LEARNING THE LESSONS

Improving policing policy and practice

IOPC Independent Office for Police Conduct

CUSTODY

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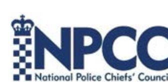

www.policeconduct.gov.uk

WELCOME

Alive to vulnerability: achieving better custodial practice

We have long recognised that those working in custody have an extremely challenging role to play in policing. The custody environment is busy and demanding, and officers and staff are often responsible for the welfare of people who are vulnerable and at-risk.

The case studies included in this issue reflect this, with themes including young people, mental ill-health, and substance misuse. Officers and staff in custody must be aware of different vulnerabilities and respond to each person individually so they can provide the right service.

In 2022/23, 23 people died in or soon after police custody, a worrying statistic referenced in the July publication of our annual report 'Deaths during or following police contact: Statistics for England and Wales'. Of these, eight were taken ill or were identified as unwell in a police cell. Five were taken to hospital where they later died, and three people died in a police custody suite. In this issue we explore learning around how we can prevent police-related deaths in custody in the future.

Other themes arising from cases in this issue include setting the right observation levels, searches, provision of healthcare, CCTV observations and cell checks, prevention of self-harm and suicide, children and young people, and the provision of appropriate adults.

Several cases in this issue also explore learning arising from searches in custody, including one where a woman was strip searched and which led to us making recommendations to both the NPCC and the force.

We recently brought together organisations including the College of Policing, the Children's Commissioner for England, and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services to discuss concerns around strip searches, specifically of children. We collectively considered the legislative and practical challenges around making sure children's wellbeing and safeguarding needs are met when police use these powers.

We also include examples of good practice in custody. The College of Policing's national roll-out of immersive training allows trainees to simulate busy custodial environments. It is akin to flight simulator training for pilots: trainees are immersed into a simulated busy custodial role and navigate their way through different scenarios and dilemmas based on real-life incidents. This innovative training helps officers and staff identify vulnerability and risk in the custody environment. You can read more about this on page 12.

We hope that the learning highlighted in this magazine helps to achieve better custodial policy and practice. As always, we welcome your feedback.

Thomas Whiting

Tom Whiting
Acting Director General, IOPC

Content warning

This issue contains descriptions of incidents involving mental health problems, domestic abuse, substance misuse (alcohol and drugs), child sexual assault, violence, self-harm, and suicide.

Reading this content can have a triggering impact.

Please see page 42 for organisations you can contact if you are affected by the content in this issue.

Key to case topics

- Custody and detention
- Mental health
- Neighbourhood policing
- Personal safety
- Professional standards
- Guidance

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Contact learning@policeconduct.gov.uk for more detail about the learning recommendations in the case studies in this issue.

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CONTACT US

030 0020 0096
enquiries@policeconduct.gov.uk
www.policeconduct.gov.uk
@policeconduct

Tackling obstacles to learning from police-related deaths

The Chair of the Independent Advisory Panel on Deaths in Custody discusses the significance of learning from deaths during and after police contact, improving policy, practice and preventing tragedies.

A core police duty is to protect lives and keep people safe. But when police action, or inaction, leads to the loss of life, it can shatter families, communities, and public confidence. Each death is made all the more devastating when lessons are not learned and embedded in policy and practice.

This issue has been brought to the fore by an alarming increase in police custody deaths over the past year. Twenty-three people died in police custody in 2022/23, more than double the number of deaths in the previous 12 months and the highest figure in five years. Of the 23 people who sadly died, 13 of them had mental health concerns.

The total number is significantly higher when looking at all deaths following police contact. It raises concerns about a lack of multi-agency partnerships in responding to mental health crises and an inconsistent approach to sharing learning, both proactively and systematically.

The Independent Advisory Panel on Deaths in Custody has the sole purpose of advising ministers and senior leaders on how they can meet their human rights obligations to prevent the deaths of those in their care. Last year, we published a report on preventing deaths during and after police arrest. Our objectives were simple: to provide evidence of good practice across police forces and to demonstrate how learning can be derived and embedded to prevent deaths.

You can read the report here: www.iapondeathsincustody.org/news/2022/12/1/avoidable-deaths-in-police-custody-more-can-be-done-to-protect-lives-says-iapdc

Our consultation with Police and Crime Commissioners found examples of partnerships between police and health services to make sure people experiencing a mental health crisis receive appropriate and timely support. This includes schemes such as street triage; a collaborative approach between relevant services to respond to individuals in crisis. This took different forms across force areas. We found examples of gathering, implementing, and disseminating learning; processes which are vital to avoiding repeat deaths But while these practices are well established in some police areas, they are patchy or non-existent in others.

Bereaved families often make clear their hope that lessons are learned from the deaths of their loved ones so that no other family has to experience what they have. In our report, we made recommendations to help standardise and improve how police forces learn from deaths, and how bodies including the Independent Office for Police Conduct, College of Policing, and National Police Chiefs' Council can help facilitate this.

Sharing and embedding learning from police-related deaths

New initiatives at a national level in policing must be informed by robust evidence and evaluation. Police forces should understand and share learning from a death at the earliest possible stage. Relevant reports from coroners and the IOPC should be shared within and between forces and learning from such deaths should be embedded into training. Forces should also engage meaningfully with bereaved families and actively integrate their views into the learning process. Learning can also be derived from near misses, and data and findings should be collated and shared from these incidents to inform necessary changes to policy and practice.

On the frontline, staff should actively create relationships with healthcare partners and other relevant bodies to enable services to play to professional strengths. All staff should adopt an open and proactive approach when responding to deaths to make sure learning is used for the purpose it is intended – to improve policy and practice and avoid future tragedies. ■

Lynn Emslie is Chair of the Independent Advisory Panel on Deaths in Custody.

College of Policing Authorised Professional Practice: Observation levels in custody

Level 1: general observation

Following full risk assessment, this is the minimum acceptable level of observation required for any detainee.

Level 2: intermittent observation

Subject to medical direction, this is the minimum acceptable level for detainees who are under the influence of alcohol or drugs, or whose level of consciousness causes concern.

Level 3: constant observation

If the detainee's risk assessment indicates a heightened level of risk to the detainee (for example self-harm, suicide risk or other significant mental or physical vulnerability) they should be observed at this level.

Level 4: close proximity

Detainees at the highest risk of self-harm should be observed at this level.

For more information, including the actions required for each observation level, visit:
www.college.police.uk/app/detention-and-custody/detainee-care/detainee-care

photo: Alamy

CASE STUDY 1

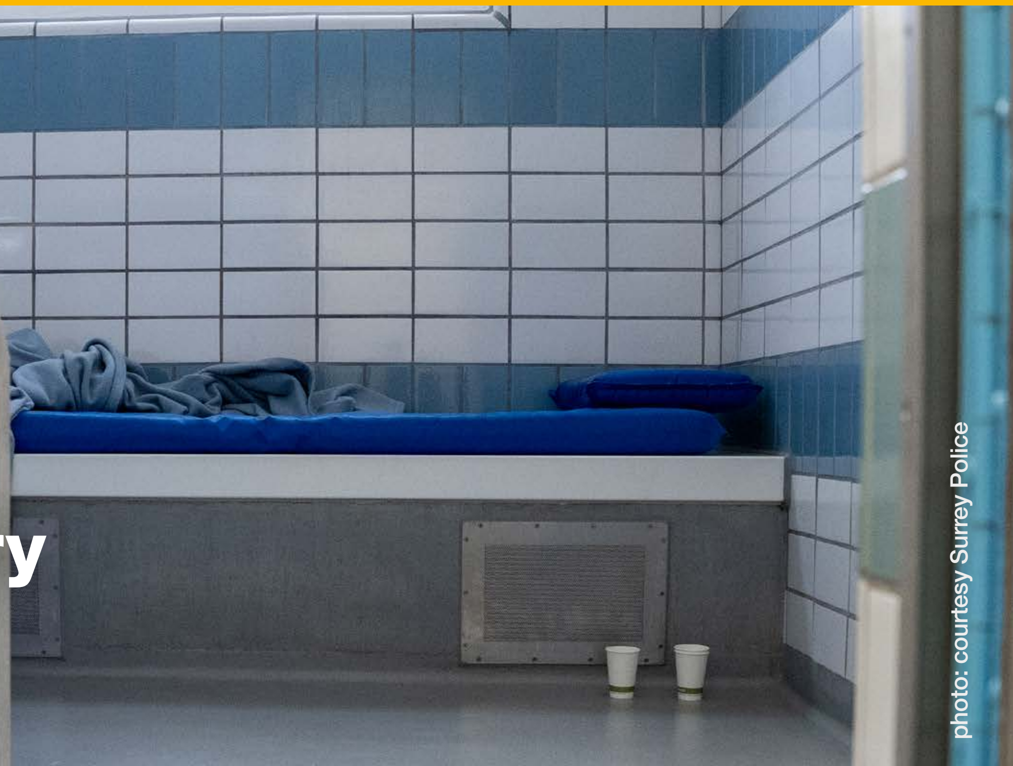


photo: courtesy Surrey Police

Risks of plastic cutlery left in a custody cell

This case was locally investigated by the force. The IOPC then conducted a review of the investigation to decide whether there was indication of serious misconduct, a criminal offence, or an opportunity for learning.

A man was arrested on suspicion of sending malicious communications and taken into custody. During the booking-in process, the man told the custody sergeant about his history of poor mental health, self-harm, and suicide attempts. The man also disclosed current suicidal thoughts and a specific intention of how he wanted to take his own life. The man noted he was on medication for his mental health.

The custody sergeant attached suicide and self-harm warning markers to the man's custody record and noted his previous self-harm attempts in custody. Despite the self-harm risk, the custody sergeant placed the man on level one observations with checks required every 30 minutes. The man was also provided with custody trousers. The custody sergeant's rationale for the observation level was that the man's preferred method of self-harm was not possible in custody. She believed he presented as '*helpful and converse*' and believed his medication would help him deal with stressful situations. The IOPC review noted in this circumstance, the man should have been placed on level three observations as a minimum.

After his criminal interview, the man was returned to his cell and was given a food box. This contained a plastic 'spork'; a cross between a spoon and a fork commonly used in custody. The spork was not removed from the man's cell after he finished eating. This was not in line with the College of Policing's Detention and Custody Authorised Professional Practice (APP) which states '*all items connected with meals and drinks should be removed from cells immediately after use to prevent them from being used to cause injury or damage*'.

The man became agitated two hours later and was abusive towards staff. As a result, his cell buzzer was silenced for 30 minutes. This meant he could not get the attention of custody officers but could continue to be monitored via CCTV.

Ⓖ College of Policing Detention and Custody APP: Detainee care

Where a detainee has persistently used the cell call system to gain attention with no genuine need, the custody officer responsible for that detainee may decide to switch off the call system for that cell for a short and limited time.

When this course of action is taken, the custody officer must mitigate the increased risk by implementing control measures. These may include moving the detainee to a cell with CCTV where they can be continuously monitored or increasing the level at which they are being monitored.

More information
www.college.police.uk/app/detention-and-custody/detainee-care/detainee-care

Around 30 minutes later, a custody officer saw the man on CCTV '*messing with something in his hands*'. He went to check on him and noted the man was '*abusive and aggressive*' during this interaction. CCTV footage from the cell showed the man pacing up and down and periodically kicking the cell door. He also appeared to be sharpening the spork which he still had from his meal box. This was not noticed by custody staff.

Following the custody officer's departure, CCTV showed the man using the spork to dig the elastic out of the waistband of his custody trousers. The IOPC review noted that although the man spent a lot of time doing this, there were no notes about it in the custody record. The man was able to use the spork to undo the stitching and successfully removed the elastic to make a noose. He then tightened the noose with the spork.

With the noose around the man's neck, he fell from his mattress and appeared to lose consciousness. The custody officer saw on CCTV that the man was face down on the floor and rushed to the cell to remove the elastic from his neck. The man regained consciousness and sat up. Soon after, a paramedic arrived to check over the man. He was considered fit to stay in custody.

The man was upgraded to level four close proximity observation for the rest of his time in custody. Arrangements were made for the man to be detained under Section 136 of the *Mental Health Act* from custody, and taken to a place of safety for assessment. ■

You can call the Samaritans 24/7 helpline for free on 116 123 if you have been affected by this case and would like support. You can also email jo@samaritans.org, or visit www.samaritans.org

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How does your force make sure custody staff comply with APP and remove cutlery from cells after use?
- What steps does your force take to highlight risks about cutlery left in cells, including when a person is at risk of self-harm or suicide?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What key factors do you consider when deciding the appropriate level of observation for an individual?
- How do you make sure a person is not left with cutlery in their cell for longer than necessary?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

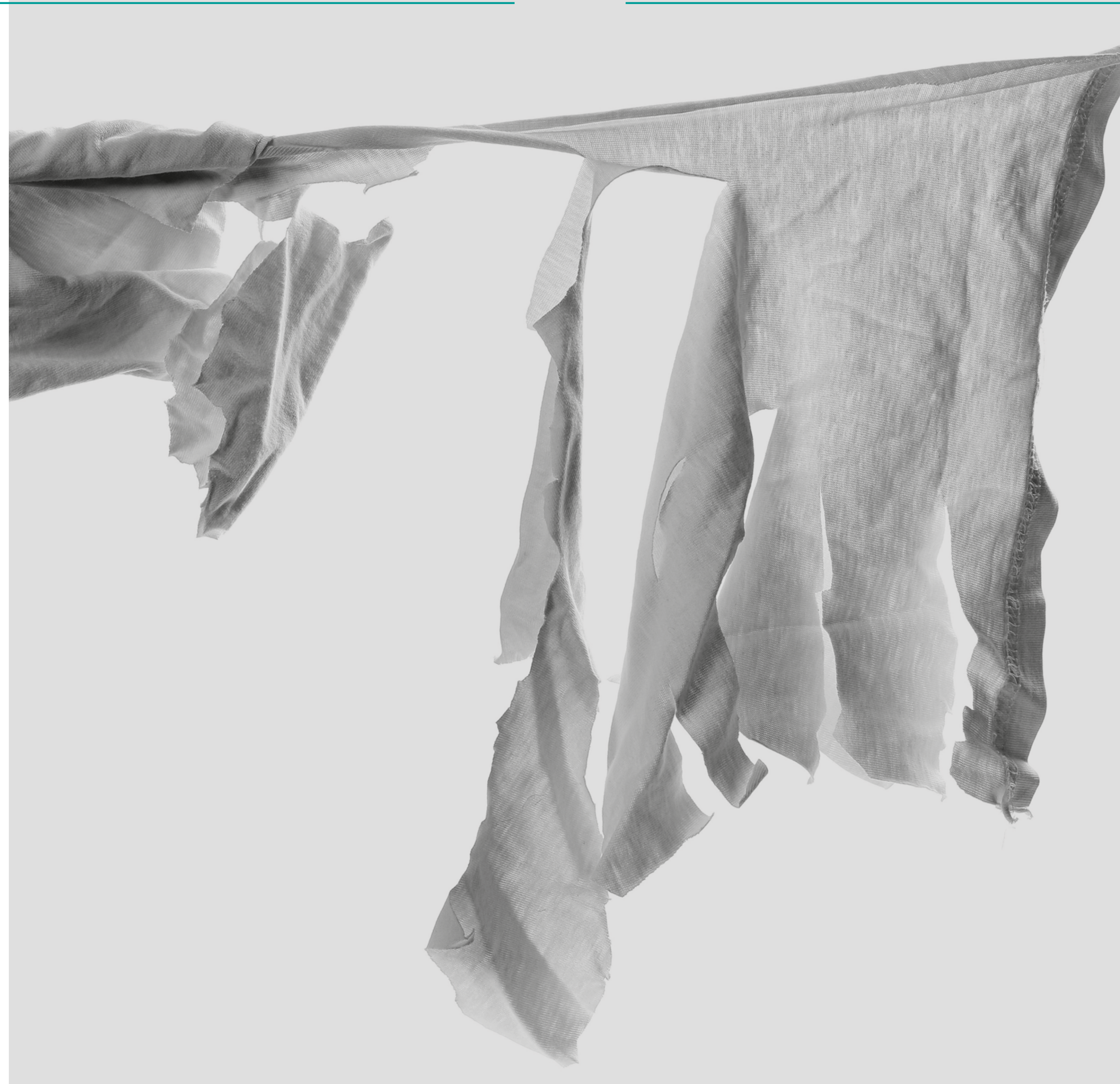
- The IOPC issued two learning recommendations around the risk of cutlery left in cells.
- One learning recommendation was issued nationally to the National Police Chiefs' Council (NPCC). It asked force custody leads to remind staff of the detention and custody APP on cutlery, and to review their policies and procedures to clarify what staff should consider when providing cutlery to a person who is at risk of self-harm or suicide. The NPCC circulated the recommendation to all heads of custody and chief constables.
- The second recommendation was issued to the force. This asked them to make sure custody officers were made aware of the risk of leaving cutlery in cells and asked them to review custody policies to clarify guidance around providing cutlery to people at risk of self-harm or suicide. The force delivered further training to custody officers and updated their procedure to cover the removal of sporks when they are no longer required. They also now include reminders to remove items from cells in a regular publication circulated amongst custody staff.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC's review, there was no indication any individual may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Anti-rip clothing in custody: minimising use and safer practices

The Independent Custody Visiting Association highlight concerns about the use of anti-rip clothing in custody, and action forces can take today.



A top priority in police custody is the safety of detainees. There is a balance needed on how that safety is best achieved, which can conflict with cultural and operational issues in policing. Anti-rip clothing is a tool available in many custody suites and highlights the cross-section of that conflict.

The Independent Custody Visiting Association (ICVA), the membership organisation for custody visiting schemes, has duties under the UK's international human rights obligations to contribute to the prevention of degrading treatment of detainees. As part of this, ICVA has focused on the use of anti-rip clothing in custody and found there is significant work required to increase oversight of the use of anti-rip clothing, and to prevent unsafe practices.

Anti-rip clothing in practice

Anti-rip clothing is intended to remove the risk of people creating a ligature out of their own clothing to cause harm to themselves. In practice, anti-rip clothing itself creates a number of issues around safety and dignity.

ICVA reviewed available evidence on the use of anti-rip clothing in custody. It uncovered serious issues around the proportionality and justification of its use and detainee dignity. Poor practices included forced use of anti-rip clothing in the absence of risk information, often on people who were perceived as '*difficult*', and sometimes in a punitive manner.

ICVA and Dyfed-Powys Police: A pilot approach

Over the past year, ICVA, in collaboration with Dyfed-Powys Police, have led a pilot to enable progress towards addressing safety issues locally and nationally. The pilot aims to remove the use of anti-rip clothing in the absence of risk information, and to increase the quality of recording practices in forces.

Following an interim evaluation of the ongoing pilot in Dyfed-Powys Police, ICVA made a series of recommendations to the Home Office, National Police Chiefs' Council and the College of Policing. Themes included availability of data, reporting practices, and updates to national guidance.

You can read more about the pilot and recommendations made here: https://icva.org.uk/anti-rip-clothing-an-interim-evaluation-of-the-joint-pilot/.

The future of anti-rip clothing in custody

Based on the evidence, ICVA is calling for the removal of the use of anti-rip clothing at a national level, in favour of effective observations, harm minimisation and de-escalation techniques. Already some large forces do not use anti-rip clothing, including the Metropolitan Police Service and Thames Valley, Leicestershire and Kent Police.

While there is more work needed, there is progress to be celebrated and increased awareness across custody and with key stakeholders around anti-rip clothing. Eight additional police forces have expressed interest in improving their own recording practices around anti-rip clothing, and ICVA are providing support by sharing information and resources. Four of these forces now have a form of scrutiny in place around the use of anti-rip clothing with the aim of improving recording and reducing problematic uses. ■

"As a result of the work undertaken by ICVA and Dyfed-Powys Police, the College of Policing were able to update its Authorised Professional Practice (APP)… this update provides clarity on when the use of anti-rip clothing is appropriate and when it is not."

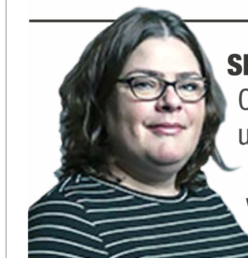
Tony Maggs
Custody lead, College of Policing

"The findings of this report are welcomed with the work supporting a number of the principles of the [National Police Chiefs' Council] Custody Strategy."

Nev Kemp
Custody lead, National Police Chiefs' Council

"We are currently undertaking detailed policy work relating to the removal of clothing by police, including whether amendments to the PACE codes may be required. A proposal for data on the use of anti-rip clothing to be added to the Home Office's annual data requirement for police custody is currently under consideration."

The Home Office



Sherry Ralph is Chief Executive Officer of ICVA. ICVA volunteers make unannounced visits to police custody to check on the rights, entitlements, wellbeing and dignity of people in police custody.

CASE STUDY 2

Missed opportunity to use a metal detector wand

This case was locally investigated by the force. The IOPC then conducted a review of the investigation to decide whether there was indication of serious misconduct, a criminal offence, or an opportunity for learning.

A police officer attended an incident where a man had fallen over in the street. Ambulance staff examined the man and confirmed he did not require medical treatment. The man was identified as homeless.

The police officer conducted a Police National Computer check. This revealed the man had failed to attend court and a warrant had been issued for his arrest. The police officer arrested and searched the man. He found multiple syringes in the man's pockets. The man was not placed in handcuffs as he was compliant.

A van was arranged to transport the man to custody. In his account, the police officer noted he roused the man several times during the journey as he was slumped forward.

At the custody suite, the police officer told the custody officer about the syringes. He suggested a metal detector wand would be needed to check the man.

The custody officer had no recollection of this conversation. CCTV showed the custody officer retrieving the metal detector wand. However, he failed to use it. The custody officer later accepted he should have used a metal detector wand to check the man, but he believed it would have been safer to search the man's clothing after he had removed them.

A custody sergeant then conducted a risk assessment and placed the man on level two observation with rousing checks every 30 minutes because he believed the man was under the influence of a substance. He also requested a healthcare professional (HCP) examination.

The man was given safety clothing as his clothes were wet and he had told custody staff he felt suicidal. He was escorted to the cell where he changed in the presence of two custody officers.

Shortly after, cell CCTV footage showed the man removing an item from his buttocks and getting into bed. Around 17 minutes later, the man was found unresponsive following a suspected opiate overdose. A metal spoon was removed from the man's hand. The HCP administrated an injection of naloxone to counter the effects. The man regained consciousness and was taken to hospital.

It could not be determined if the drugs were ingested while the man was in custody. However, during the force's investigation into the incident, a test found that if the metal detector wand had been used, the metal spoon would likely have been detected which could have identified concealed drugs. ■

You can call the Samaritans 24/7 helpline for free on 116 123 if you have been affected by this case and would like support. You can also email jo@samaritans.org, or visit www.samaritans.org

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- What guidance or training does your force have to make sure custody staff use metal detector wands to complement searches of people in custody?
- How does your force ensure officers and staff are aware of the risks to the safety of detainees and staff if concealed items are not identified?
- How does your force monitor the use of metal detector wands in custody?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What steps do you take to retain and record information shared with you by arresting officers?
- What steps do you take to routinely use metal detector wands when searching people in custody?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued two learning recommendations around the use of metal detector wands in custody.
- One learning recommendation was issued nationally to the National Police Chiefs' Council (NPCC). It asked force custody leads to review their policies, procedures and training to make sure metal detectors are used as part of all searches when booking people into custody if safe to do so. The NPCC circulated the recommendation to all heads of custody and chief constables.
- The second recommendation was issued to the force. It asked them to review their policies and training in line with the recommendation made to the NPCC. Custody staff should also be made aware that metal detectors do not replace the need for a thorough search. The force implemented a new policy which notes metal detector wands should be used to complement searching people in custody. They have also placed metal detector wands in all police vans, as well as the van bays of each custody suite. Posters outline that metal detector wands should be used for all people entering custody, and daily checks are in place to ensure they are in place and working.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC's review, there was no indication that any individual may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

! Important update - IOPC national learning recommendation on metal detector wands

We issued a national learning recommendation since this incident to the National Police Chiefs' Council (NPCC) around the use of metal detector wands. It followed a separate incident the IOPC investigated in which a detained person entered custody with a gun.

A man had been stopped and searched, arrested, and transported to custody. Officers prepared to search the man with a metal detector wand when he produced a concealed gun, which had not been found during an initial search. While still handcuffed, the man fatally shot the custody sergeant.

We recommended the NPCC consider the implementation of handheld metal detectors or search wands in all response vehicles and vehicles used to transport detained people. We believe this will help officers find concealed metallic items or weapons at an earlier stage and improve officer safety. We also recommended the NPCC consider:

- Evidence regarding instances where metallic items or weapons concealed upon detained persons have been brought into custody suites.
- Policies, guidance or training that need to be developed or updated to ensure the effective implementation and use of handheld metal detectors by officers.
- The financial implications and any potential unintended consequences of implementing handheld metal detectors, including how these might be mitigated.

The NPCC accepted the recommendation. Many forces have already issued handled metal detectors to officers assisting with searches outside of custody. The NPCC and others are working together to inform the Chief Constables' Council of the financial implications. They have suggested similar outcomes could be achieved if a wand search took place at a police station but before entry to custody.

The College of Policing's new 'Vulnerability in Custody' training

photo: courtesy Surrey Police

A new immersive training package allows trainees to simulate busy custodial environments, allowing officers to navigate their way through different scenarios. **Tony Maggs** discusses the new training and why every contact made in custody matters.

Taking away a person's liberty is the state exercising its most extreme powers. Police custody is where we investigate, probe, secure and preserve evidence, and where we do our best for victims and witnesses. It is also a place where we deal with incredible vulnerability, with people experiencing a wide range of issues which may affect their time in detention. How officers and staff deal with people really matters. Policing sets the tone, and the attitudes and behaviours of staff affects the attitudes and behaviours of those in custody.

People working in custody hold critically important positions within policing. Detention officers, custody sergeants and custody inspectors are all involved daily in looking after vulnerable people. Decisions made by custody sergeants can only be overturned by a superintendent, demonstrating the incredibly powerful position they fulfil. But with great power comes great responsibility, and policing must be careful with that power. Treating people in custody fairly, with professionalism and courtesy, must be a priority.

"My big hope for those that do the training is that they leave feeling that they've really been tested. They've had to stop and think, that they understand that their decisions and their actions have a direct impact on what happens in custody and, importantly, the safety of those within custody."

Deputy Chief Constable Nev Kemp QPM, NPCC custody lead

Introducing the 'Vulnerability in Custody' training package

The College of Policing was asked by the National Police Chiefs' Council (NPCC) to develop a one-day 'bolt on' package for forces to deliver at the end of custody sergeant and detention officer training. It is designed to embed theoretical and legal learning in an immersive format. The training is used in a Hydra suite; an environment created to simulate realistic experiences. The training is also available in classroom format for forces that do not have access to a Hydra suite. The training emphasises that every interaction matters, and every contact with every person in custody leaves a trace.

Immersive learning is akin to flight simulator training for pilots. Trainees are immersed into a simulated busy custodial role and navigate their way through different scenarios and dilemmas based on real-life incidents. It encourages awareness and understanding of key risks posed in custody, including the identification of a range of vulnerabilities. Information comes into trainees in a variety of formats, including film clips and documents containing information about the people in their care.

Staff undertaking the training use the National Decision-Making model develop rationale for decisions, and document those decisions. The training allows trainees to explore such decision-making in a training environment with their peers, including discussing decisions made, and reflecting on their approach.

Accessing the training

This training is being rolled out nationally to all forces. All custody professionals within policing should undertake this training. It is suitable for both new-to-role staff, and as a one-day continuous professional development (CPD) module. ■

Tony Maggs, lead for custody, College of Policing.

CASE STUDY 3

Use of a spit guard after an incapacitant spray

A complaint was locally investigated by the force. The complainant exercised their right to appeal to the IOPC following the force's investigation. Following the IOPC's direction of a force re-investigation, the complainant exercised their right to appeal again.

A man was arrested on suspicion of grievous bodily harm and making threats to kill.

He was asked to provide fingerprints once in custody. He became *"aggressive, abusive and threatening"* and refused to cooperate with officers.

The man did not comply with communication techniques that were used to try to defuse the situation. An officer took hold of the man's arm to gain his compliance. CCTV showed a struggle with two officers trying to take the man to the floor. The man resisted and remained on his feet. One officer sprayed the man with incapacitant spray in close proximity. He was then handcuffed with his hands behind his back.

Force policy indicated that incapacitant spray should be *'used at a distance of between 3-10 feet from the subject'* but noted it could be used closer than three feet if *'necessary and proportionate'*. The officer did not justify his reasons for using the incapacitant spray closer than three feet.

> **The IOPC's consideration of the appeal believed it was unreasonable for the man to be left in a spit guard after use of an incapacitant spray for this length of time**

The man started spitting after the discharge of the incapacitant spray and was placed in a spit guard. A spit guard is a breathable, mesh material which covers the face and head to prevent someone from assaulting officers by spitting. The man's face was first wiped due to the amount of saliva.

A technical issue with the fingerprint machine meant the man waited for an hour until it started working.

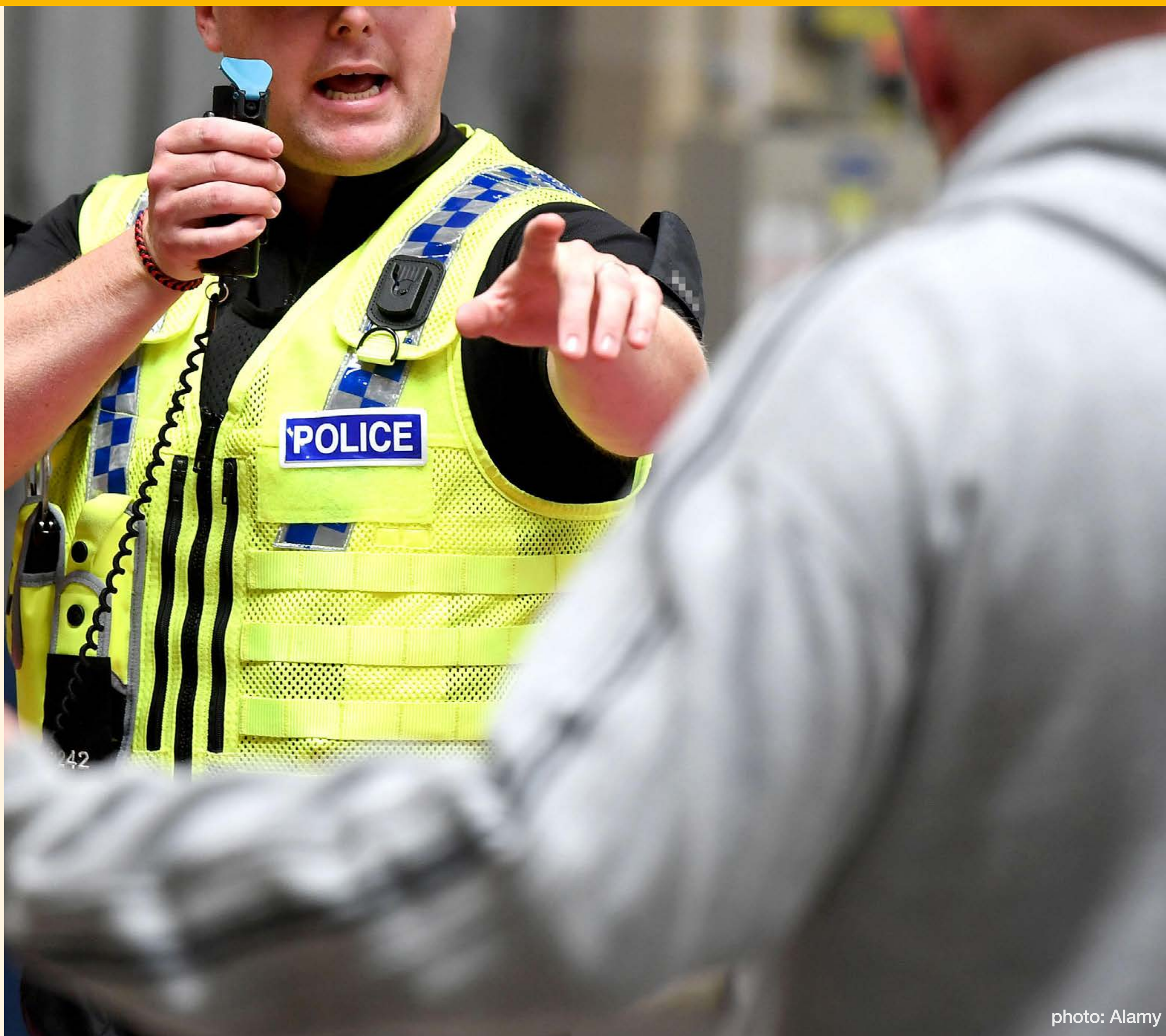


photo: Alamy

The IOPC's consideration of the appeal believed it was unreasonable for the man to be left in a spit guard after use of an incapacitant spray for this length of time. This may have extended the man's discomfort caused by the close proximity of the incapacitant spray. Officers had gained compliance of the man after about ten minutes.

The IOPC's consideration of the appeal explained that the force policy in place at the time did not state that a spit guard cannot be used after an incapacitant spray is used. However, the appeal found that the man was not directing his spit at an officer, nor did any officer fear he would spit at them. Therefore, the use of a spit guard was *'disproportionate and unnecessary'*.

The man was taken to a cell where he refused to go to his knees for officers to remove the handcuffs. Officers took the man to the ground and the handcuffs were removed. The second officer, in his haste to leave the cell, forgot to remove the spit guard. CCTV showed that seconds later the officer returned to the cell and removed the spit guard. ■

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How does your force make sure staff understand the risks associated with incapacitant spray?
- What policies, guidance or training does your force have around the use of spit guards after incapacitant spray is used?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What precautions do you take to ensure the welfare of a person after using incapacitant spray?
- What risks do you consider before using a spit guard?
- How do you make sure someone is not left in a spit guard for longer than necessary?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued two learning recommendations around the use of spit guards.
- Both learning recommendations were issued to the force. They asked the force to review their policy for cell extraction and the removal of spit guards, and to review their policy about the use of a spit guard after an incapacitant spray has been used. The force updated their policy to ensure staff are aware that the use of a spit guard can lengthen the effects of incapacitant spray. This means further monitoring of people in custody is required. The policy now also highlights the need for a safety officer to be present during a cell extraction to make sure that a spit guard is removed before someone is left alone.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The force indicated the officer's failure to justify using incapacitant spray within three feet of the man would have resulted in unsatisfactory performance with the requirement of additional training. The officer retired before the appeal was complete.
- During the IOPC's consideration of the appeal, there was no indication any police officer had committed a criminal offence or had behaved in a manner that would justify the bringing of disciplinaryproceedings. However, the IOPC partially upheld the appeal in two areas; in relation to the unreasonable length of time the man was left in the spit guard after incapacitant spray, and in relation to the failure to initially remove the spit guard. The IOPC would have subjected the retired officer to additional training.

Honest insights from a Detention and Escort Officer

photo: courtesy Surrey Police

West Midlands Detention and Escort Officer (DEO) **Mark Bryan** answers our questions, discussing the challenges of his role and how using learning is key to good custodial practice.

What three words best describe your role?
Challenging, intense, demanding.

What is the most challenging part of your role?
The environment I work in is unpredictable and can involve confrontational situations. I need to act quickly and use my initiative to respond to an array of situations; including those that result in the need to use physical restraint on people in custody who act aggressively or violently. I need to be able to empathise, communicate effectively and use sensitivity to respond to people in custody who are at risk of self-harm or suicide, have mental health concerns, or who engage in substance misuse.

Working under pressure within a small team can also be challenging. Aside from responding to live incidents, we have regular deadlines to meet to make sure we fulfil the needs of people in custody, including regular visits to cells to ensure their welfare, provide meals, and co-ordinate visits.

How do you keep up to date with training to fulfil your duties?
Emails remind me when training is due, and we have yearly personal safety training courses which incorporate first aid refresher training.

We also complete eight training days a year to review new policies and procedures. This often involves additional input and talks from people with different areas of expertise including mental health, religion, and immigration. Training days help us to identify issues and the needs of people coming into custody. I also personally seek out additional courses through outside agencies to improve my knowledge.

A recent training day around mental health compelled me to study a level three diploma in self-harm and suicide prevention. This has given me a greater understanding of key issues which benefit my role, while gaining a recognised qualification.

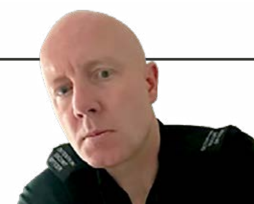
Can you describe a change to policy or practice which has improved your ability to fulfil your duties?
Three come to mind:

1. Reducing the number of people in custody on level three observations that a member of staff can watch on CCTV at any given time. This has improved our ability to conduct more thorough observations. People in custody on level three observations are often the most vulnerable, so by focusing on monitoring a smaller number of people, we are able to complete more effective observations to keep people safe.

2. The practice of using Digital Person Escort Records online instead of paper forms has improved the quality of the handovers we provide to colleagues and external agencies. Using online records means important risk markers and other risks associated with the movement of a person cannot be bypassed. This reduces risks associated with moving people from custody to court. It also allows us to be more effective in ensuring the safety of the person in custody and the staff transporting them.

3. The custody system we now use has improved our efficiency by alleviating the volume of physical storage required and reducing the risk of lost or damaged physical records.

How does your force share learning with other custody suites?
Our force uses *Learning the Lessons* magazines to share learning, and we regularly engage with other forces to identify key issues such as ligature risks and concealed weapons which can benefit collective understanding. ■



Mark Bryan is a Detention and Escort Officer for West Midlands Police.

CASE STUDY 4

Failure to rouse an intoxicated man during transportation to custody

This case was independently investigated by the IOPC.

A police officer and a police community support officer (PCSO) stopped a man and a woman pushing a shopping trolley full of alcohol. The officers suspected the items were stolen as the man and woman were known to the police for previous shoplifting and drug offences. They were unable to account for the items and were arrested on suspicion of theft.

The woman was compliant and was placed in a police car. The man was non-compliant and pushed the trolley into the river nearby. Officers were concerned the man could become violent and requested assistance. The police officer did not have handcuffs as she had used them during an arrest earlier that day, so decided to take the man to the ground on his front. This involved use of restraint and repeated strikes to his legs.

The College of Policing's Detention and Custody Authorised Professional Practice (APP) states that when a person is being restrained, they *'should be placed on their side or in a sitting, kneeling or standing position as soon as practicable'*. During the IOPC investigation, the police officer stated she did not know how to effectively restrain someone on their side without handcuffs. Body worn video of the officers showed the man restrained on his front for six minutes.

More officers arrived at the scene and handcuffed the man. The man was searched, and a needle was found in his pocket. There were warning markers on the man's Police National Computer record that he was a drug user with known history for heroin use. Despite this, the police officer stated that she suspected the man *'to be intoxicated due to alcohol only'*.

The man was placed in the back of a police van. The two transporting officers also assumed the man was drunk. They decided to take him to custody. The journey took 53 minutes as there was no custody suite in the local area. Transporting officers said that the man was *'alert and responsive'* during the journey, and they could see him breathing. CCTV showed the man lying on the van floor appearing to be asleep throughout the journey. There were no attempts by officers to rouse the man and no force policy in place around rousing checks during transportation.

At the same time, the woman was transported to the same custody suite in a separate vehicle. During the journey the woman told an officer that she had taken *"white and brown"* (slang for heroin and crack cocaine) with the man around two hours before they were arrested. This information was not passed to the custody suite before they arrived.

Once at custody, officers accompanying the man tried to rouse him in the van dock. He was asked to stand up. He made no effort to do so and was held up by officers in a sitting position. The man appeared unresponsive and was asked if he had taken any drugs. His response was incoherent.

(G) College of Policing Mental Health APP: Moving and transporting detainees

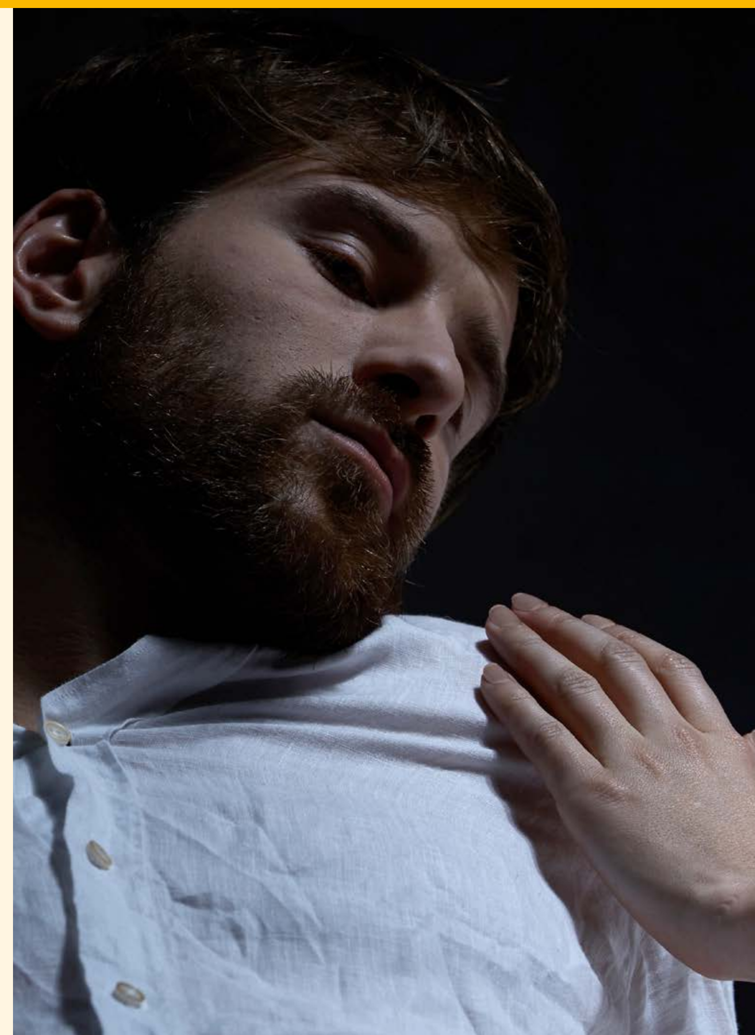
Officers responsible for any movement of a detainee should be fully briefed on any heightened risk or increased vulnerabilities that have been identified for that detainee prior to departure. There must be constant supervision and monitoring if officers and staff have any concerns relating to the detainee's physical or mental health…

An ambulance must be called for any detainee who appears to be unconscious or requires urgent medical assessment.

More information
www.college.police.uk/app/detention-and-custody/moving-and-transporting-detainees

The arresting officers then informed the custody sergeant of the drug use by the man and woman. The custody sergeant assessed the man's responsiveness in line with first aid training. The custody sergeant did not have access to a healthcare professional (HCP) at the time, so sat the man in a wheelchair to observe his medical condition himself. The custody sergeant concluded that as the man was still conscious and breathing, but not alert, his condition was *'not a critical emergency'* but decided to phone ambulance services for advice.

Multiple officers tried to rouse and engage with the man over the next few minutes. One officer attempting to rouse the man stated that *'his eyes were in the back of his head and bright red'*. The man remained unresponsive.



The custody sergeant called an ambulance approximately 13 minutes after the man's arrival in custody. Officers followed instructions by ambulance staff over the phone to give the man CPR and chest compressions. Shortly after, paramedics arrived and took over medical care.

The man was taken to hospital and treated for a stroke, drug overdose and alcohol excess. It was noted on medical records that multiple wraps had been ingested by the man causing opiate toxidrome; a set of symptoms caused by opioid overdose. The following day he was released from hospital and returned to custody. ■

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- What policies and guidance are in place in your force to ensure the safe transportation of people to custody, including observation levels and rousing checks?
- What steps does your force take to make sure HCPs are available where required?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- Do you feel confident to restrain someone effectively and safely without handcuffs?
- Are you aware of the risks associated with restraining a person on their front, including positional asphyxia?
- What steps should you take to appropriately monitor and assess the condition of someone during transportation to custody?
- As an arresting officer, what steps do you take to share information about a person's welfare before they arrive in custody?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued three learning recommendations around transportation to custody.
- All recommendations were issued to the force. They suggested new guidance and training for transporting people to custody, observing people during transportation (including implementing rousing checks) and ensuring arresting officers share risks with custody staff before arriving. The force created bespoke training for their detainee transport team and further training for PCSOs to assist with detainee transport. They also introduced a new process which requires arresting officers to call and update custody suites before bringing someone into custody and are currently developing a new detainee transport policy.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC's investigation, there was no indication that any individual may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.
- However, the two arresting officers received management action outside of the formal disciplinary process around the use of force and the way the man was initially restrained on the ground during his arrest.

Resources for identifying vulnerability in custody

New resources can help professionals in police custody to identify and act on 'PACE vulnerability'. **Chris Bath** from the National Appropriate Adult Network (NAAN) discusses.

photo: Alamy

A key challenge in police custody is identifying people who require additional support. Police must secure an appropriate adult (AA) if there is any reason to suspect that someone may be a 'vulnerable person' under the *Police and Criminal Evidence (PACE) Act 1984* statutory codes.

Evidence suggests that only 7% of adults in custody are recorded as requiring an AA, while 39% have a mental health condition or learning disability. Police secure an AA for only one in five who are assessed as vulnerable by NHS England liaison and diversion services when in custody.

Understanding 'PACE vulnerability'

'PACE vulnerability' has a specific and complex legal definition. Broadly, it arises through a combination of the context of detention and questioning, and personal factors including neurodiversity, mental health or learning disabilities.

Failure to identify and address people's needs risks breaching both PACE and equality legislation. It jeopardises people's rights, welfare, and effective participation. It compromises the efficiency, effectiveness, and legitimacy of custody and investigations, and increases the likelihood of unjust outcomes and unsuccessful prosecutions. Police forces need to equip officers with the right support, training, and tools to identify PACE vulnerability, even where resources are tight.

Taking action

The need for a just and inclusive criminal justice system is widely recognised. Policing is becoming more aware of vulnerability in general and has embraced initiatives around some specific conditions. However, the identification of PACE vulnerability and application of the AA safeguard remain a significant risk. Forces can take immediate steps to raise the visibility of the issue and support the development of officers and staff using new resources from NAAN.

NAAN tools and resources

1. Vulnerability identification tracker

The tracker uses data from custody IT systems to monitor the monthly recorded identification of PACE vulnerability over time. Users compare data against other forces and national averages. Forces use the tracker to drive internal discussions, support engagement with stakeholders, and measure the impact of improvement initiatives.

> ***"I am incredibly impressed and grateful for the vulnerability videos and vulnerability tracker on your website. They are so good that I have instructed our training team to use [them] exclusively on the custody officer course… the critical concepts that you cover percolate across the policing profession."***
>
> **Inspector Anton Menzies,**
> Custody Performance and Governance,
> South Yorkshire Police

The tracker is maintained by NAAN. Data on AAs is now included in the National Police Chiefs' Council Custody Performance Framework and the Home Office annual data request.

2. Training videos

NAAN has created three training videos in collaboration with Dr Roxanna Dehaghani (Cardiff University) which explain the importance of PACE vulnerability, its legal definition, and the roles of different professionals in identifying and acting on it.

The videos are designed for those working in a custody environment. They are recommended resources for police officers, police staff and healthcare professionals. ■

Visit https://www.appropriateadult.org.uk/ for free, online access to the tracker and videos.

Chris Bath is Chief Executive of the National Appropriate Adult Network. NAAN was set up to improve the effectiveness of the appropriate adult safeguard.

CASE STUDY 5

Police response to an autistic, non-verbal young adult with epilepsy

This case was independently investigated by the IOPC.

A woman called the police to report that her 19-year-old son had just been released from hospital and needed to be sectioned. She explained that her son had a fight with his father.

The family were visiting relatives in a different force area. The woman said she required urgent help from the police to take her son to the local psychiatric unit. She explained that she would usually call their local police force to take him to a unit near their home.

Two police officers arrived at the house. Due to the force's *'crime before capacity'* approach which indicated arrest and detention of a person should take place first, and then the person can be assessed at custody, the officers advised they needed to prioritise arresting the young adult. Officers decided that any mental vulnerabilities would be followed up in custody.

The officers tried to explain to the young adult that he was being arrested. Police had been advised that the young adult had autism and severe learning disabilities, and he did not appear to understand what was said to him.

After failing to communicate effectively, one officer placed his hand on the young man's arm, resulting in extreme distress and resistance. Officers then detained him using manual restraint, incapacitant spray and two sets of handcuffs. Four other police officers were called for back up during the arrest and took statements from his parents.

The young adult's parents expressed concerns about the force used by the two officers during the arrest, and for their son's welfare. They told officers their son had epilepsy, learning disabilities, was non-verbal and had the mental age of a two to four-year-old. Officers advised the parents they would require proof of lack of capacity for their son and that he needed to be *"arrested for domestic assault until his non-capacity could be established by a mental health professional"*.

This contradicts the College of Policing's Mental Health Authorised Professional Practice (APP) which states: *'If an officer or member of police staff has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, they should treat the person as such in the absence of clear evidence to dispel that suspicion.'*

Ⓖ College of Policing Mental Health APP: Mental vulnerability and illness

Decision making concerning health care matters should be made by clinically trained professionals and not police officers. When police officers are called to respond to a situation involving a mentally vulnerable person, it is important that they have access to relevant information that may inform risk management...

Parents, carers, family or others who know the individual experiencing mental ill health or with learning disabilities can be an important source of information and support in a range of situations.

More information

www.college.police.uk/app/mental-health/mental-vulnerability-and-illness

The parents gave a bag of medication to the officers. They told the officers one tablet would need to be taken at a specific time that evening and the other medication two hours later. They informed officers their son needed to take the medication, or he may have an epileptic fit. They also stated that this was detailed in the hospital medication notes inside the medication bag.

Two officers took the young adult to custody and handed the medication in. The medication was booked into the property store by a detention officer. However, the medication type, quantity and detail on when it should be taken were not specified on the

> **"Police had been advised that the young adult had autism and severe learning disabilities, and he did not appear to understand what was said to him"**

custody record. The detention officer booking in the medication stated: *'I don't recall the arresting officer telling me about any medical needs or medication.'*

The young adult was assessed by a custody sergeant. During his risk assessment, the custody sergeant noted on the custody record: *'DP (detained person) has mental health issues and will not answer questions'*. It was also indicated that the young adult was not read his rights at the time as *'it was not clear that he understood what was happening'*.

G National Autistic Society: Autism – a guide for police officers and staff

The National Autistic Society has produced a guide for police officers and staff working with autistic members of the public.

More information
www.autism.org.uk/shop/products/books-and-resources/autism-a-guide-for-police-officers-and-staff

A healthcare professional (HCP) was requested by the custody sergeant to assess the young adult's fitness for detention following the incapacitant spray used during the arrest. The HCP's assessment noted: *'no concerns following being sprayed however he will require mental health assessment following period of rest'*.

The HCP recommended that an appropriate adult was secured, and the young adult should be placed on level one observations. He noted the *'risk to self-harm is low'*. APP states that any person in custody who may have a heightened level of risk, including *'significant mental or physical vulnerability'*, should be placed on at least level three observations. During the IOPC investigation, the HCP stated he was aware of the young adult's epilepsy and that the epilepsy medication had been brought into custody, but he was not asked to administer it.

The custody sergeant decided an appropriate adult was not necessary as the young adult *'did not exhibit any learning disabilities or difficulties'*. This was despite information provided by the young adult's parents about his vulnerabilities and learning disabilities and the HCP's recommendation. The young adult was placed on level one observations in a cell with CCTV. Cell checks were due every 30 minutes.

> **"The HCP stated he was aware of the young adult's epilepsy and that the epilepsy medication had been brought into custody, but he was not asked to administer it"**

The young adult's mother telephoned the custody suite an hour after he was arrested and asked to speak to the custody sergeant. She told him that her son had recently been discharged from hospital and asked if he had been taken to the psychiatric unit.

The custody sergeant stated that he first had to answer questions about the assault before being taken to hospital. The mother reiterated her son's vulnerabilities during the call, including that he suffered from psychosis and seizures. She asked if he had been given his epilepsy medication. The custody sergeant told her that he was unaware of any medication, although he would check with the nurse.

Following the call, the custody sergeant raised the risk assessment level for the young adult from level one to level four, with one-to-one observations required. A further HCP assessment for his epilepsy was not requested.

A handover from the custody sergeant to another took place after the mother's call. The incoming custody sergeant was briefed on the risk assessment level for the young adult.

The mother called again a couple of hours later to check if the medication had been administered. The custody sergeant requested a further mental health assessment from another HCP to re-assess the young adult. His parents arrived at the custody suite before this took place to check if their son had been given his medication, stating that it could be *"life-threatening"* if it was not given to him.

The young adult was given his epilepsy medication six hours after the initial arrest following a mental health assessment by the second HCP. He was taken to a local psychiatric unit where he was assessed and pronounced not fit to be detained in custody. This was confirmed in a letter by a psychiatrist specialising in learning disability. It stated the young adult *'has a learning disability and autism. He lacks the capacity to understand the consequences of his actions. He is not fit for detention, nor interview.'* ■

You can visit the National Autistic Society website www.autism.org.uk/what-we-do/help-and-support if you have been affected by this case and would like support.

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How does your force provide training and support to police officers about alternatives to arrest when a person has significant vulnerabilities?
- What guidance or training does your force give to officers and staff on assessing the need for an appropriate adult in custody?
- Does your force have partnerships in place to help in situations where a person in custody has specific vulnerabilities or needs, including autism?
- How does your force make sure medication is managed and administered appropriately in custody?
- What guidance or training does your force give to officers and staff to raise awareness about autism and neurodiversity?
- How does your force make sure that neurodivergent people are supported in custody?
- How does your force retain information about a person previously deemed not fit to be detained?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How would you approach engagement with a person who is non-verbal?
- What de-escalation techniques do you regularly consider as an alternative to using force?
- What steps would you take to assess if someone lacks capacity in accordance with the *Mental Capacity Act*, or has vulnerabilities in line with Pace Code C?
- How would you gather and record information about a person's medical condition to make sure medication is administered correctly in custody?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued five learning recommendations around vulnerabilities in custody.
- All recommendations were issued to the force. They asked the force to consider training for police officers and custody staff on hidden disabilities and neurodiversity, and making police custody suites a suitable environment for neurodivergent people. This includes training for staff on securing appropriate adults for vulnerable detainees. They also asked the force to remind staff of their powers under the *Mental Health Act* and the *Mental Capacity Act*, making sure medication is appropriately handled in custody. The force established a working group to progress neurodiversity training and custody environment changes, and issued communications to staff on the identification of neurodiverse needs, securing an appropriate adult and recording medication. They also refreshed their 'crime before capacity' messaging.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC's investigation, there was no indication that any individual may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.
- However, the investigation found the service provided by the police unacceptable in relation to the force used during the arrest, and the treatment of the young adult in custody, including being denied medication.
- The IOPC recommended that the officers undertake the Reflective Practice Review Process; the process used for handling underperformance or conduct which falls short of the expectations of the public and the police service but does not amount to misconduct or gross misconduct. The IOPC also recommended that a representative from the force meet with the family to apologise, to listen to their experience and to learn from it, reflecting on additional opportunities to improve their response in the future.

Being an appropriate adult: a video for families

Dr Miranda Bevan highlights a video for new appropriate adults supporting children or vulnerable adults in custody, and why it came about.

"I'd not been in that situation before so I just went along with everything... I'm not really clued up with it all, you know what I mean?"

"I feel like I let [my son] down with not knowing."

These quotes come from research interviews I conducted with family members who had acted as appropriate adults (AAs) for children in police custody. Their words tell a common story of family members feeling out of their depth and intimidated when fulfilling this important role.

Police and Criminal Evidence Act 1984 Code C requires custody sergeants to advise AAs of their duties, and includes a summary to help them. However, it remains a challenge for busy custody sergeants to explain the role of an AA in detail, and information may be difficult to absorb for anxious parents or carers in a stressful and unfamiliar situation.

The video

These accounts led me to approach Chris Bath at the National Appropriate Adult Network to discuss producing a short and accessible video animation for family members asked to fulfil the role of an AA. The video (funded by the Economic and Social Research Council) clearly explains the role of AAs and the rights of the person they are supporting. It also prepares AAs for potential emotional challenges in police custody. The video is suitable for AAs supporting children or vulnerable adults, in police custody or attending voluntary interviews. It is supported by the Home Office and the National Police Chiefs' Council custody portfolio and has been identified as good practice in HMICFRS custody inspections. ■

Accessing the video

Watch the video here: https://vimeo.com/672820069

Information about how your organisation can make use of the video, including a downloadable poster with an embedded QR code, is available here: www.appropriateadult.org.uk/information/family/video-implementation#resources.

Dr Miranda Bevan is a lecturer at Goldsmiths, University of London. Dr Bevan's research focuses on the experiences of children and young people in custody, and on the participation of children and vulnerable adults in the criminal justice process.

CASE STUDY 6

Eleven-year-old boy detained overnight in an adult police cell

A complaint was locally investigated by the force. The complainant exercised their right to appeal to the IOPC following the outcome of the force's investigation.

A girl was reported missing by staff at a children's home. She was found that evening by police in a park. The girl told officers she had been sexually assaulted by another resident at the children's home - a boy aged 11.

The police took the girl back to the children's home and discussed the reported offence with the staff. An hour later, police told staff that the boy would be arrested. Concerns were raised by staff about the boy's age, and they offered alternatives to custody. This included considering use of a hotel room. Officers considered alternatives but had continued concerns over the safety and welfare of the boy as a high-risk missing person in an unfamiliar area if he left the hotel. The officers decided to continue with the arrest and said the boy's detention was authorised in order *'to secure and preserve evidence and obtain evidence by way of questioning'*.

Ⓖ The national protocol on reducing unnecessary criminalisation of looked-after children and care leavers: Responding to incidents

If the decision to call the police is made, then, upon the arrival of the police at the scene, a joint view (police and carer) should inform whether arrest is necessary and proportionate.

More information
www.gov.uk/government/publications/national-protocol-on-reducing-criminalisation-of-looked-after-children

The boy was taken to the police station and his detention was authorised by a custody sergeant shortly before 11pm. He was put in an adult cell and observation levels were set at level one, with regular cell checks every 30 minutes.

During the force's investigation into this incident, the custody sergeant said the decision to hold the boy was made "to maintain the integrity of the investigation, and to allow safeguarding measures to be put in place around both the detainee and the victim, particularly in view of the nature of the offence." The force's investigation determined that the boy's overnight stay in custody was appropriate given the safeguarding issues, requirements for interview, and lack of viable alternatives.

However, the custody sergeant did not record information on the custody record about why an adult cell was used rather than another room in the station, or why an alternative station with appropriate cells for children was not considered. This was not in line with PACE Code C.

Ⓖ PACE Code C: Conditions of detention

A juvenile shall not be placed in a police cell unless no other secure accommodation is available and the custody officer considers it is not practicable to supervise them if they are not placed in a cell or that a cell provides more comfortable accommodation than other secure accommodation in the station...

...If a juvenile is placed in a cell, the reason must be recorded.

More information
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903473/pace-code-c-2019.pdf

The boy was seen by a healthcare professional (HCP) two hours after arriving in custody. The HCP advised that the boy was fit to be detained and an appropriate adult was secured.

An entry was made on the custody record by the inspector on duty. This documented the rationale for the boy being detained and emphasised safeguarding concerns for other residents at the children's home.

The cells were checked throughout the night. The boy was recorded as awake during the early hours.

The boy was interviewed and released under investigation around midday, more than 12 hours after his arrest. No further action was taken on the offence. The incident log stated there would be a discussion with relevant parties about safeguarding of the boy and girl upon release. ■

photo: Alamy

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- What training is given to police officers to help make decisions about taking a child into custody, including considering the child's age and time of arrest?
- What support do you offer custody sergeants to help them make decisions about keeping a child in custody?
- What guidance or support do you give to custody sergeants to help them make decisions about alternatives to custody for a child, particularly at night?
- What provisions are in your force's custody estate to make sure children are placed in cells suitable for young people?
- What guidance or training do you give custody staff on the treatment of children in custody?
- What steps does your force take to work with local authorities to make sure looked after children who are arrested, or victims of crime, are safeguarded?
- How does your force monitor the number of children and young people held in custody, including overnight?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What considerations would you make when considering the arrest of a looked after child?
- How would you identify appropriate cells within another suite for a child in custody?
- What details would you record on a custody log about how decisions were made about the detention of a child?
- What tools could you utilise to make sure vulnerable children are looked after in custody?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued two learning recommendations around the detention of children.
- Both recommendations were issued to the force. They asked the force to make sure custody sergeants are supported to decide whether to authorise keeping a child in custody, and to make sure they record reasons for putting a child in a cell. The force introduced children in custody awareness training, monthly reviews of children in custody to identify issues and learning, and new principles for making sure the needs of children in custody are met. 24-hour support for custody sergeants is also now available, and PACE guidance was circulated to all inspectors managing children in custody. The force is also creating specific cells for children.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC's consideration of the appeal, there was no indication that any individual may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.
- However, the IOPC partially upheld the appeal and told the force to consider learning for the custody sergeant. Learning was provided to the custody sergeant that highlighted the importance of accurate record keeping. This included recording a rationale when a child is detained in an adult cell, and why alternative stations with cells for children are not deemed appropriate.

Trauma and impact: detention of children in police custody

The United Nation's report on children's rights must be a wake-up call to respect the rights of children in police custody argues **Louise King**, Director of the Children's Rights Alliance for England.

Children should be dealt with outside of the criminal justice system wherever possible – a point made clear by the United Nations Convention of the Rights of the Child (CRC) which the UK signed more than 30 years ago. Children should not be held in police custody at all in most cases. It should only happen as a last resort and for the shortest possible time. The CRC also states that the best interests of the child must be a primary consideration when any decision is made.

The *Police and Criminal Evidence Act 1984* (PACE) requires that detention of children is only authorised when strictly *'necessary'*. The National Police Chiefs' Council also emphasises the importance of the CRC and a child-first approach in both its strategy for policing children and young people, and its national strategy for police custody.

It is important that the police place children's rights and welfare front and centre rather than treating them as 'mini-adults'. Children coming into contact with the police are some of the most vulnerable in society. They have often experienced neglect and abuse, spent time in care, and have poor mental health or special educational needs. Yet lengthy police detention continues to cause trauma to children and makes them feel they have been unfairly punished.

Research and findings

There has been a decrease in the number of children detained in police custody overnight in recent years, consistent with the reduction in child arrests. However, every year thousands of children in England and Wales are still held in police cells overnight both before and after being charged with a criminal offence.

Research by Transform Justice, a charity who aim to reduce crime and the harm caused by the criminal justice system, found that once people are arrested, the decision to keep them in police custody by custody sergeants is almost never refused. This indicates a lack of scrutiny of detention decisions, and many children are held in custody unnecessarily as a result.

Last autumn, the Home Office published national statistics for the first time on how many children were held in police cells. A total of 35,114 children were detained in police custody in 2021/22, and 45% of these were detained overnight.

Research at Just for Kids Law also found significant racial disparity in relation to children in custody all-night: 21% were Black, 6% Asian and 9% of mixed heritage. Our research also revealed that 244 children aged 12 and under were held overnight, and nine children were just 10 years of age. The actual figure of very young children held in police custody is likely to be much higher as only a minority of police forces provided data fully broken down by age.

Trauma and the impact on children

Children have told us how intimidating and frightening it is to be held in a police cell. Police custody facilities are designed for adults suspected of criminal activity and offer little in the way of comfort or emotional reassurance. For a child – especially one deprived of familial support – a prolonged stay in this environment is extremely harmful:

> ***"It's horrible when they keep you in there at night. You don't know what's going on, you don't know what's going to happen or what to do with yourself. It's just horrible."***
>
> 15-year-old boy and Looked After Child, held overnight in police custody on multiple occasions.

> ***"I didn't know they could do that to you…It was awful, and I wasn't sure I was going to be ok."***
>
> 12-year-old boy after his first experience being held in police custody overnight.

> ***"They just put me there and left me there. I didn't know how long I was going to be there for. I didn't know what to do. My grandma started talking to me. I thought I was going crazy, so I started banging my head against the door. That's when the police came to check on me."***
>
> 17-year-old boy and Looked After Child, manifesting a complex form of post-traumatic stress disorder with reported episodes of psychosis. Arrested and held overnight in police custody.

A call to action

In June 2023, the United Nations Committee on the Rights of the Child published a report on how the UK is respecting its child rights obligations under the CRC. It concluded it is *'…deeply concerned about the draconian and punitive nature of its [the UK's] child justice system, and the limited progress in implementing the Committee's previous recommendations to bring the State party's child justice system in line with the Convention.'*

It specifically highlighted children held in police custody for long periods of time as an example of our failure to respect children's rights. It went on to recommend that the UK *'ensure that no child is held in police custody overnight.'*

In response to the report, Just for Kids Law is calling for the UK government to set a much-reduced legal time limit on how long a child can be kept in police custody. Immediate practical steps must also be taken at force level.

All officers should treat children as children first and place their welfare and best interests front and centre. Police chiefs should make sure that their force has signed the Concordat on Children in Custody; guidance for police forces and local authorities in England on their responsibilities towards children in custody. Officers should make sure that children are not arrested outside of working hours (between 5pm and 9am and on weekends) wherever possible. They should also monitor and review arrest times, wrongful requests for secure accommodation, decisions to authorise police detention and continued detention, decisions to refuse post-charge bail under Section 38 of PACE, and prolonged detention periods.

More information: www.gov.uk/government/publications/concordat-on-children-in-custody

The United Nation's conclusions and recommendations cannot be ignored. To do so would be to disregard the trauma and harm caused to children by holding them for long periods of time in police custody. ■

Louise King is Director of the Children's Rights Alliance for England (part of Just for Kids Law). Louise has campaigned on children's rights issues including policing and youth justice, and the establishment of the Children's Commissioner for England.

CASE STUDY 7

Recording and handling of a female strip search

This case was independently investigated by the IOPC.

A woman was arrested on suspicion of criminal damage and public order offences following an incident outside a prison where she was refused entry. She was aggressive to staff and refused to leave. A prison staff member believed the woman was drunk.

The arresting officers were told by radio that the woman *"conceals her mobile phone in her underwear"*. An officer explained they needed a female officer to search the woman. It was noted she had warning markers for assault and concealed drugs.

A female officer arrived at the scene and searched the woman. The officer suggested there may be a *"hard item in the base"* of her bra.

The woman was transported to custody. An officer communicated over the radio that the woman would require a strip search on arrival. He requested a female officer be found. A female officer arrived to assist.This officer believed a third female officer was required due to the woman's *"aggression"*. Another female officer was dispatched. Her journey would take approximately 35-40 minutes.

In the meantime, the woman spat at one of the officers and was taken to the floor. She was further arrested for assault. A spit hood was placed over her head before being taken into a cell.

The custody sergeant explained he had *"no clue what to do"* but stated *"we're gonna have to search her"*. The second female officer said this was *"not safe to do with two [female officers]"*. The custody sergeant stated *"let's do it now…the male officers are going to have to help"*. This was not in accordance with the *Police and Criminal Evidence Act* (PACE) Code C which notes a police officer carrying out a strip search 'must be the same sex as the detainee'.

The custody sergeant explained to the woman that they had waited for other officers to do the strip search *"properly"*, but it was no longer safe to wait. The woman expressed it was *"not right"* and *"not legal"*. The custody sergeant indicated that only the woman's top half should be strip searched, because of the potential item identified in the initial search.

The woman's top half was strip searched. Four male officers, two female officers and a female healthcare professional were present.

A female officer asked if the woman had anything in her bra. She responded *"I don't know"*. The female officer explained they would have to remove the bra. The custody sergeant told the male officers to *"look up"*. The woman's bra was removed. The female officer stated the search was complete just over a minute after it began.

The IOPC investigation found that the custody sergeant did not provide a rationale on the custody record for the presence of male officers during the search. The investigation also found the custody sergeant had breached the standards of professional behaviour by ordering officers to strip search a female woman with male officers present. He also failed to make reasonable attempts to request further female officers to assist.

One of the officers had asked the CCTV monitoring officer to ensure he had turned the CCTV monitor for the cell off before the strip search started. However, the IOPC investigation found that while the monitor could be switched off, it continued recording in the background. The force's policy noted *'the custody officer will ensure that cells equipped with CCTV should not be used to conduct a strip search whilst monitoring is in operation'*. All cell CCTV is saved onto a hard drive, however custody staff cannot view the 'live link' of the strip search.

Ⓖ College of Policing Detention and Custody Authorised Professional Practice (APP): CCTV

There may be occasions when recording a strip search via CCTV is desirable for the protection of staff, but officers must consider PACE Code C Annex A paragraph 11(b). The recording of the search must be shown to be necessary and proportionate in the circumstances.

More information
www.college.police.uk/app/detention-and-custody/cctv

The IOPC investigation noted that the recording of a strip search on CCTV interferes with Article 8 of the *European Convention of Human Rights* (ECHR), namely the right to respect for a private and family life, and therefore the recording must be justified. Additionally, the investigation noted the force practice was not in line with APP. ■

> **"The IOPC investigation found that the custody sergeant did not provide a rationale on the custody record for his and the two other male officers presence during the search"**

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- What steps does your force take to make sure APP around recording strip searches is followed?
- What measures does your force have to make sure the decision to strip search is appropriately justified and that justification is recorded?
- How does your force make sure staff understand Article 8 of the ECHR and apply it when deciding whether to record a strip search on CCTV?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What steps do you take as a custody officer to make sure strip searches are conducted in line with legislation and guidance?
- What steps could you take to locate additional female officers to conduct a strip search of a woman?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued four learning recommendations around the use of CCTV and strip searches.
- One learning recommendation was issued nationally to the National Police Chiefs' Council (NPCC). It asked force custody leads to update policies to reflect that strip searches should not be recorded on CCTV without justification, and that legislation should be applied when deciding whether recording a strip search on CCTV can be justified and rationale must be documented. The NPCC circulated the recommendation to all heads of custody and chief constables, and informed key stakeholders of the change.
- The other three recommendations were issued to the force. They asked the force to implement measures to prevent their existing practice of the routine CCTV recording of strip searches of people, and to ensure policy and training reflected these changes. The force suggested recording of strip searches is not prohibited by PACE but recognised that the privacy of people can be preserved by switching off monitors and controlling access to CCTV. They explained that CCTV would only be viewed where there was a *'urgent and lawful'* need and have reviewed their strip search policy. They have communicated with staff to make sure justification and documentation is fully lawful and reiterated the legal basis of a strip search. They have also reviewed their training package for all new starters.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC investigation, there was no indication that any individual may have committed a criminal offence. However, the custody sergeant had a case to answer for misconduct in relation to the strip search of the person in custody.
- Misconduct was proven and the custody sergeant received management advice. He was required to refresh his knowledge of the *Police and Criminal Evidence Act* (in particular regarding strip searches) before being allowed to authorise strip searches without oversight.

HMICFRS
His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Three areas of focus: keeping people in custody safe

The custody inspection team at His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) share recent findings from their custody inspection programme and discuss how forces can mitigate risks to keep people in custody safe.

photo: courtesy Surrey Police

HMICFRS' national rolling programme of police custody inspections assesses how forces provide custody services. We focus on how well forces manage risk to keep people in custody safe. Our inspections have found similar themes in all forces over the last 12 months. We share three key areas of focus and practical steps on how forces can help keep people safe.

1. Identifying detainee risks

Forces usually identify risks well, with custody officers focusing on vulnerability and welfare concerns when completing risk assessments. However, common suggestions we make to custody officers include:

- Making use of the full range of available information to inform the risk assessment, including looking at the Police National Computer (PNC) and previous custody records.
- Asking arresting or escorting officers for information about the person in custody to help manage associated risks.
- Triaging children and vulnerable adults on arrival in custody.

We generally find that people in custody are released safely. But pre-release risk assessments are not always done with the person present, and do not always consider the previous assessment or the behaviour of the person while in custody. Risk assessments for people going straight to court are sometimes completed too early. Further checks are not made before they leave custody to see if there are any risk updates.

> "We often find risks are not managed well enough to make sure people are safe during their time in custody"

2. Managing detainee risks

We often find risks are not managed well enough to make sure people are safe during their time in custody. Our concerns are often around how risks for people under the influence of alcohol and drugs are managed, and how well observations of people at high risk of self-harm are carried out. Many risk management practices do not follow the College of Policing's Authorised Professional Practice.

Forces that manage risk well make sure that:

- People under the influence of alcohol or drugs are placed on a minimum of level two observations with frequent rousing.
- The same staff carry out rousing checks for continuity, recognising changes in behaviour or deterioration in a person's condition.
- The custody officer briefs officers responsible for level four close proximity observations, and officers keep accurate logs for the custody record.
- Custody staff carry personal-issue anti-ligature knives to respond quickly if someone tries to self-harm.
- Handovers involve all relevant in-going and out-going custody staff (including healthcare teams) so information about risk can be shared.

3. Removal of clothing

In most forces we have had concerns about the routine removal of detainee clothing and footwear, rather than individually assessing the need for this. This can undermine a person's dignity. In some cases, clothing is removed using force which can escalate risk further.

People do not always agree to have their clothing removed or wear a safety suit when they are considered to be at a high risk of self-harm. When this happens, we expect forces to encourage and help the person to put the clothing on. Forces are not always proactive in doing this, and our inspections found instances where people remained naked in their cells. We expect that:

- Clothing is removed only where necessary and proportionate in line with individual risk assessments.
- Any use of force is justified and recorded on the custody record, with oversight by the custody officer.
- Safety suits are used as a last resort and justified in line with the risks.
- All reasonable action is taken to ensure a person's dignity.

Improving policing practice

We work collaboratively with forces to promote good practice and improvements that support the safety and wellbeing of people in custody, diverting vulnerable people away from this environment. Our inspections assess the outcomes for people in custody in line with our expectations. You can read more here: www.justiceinspectorates.gov.uk/hmicfrs/publications/expectations-for-police-custody-june-2022/

HMICFRS Custody Inspection Team
HMICFRS independently assesses the effectiveness and efficiency of police forces and fire & rescue services – in the public interest.

CASE STUDY 8

Inappropriate recording of cell observations

This case was locally investigated by the force. The IOPC then conducted a review of the investigation to decide whether there was indication of serious misconduct, a criminal offence, or an opportunity for learning.

A man was arrested on suspicion of making threats to kill and taken into custody. The arresting police officer described the man's speech as a *'little erratic'*. The previous week the man had been detained under Section 136 of the *Mental Health Act*.

The man was placed in a cell with CCTV when he arrived in custody. He was described by custody officers as experiencing mental ill health but was deemed to be physically well. The custody sergeant placed the man on level one observations with checks required every 30 minutes. The custody sergeant was aware the man had recently been detained under the *Mental Health Act* and had been assessed by a nurse during his previous time in custody. The custody sergeant believed that no specific medical attention was needed.

The man was awake and talking to himself at the first 30 minute cell check. During the next check, custody staff saw on CCTV that the man was laying on the floor. A healthcare professional (HCP) and custody staff went to the cell and found the man *'not fully conscious'* with an injury to his face.

The HCP called an ambulance and the man was taken to hospital. He was subsequently admitted and treated for alcohol withdrawal.

> "Custody staff continued to write updates in the custody record on the man's condition, despite the man being taken to hospital"

Custody staff continued to write updates in the custody record on the man's condition, despite the man being taken to hospital. The IOPC review found that standardised multi-cell observation records were being entered across several detainee custody records. This meant the same information was copied and pasted across custody records instead of individual updates for each detainee, suggesting a lack of care and awareness for individual detainees.

Prior to this incident, His Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) had identified the same issue with multi-cell observation records during their last inspection. They recommended that each individual custody record should only contain information about that particular individual.

In this case, the records were inaccurately reporting on the man's condition when he was no longer in custody. Comments included the detainee was *'sitting on their mattress and movement/breathing were seen'*.

The IOPC also found conflicting information within the man's custody record. One entry claimed the man was not accompanied by police to hospital, but another entry stated he was accompanied, demonstrating further inaccuracy of the custody records.

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How do you make sure custody staff do not enter standardised multi-cell observation records in individual custody records?
- What steps does your force take to quality-assure information recorded in custody records?
- How would your force identify and resolve conflicting information in a custody record?
- How does your force make sure recommendations issued by policing bodies such as HMICFRS are implemented in a timely way to introduce positive change?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How do you make sure detainee custody records tell the individual story of a person in custody in line with national guidance?
- What would you do if you noticed inaccurate information in a custody record?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued three learning recommendations around the inappropriate practice of multi-cell observation records.
- All recommendations were issued to the force. They asked the force to make sure entries on custody records relate specifically to the person being observed, and to remind staff of the importance of accurate records. The force agreed to provide further training to custody staff around observation records and to monitor compliance.
- To raise awareness, the IOPC shared the recommendations made to the force with HMICFRS and the College of Policing. The College of Policing noted that this practice may be occurring in other forces and amended their Detention and Custody Authorised Professional Practice to state that *'multiple detainee cell checks should not be recorded in individual custody records'*.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC's review, there was no indication that any individual may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Key asks and challenges: a healthcare professional in custody

photo: courtesy Surrey Police

We spoke with experienced custody nurse **Dave Tremlett** to discuss some of the key issues arising from our case studies, and to find out more about the important work of healthcare professionals (HCPs) in custody.

What are the biggest challenges you see in custody healthcare?

The biggest challenge is recruitment. On-boarding new staff can take months, so covering gaps in rotas when staff levels are low is a challenge. To tackle this, we are striving nationally to raise the profile of custody healthcare by working with universities to offer student nurse placements, using social media and writing articles in health journals to encourage people to consider custody healthcare as a viable career.

Another challenge is increased assessments of patients with multiple complex medical needs and who are difficult to manage in custody for longer periods of time. It is common to need to verify multiple medications and complete repeat visits to care for them appropriately.

We see from our cases that effective communication between HCPs, arresting officers and custody staff is key. What does good practice look like to you?

HCPs generally work in large custody suites and are required to triage and clinically prioritise their workload so those with the most need are seen as a priority. Officers are always welcome to locate the HCP or the custody sergeant to raise concerns about a person's medical needs, or to share information they may have disclosed relevant to their health, including before the person is booked into custody.

In a recent development, HCPs now approach arresting officers for background information regarding the use of Taser where it has been used. This enables the HCP to understand potential injuries and to obtain any comments disclosed about the person's health during transportation to custody.

Can you describe a change to practice which you have found useful as a HCP?

The launch of Summary Care Records; a system which allows HCPs to access information about medication prescribed by GPs with consent from the person or via emergency access. This has made custody safer; we are now able to establish confirmed medical diagnosis, medications and allergies from the NHS. Understanding the detainee's medical history is especially helpful if there is a medical emergency on arrival to custody or the person is heavily intoxicated. It also helps HCPs to verify medications to confirm the prescription, doses and frequency.

> **"Communication is vital. The best thing that arresting officers and custody staff can do to help HCPs is provide as much detail as possible to enable us to triage and manage cases effectively"**

In your experience, what are some key risks to look out for when assessing someone in custody?

A high-risk group is people with alcohol dependence. This is because they can deteriorate rapidly into a medical emergency through withdrawal. Even people with dependence who are intoxicated on arrival should be monitored closely as they will sober quickly and may not let staff know during checks if they are feeling unwell.

People with injuries are also a high-risk group, especially people who are intoxicated with a head injury. Symptoms of a head injury can be mistaken as signs of being intoxicated. This can also be the case with diabetes symptoms.

HCPs should always avoid 'anchoring'; a term used in healthcare to describe a tendency to stick with initial impressions about a medical need, even as new information becomes available. HCPs should continue to consider and rule out differential diagnosis in every assessment.

We also see from our cases that medication for people in custody needs to be carefully managed. What role do HCPs play?

HCPs establish what medication a person needs during their stay in custody, and whether a person is clinically safe to take the medication. They also confirm the prescriptions by the box and label or Summary Care Records before writing them up on the custody record and administering.

It is helpful when officers bring medications into custody from home addresses and pharmacies as this helps us manage the person in custody safely. All custody suites stock medications for general pain relief, antibiotics, and withdrawal and emergency interventions.

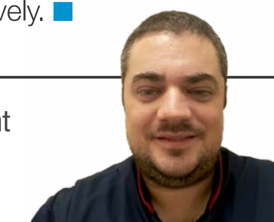
How do you hear about emerging good practice in custody settings?

I am involved with the UK Association of Forensic Nurses and Paramedics. They hold a yearly award for individuals and teams who have found innovative ways of delivering best practice in custody and sexual assault referral centres. Every year we get to see great examples of pilots, projects and procedure changes which help drive standards nationally. I also keep up to date with emerging good practice through national custody stakeholder engagement meetings.

What key ask do you have of arresting officers and custody staff to help HCPs?

I had a case many years ago for a person in custody who was intoxicated with a head injury. I assessed that they were fit to be detained with observations and rousing checks. An hour after my assessment, the arresting officer told the custody sergeant that the person said on their way to custody that they had been released from hospital three days earlier after having neurosurgery. This changed our approach, and we sent the person straight to hospital.

Communication is vital. The best thing that arresting officers and custody staff can do to help HCPs is provide as much detail as possible to enable us to triage and manage cases effectively. ■



Dave Tremlett is a Nurse and Patient Safety Specialist.

CASE STUDY 9

Medical emergency in custody

This case was independently investigated by the IOPC.

A man called the police to report that his daughter was scared to leave her address because her mother was outside and *"apparently drunk"*. They had also called an ambulance as the mother said she could not breathe.

Paramedics arrived and requested police attendance because of a reported domestic abuse incident between the woman and the man, who was her ex-partner.

When officers arrived, they were told by paramedics that the woman had recently been in hospital for a minor stroke. Her ex-partner also said she had an alcohol dependency.

The woman told the officers she had been *"punched in the head"* by her ex-partner. She further explained *"he's on record for punching me in the head before… this is why I've got this blood clot in my head"*. One of the officers noted the woman had recently been sick into a bin.

The woman told officers she was not drunk or dependent on alcohol. In one of the officer's accounts to the IOPC, he said that although the woman was slurring her words, she did not smell of alcohol and did not appear to be under the influence.

The officers spoke to the woman's family. They said the woman had instigated the altercation.

Paramedics believed the woman was experiencing anxiety, did not have symptoms of a stroke, and did not need to go to hospital. Based on this, officers agreed the woman was fit to be arrested on suspicion of domestic common assault.

During the journey to custody, the woman held her head multiple times. She explained something was causing pressure and making her feel nauseous. Once at custody, she was sick. She explained her head was *"pounding"* and she had a *"brain trauma"*.

At custody, an officer explained to the custody sergeant that the woman had been sick. The attending officer explained the woman said she did not have an alcohol dependency but had recently had a stroke. The custody sergeant called an ambulance.

A healthcare professional (HCP) assessed the woman while waiting for an ambulance. She decided the woman was fit to be detained. She later explained to the IOPC that she was not aware of the domestic incident and the woman did not say anything about brain trauma during the assessment.

The HCP had started her role four weeks previously and did not have access to the 'summary care records' system. This system allows HCPs to access information about medication prescribed by GPs with someone's consent. The IOPC investigation found the system had a fault at the time and could not be accessed. This had been reported two months before this incident and had not been addressed.

The ambulance was cancelled by the custody sergeant following the HCP's assessment.

The woman joked with officers while being booked into custody. She requested paracetamol but this was not provided.

The woman was placed on level one observations with cell checks required every 30 minutes. The CCTV in the woman's cell had been obscured by a previous detainee. This meant CCTV did not show the woman at any stage of her detention.

The woman pressed the call button over an hour after being in the cell to get the attention of custody staff. The woman explained she was still waiting for paracetamol and the custody sergeant requested an additional HCP assessment.

The woman was given two paracetamol tablets by the HCP around 30 minutes later. The HCP decided the woman was *"alert and oriented"* and maintained she was fit to be detained.

The IOPC investigation sought expert opinion on the actions taken by the HCP. The expert decided that on both occasions the HCP's assessment of the woman was conducted appropriately and there were *"no signs of any significant or treatable illness"*.

The woman was criminally interviewed a few hours after she received paracetamol. She explained the injury was *"hurting anyway because that is where my… cluster of blood is"*. She was unable to explain where her ex-partner punched her.

The woman had a seizure shortly after returning to her cell. Two HCPs immediately attended. An ambulance was called due to concerns the woman was having a stroke.

It was identified at hospital that the woman had a bleed on the brain. She died the following day.

The post-mortem report concluded there was no evidence of any third-party assault. The fatal haemorrhage was linked to the woman's previous stroke. The pathologist was unable to prove if there was a relationship between the reported incident and the woman's death. ■

You can call the Refuge National Domestic Abuse 24/7 helpline for free on 0808 2000 247 if you have been affected by this case and would like support. You can also visit refuge.org.uk/i-need-help-now

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How do you make sure new HCPs are given access to relevant systems before starting in that role?
- What steps does your force take to make sure HCPs are equipped with the right level of information to make an informed assessment on a detainee?
- How does your force make sure issues relating to healthcare systems are dealt with quickly?
- What guidance does your force have to make sure cells are suitably checked and maintained before use?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How do you continue to assess the medical needs of a person during transportation to custody to identify any changes to a person's condition?
- How do you ensure information gathered about the welfare of a person during their arrest or transportation to custody is passed on to custody staff, including HCPs?
- What steps do you take to make sure CCTV cameras in cells are not obscured or damaged?

LEARNING RECOMMENDATIONS AND ACTION TAKEN

- The IOPC issued four learning recommendations around the work of HCPs and cell inspections.
- All recommendations were issued to the force. They asked the force to create a memorandum of understanding (MOU) with service providers about system maintenance issues and asked the force to equip HCPs with the access, equipment and training for the summary care records system before starting their role. In relation to cell inspections, the recommendation asked the force to introduce a policy to make sure cells are visually inspected and searched after someone is released and before someone else enters. The force implemented a new medical records system with a new MOU, with clear guidance on responsibilities and regarding faults. They also committed to making sure new HCPs have access to the summary care records system. They also established a working group to review changes to policy around cell safety checks.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- During the IOPC investigation, there was no indication that any individual may have committed a criminal offence or had behaved in a manner that would justify the bringing of disciplinary proceedings.

Support and information

Mental health

MIND (also Mind Cymru)
www.mind.org.uk
A national mental health charity providing support, information and advice to members of the public, as well as training for professionals and awareness raising.
Tel: 0300 123 3393 (9am – 6pm)
Email: info@mind.org.uk

Samaritans
www.samaritans.org
Samaritans operate a free 24/7 helpline for anyone who's struggling to cope, who needs someone to listen without judgement or pressure.
Tel: 116 123
Email: jo@samaritans.org

Oscar Kilo
www.oscarkilo.org.uk
Oscar Kilo is the police national wellbeing service and provides support and guidance for all police forces to improve and build upon wellbeing within their organisation. Their services have been developed for policing, by policing, and they are designed to meet the unique needs of officers and staff.

Zero Suicide Alliance
www.zerosuicidealliance.com
The Zero Suicide Alliance offer free online suicide awareness and prevention training and resources. Their online courses teach people the skills and confidence to have a potentially life-saving conversation with someone who may be struggling with suicidal thoughts.

Revolving Doors
revolving-doors.org.uk
Revolving Doors champion long-term solutions for justice reform that tackle root causes of reoffending and support people's journeys towards better lives. They focus on people who have repeat contact with the criminal justice system, whose behaviours are largely driven by unmet health and social needs. These include combinations of substance misuse, homelessness, mental ill health and domestic abuse.

Substance misuse

With You (formerly Addaction)
www.wearewithyou.org.uk
With You is a charity providing free, confidential support to people experiencing issues with drugs, alcohol or mental health.

Turning Point
www.turning-point.co.uk
Turning Point work with people who need support with their drug and alcohol use, mental health, offending behaviour, unemployment issues and people with a learning disability. Support is designed to fit around each person's needs, so they can concentrate on getting back on track with life.

YOUR FEEDBACK ON ISSUE 41: Call handling (November 2022)

Thinking about the content of issue 41

98% of respondents said the structure of this magazine felt about right.

98% of respondents said the mix of cases and feature articles felt about right.

98% of respondents said the case summaries were clear and easy to understand.

Thinking about the impact of issue 41

98% of respondents said this magazine was a useful tool to help drive change in police policy and practice.

98% of respondents said this magazine provided them with useful knowledge to supplement information they receive from training, briefings or practical experience.

87% of respondents said reading issue 41 helped them to think differently about the role of their force control room.

100% of respondents in relevant police policy roles said they will consider making changes to any policy, guidance, processes and training related to call handling that they are responsible for - reflecting the learning in issue 41.

Note: Based on 55 responses to the survey.

"It's a very useful tool. I have really gained from the case studies, particularly in my police call taker role. It extends the knowledge and thought process regarding high-risk and medium-risk cases, making sure that all relevant questions are asked at point of call. Thank you."

YOUR FEEDBACK NEEDED

What do you think about Learning the Lessons?

Do you have ideas about topics you would like to see covered in future issues?

Or thoughts about the structure of content of the magazine?

Please complete our five minute feedback survey at www.smartsurvey.co.uk/s/LearningtheLessons42 to share your views. **The survey is open until 29 September 2023.**

Based on recent feedback, we have worked to focus our case studies to draw out the key learning opportunities, and brought in the expertise of those working in the roles closest to the topic being explored to share their experiences. We are also continuing to focus on sharing good practice initiatives alongside our case studies.

Interested in receiving new issues of Learning the Lessons?

The magazine is available to everyone. Email **learning@policeconduct.gov.uk** and we will let you know when a new issue is published.

Want to get involved in the development of Learning the Lessons?

We have created a virtual panel, bringing together stakeholders from the police, community and voluntary sectors, and academia, to support the development of future issues of Learning the Lessons.

Email **learning@policeconduct.gov.uk** if you are interested in joining the panel. Panel members are invited to review and provide feedback on drafts six to eight weeks before publication.