mr A disclosed that he was under the influence of alcohol
    - give sufficient consideration to Mr A's emotional state, responses to the risk assessment questions, and using personal knowledge of his previous behaviour and disclosures when dealing with him on a previous occasion
    - make sure that he conducted a robust review of information held on police systems
    - brief the HCP that Mr A required an assessment of his psychological wellbeing as well as the suspected physical condition
    - make sure that the search of Mr A was sufficiently thorough by requesting the use of a metal detector device
    - seize (or request a further search of) Mr A's coat, despite a rip in it being highlighted by the searching officer
    - make sure that a record of the search was noted on the custody record

3. No further action was taken in relation to PS B.

Detention Officer E

4. DO E was found to have a case to answer for misconduct for her failure to:

- conduct a thorough cell check on Mr A when she opened the vertical louvered cell door viewer and closed it again within less than two seconds
- seek medical assistance for Mr A and update the custody sergeant
- endorse the custody record with accurate information about Mr A's condition

5. The matter was dealt with through a misconduct meeting. DO E received a verbal warning which will remain for six months.

Questions to consider

Questions for policy makers and managers

1. Does your force remind officers to check both the PNC and NICHE when completing risk assessments?

2. What steps has your force taken to advise all officers and staff of the circumstances which constitute an adverse incident, and how these should be reported?

3. Where your force requires officers to routinely use hand held metal detectors, do you make sure that these are readily available to officers working in custody?

Questions for police officers and police staff

4. Are you aware of what constitutes an adverse incident and the correct reporting procedure in your force?