

# LEARNING THE LESSONS

## > Custody

### Issue 35

July 2019

[www.policeconduct.gov.uk/  
learning-the-lessons](http://www.policeconduct.gov.uk/learning-the-lessons)

Improving policing policy and practice



College of  
Policing



Home Office





# YOUR FEEDBACK ON ISSUE 34: MENTAL HEALTH (FEBRUARY 2019)

## Content and structure



93.2%

said the mix of cases and feature articles felt about right



96.7%

said the case summaries were clear and easy to understand



98.3%

said the feature articles complemented the cases featured in the magazine

## Impact

63%

said they will think differently when dealing with people where concerns about their mental health are identified

66.7%

said they will think differently about how they communicate with people where concerns about their mental health are identified

59.3%

said they plan to look at one or more of the sections of Authorised Professional Practice (APP) signposted in the issue



Forces can work in a 'bubble' if not careful. Yet we all face the same day-to-day challenges, just on different scales dependant on the size and perhaps geography of the force. Sharing information, and especially case studies, helps us to work smarter and learn from others' mistakes. The magazine could not have a more apt title!



I believe most people learn best by example and not theory. The magazine provides examples that can be used in anything from training, to making a point in a debate.



On receipt of the magazine, I circulate it by email to inspector rank and above, relevant police managers and staff for their information, and for wider circulation as necessary. I create actions for relevant business area leads. They consider the relevant case(s) and compare the key questions and actions taken by the force with force policy, procedure, practice and training to see if there are any gaps. If there are, remedial action can be taken. These actions are recorded on the force action plan database and monitored until completed.



61.1%

said they will consider making changes to any policy, guidance or training they are responsible for to reflect learning from the issue

77.8%

said they plan to share the issue with colleagues to share the learning within it

**Note:** Based on feedback from 65 respondents



Email [learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk) if you are interested in contacting any of the forces involved in the cases featured in the magazine. We can put you in contact with them.

# FOREWORD



Welcome to Learning the Lessons 35, which focuses on custody.

This issue includes some really interesting contributions, many of which recognise the difficult role that custody officers perform each day. I have seen this for myself during my visits to a number of custody units.

In this issue, we hear from the Independent Custody Visiting Association about the role they perform; from Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, with examples of the way some forces are working in custody; and from Dr Layla Skinns from the University of Sheffield about her work on police custody.

To support the investigations we undertake in this area, we now have an internal subject matter network focusing on deaths in custody. Tom Milsom, the Chair of the network, has written a piece about the key themes from our work in this area.

I also wanted to take this opportunity to say a big thank you to members of our Learning the Lessons Development Panel. Panel members volunteer their time and expertise to help us get each publication just right. Without them, Learning the Lessons would not be as successful as it is.

As always, we are really keen to hear your feedback. We received lots of positive comments on issue 34, which focused on mental health. 67% of respondents stated they would now think differently about how they communicate with people where mental health concerns were identified. This is a great example of the impact this publication can have. I hope you all enjoy this issue and get some practical tips to take away and use.

Michael Lockwood  
**Director General**  
**Independent Office for Police Conduct**

# CONTENTS

	CASE	PAGE
<b>Communication</b>		
Passing on information to colleagues	1, 3	4, 19
<b>Detainee welfare</b>		
Dealing with detainees with autism	1	4
Access to appropriate adults	1, 5	4, 29
Strip searching vulnerable people	1	4
Responding to/silencing cell buzzers	2	12
Dealing with detainees who are drunk and incapable	3	19
Reviewing risk assessments	3	19
<b>Equipment and supplies</b>		
Access to wheelchairs	3	19
Access to anti-rip clothing	3	19
Risk posed by red lifeline cords in toilets	6	31
<b>Checks and rousing</b>		
Levels of observation	6	31
Carrying out effective cell checks	4, 6	26, 31
Monitoring detainees during handovers	2	12
<b>ARTICLES</b>		
Improving policing: HMICFRS custody inspection programme. <i>Norma Collicott, HMICFRS</i>		9
Authorised Professional Practice (APP) – cell checks		15
Key themes in the IOPC's work around deaths in custody. <i>Tom Milsom, IOPC</i>		16
The ICVA and independent custody visitors. <i>Sherry Ralph, ICVA</i>		17
Making good: key lessons for practice from the good police custody study. <i>Dr Layla Skinns, University of Sheffield</i>		24

## CASE 1

## PLACING SOMEONE IN A CELL



A man was arrested for alleged fraud by false representation after he was unable to pay for a taxi journey. Officers were unable to resolve the situation by negotiating with the people involved. Officers placed the man in a police car and drove him to the police station.

Before entering the custody suite to be processed, detainees are held in a holding room with the officers who arrested them. When staff within the custody suite become available, the detained person is brought into the suite to be processed at the custody desk. They are then put into a cell awaiting interview after caution.

The man arrived in the holding room at around 5am.

CCTV from the holding room showed the man acting erratically before being booked in. CCTV recorded a conversation where he told officers that he had a bleeding nose and asked for his handcuffs to be removed. There is no evidence on the CCTV to show that he had a nosebleed.

While in the holding room, the man tried to press a panic strip on a wall of the room 16 times. After his eleventh attempt, one of the officers placed his hand on the man's chest and moved him against the wall of the holding room. The man briefly struggled with the officer as he was being pushed back and shouted "get off me" and "don't touch me".

The man repeatedly asked for his handcuffs to be removed, but the officer refused. While in the holding room the man told the officer that he had autism.

Around 5.30am the man was taken to the custody desk. His detention was authorised after going through the booking-in process.

One of the officers who initially dealt with the man asked the custody sergeant to carry out a strip search. He believed that the man may have drugs on him and that he may have taken drugs earlier on in the evening. When he was arrested he had dilated pupils and his behaviour had been erratic.

The strip search was authorised. The man said that he had not taken drugs and had not hidden anything.

The custody sergeant explained that the officer would carry out the strip search, but the man said that he did not want to go into a room with him and be strip searched. The custody sergeant told the man that although he could use force to conduct the search, he thought this was avoidable. He offered to come into the room with the man while the search was made, and he agreed. At no point before the strip search did the officer tell the custody sergeant that the man had said that he had autism.

The officer told the IOPC that the man's behaviour had caused the conversation to "slip his mind". He also said in interview that he was unaware the PACE Codes of Practice required an appropriate adult to be present during a strip search of a "mentally disordered or otherwise mentally vulnerable person".

Following the strip search the man, the officer and the custody sergeant returned to the custody desk. A designated detention officer (DDO) completed the booking-in process. The man confirmed that he had no injuries, had not self-harmed or attempted suicide, and did not have any medical conditions or mental health problems.

The officer told the DDO that the man had autism, and he confirmed that he had mild autism.

The officer advised the DDO that the man would require an appropriate adult. It was found that his father had performed this role for him before. The man told the officers that he could be interviewed on his own. However, the DDO told him that he was not sober enough to be interviewed.

The man declined the offer to have a legal advisor.

The man was asked if he wanted anyone to be told of his whereabouts. He confirmed that he did, but he did not give a name for anyone to be informed. The officer provided a phone number for the man's mother who he had called earlier.

CCTV showed that following this conversation the man repeatedly tried to walk away from the custody desk. However, the officer returned him to stand at the desk and prevented further attempts to walk away by placing his arm out in front of the man so that he could not leave.

When the officer asked the man to go into a cell, he said he did not want to and asked if it was necessary. The DDO told him he would have to go into a cell. The man remained leaning on the custody desk and asked if he could avoid being put in a cell. The DDO repeated that he had to go in.

The officers tried to convince the man to go into the cell but he refused. Eventually he left the desk and went with the two officers who had brought him into custody to the cell.

The custody sergeant recorded on the custody record “male is highly intoxicated and requires 4R checks to ensure his condition does not deteriorate.” 4R checks refers to the four prompts used by police officers to help them conduct checks on detainees. For more information see the full learning report at <https://www.policeconduct.gov.uk/research-and-learning/learning-and-recommendations/learning-lessons>

Officers took the man to a conventional cell but he refused to go in.

The CCTV shows that after trying to reason with him, the officers tried to push him into the cell. However, he placed his arms on the door frame to stop himself from being pushed in.

Officers eventually got the man into the cell. Once inside, he tried to leave the cell by walking towards the doorway where one of the officers was standing. The officer moved into his path and asked him to take a seat and stay in the cell. The man repeated this a number of times.

When officers told the man that they were going to leave the cell and close the door, he told them that he did not want to stay in the cell as he was claustrophobic. The man asked if the door could be left open and someone could sit in the doorway. The officers said that this was not possible. The custody sergeant arrived soon after and it was agreed that they would move him to a cell with a glass-fronted door.

The man asked if he could be interviewed, but was told the officers who were due to interview him were not yet on-duty so he would have to wait in the cell. The officers re-assured him that he would not be in there for long.

Officers took the man to the other cell. Again he refused to enter and tried to walk away from the cell but he was blocked by officers.

One of the officers took hold of the man's arms and led him towards the cell. When he arrived at the cell he just stood in front of the doorway, sat down on the floor and refused to enter. Officers tried to reason with him but he still refused to enter.

One of the officers told the man that if he did not enter the cell voluntarily they would use force to get him in.

Officers told the man to stand up. They tried to pull him up but he resisted and pushed himself back down. He remained sitting on the floor.

The custody sergeant told the man that once he was in the cell he could use the intercom to call his father. The man remained on the floor and said that he could not go into the cell.

The man asked again if the door could be left open, but the custody sergeant explained this was not possible.

The man was sat on the floor for approximately three and a half minutes from the point of arrival at the glass fronted cell. He stood up of his own accord, but he still refused to enter the cell.

The custody sergeant told the man that officers would use force to put him in the cell. The two officers moved behind the man and placed their hands on his back to push him forward into the cell. The man placed his hands on the cell doorway. Eventually they managed to push him into the cell.

The man tried to leave the cell and one of the officers extended his arm to stop him from leaving. The man tried again, and eventually the officers took hold of his arms and placed them behind his back. They then moved him over to the furthest wall from the cell entrance and held him against the cell wall. The officers let go and tried to leave the cell. Again, the man rushed towards the door before it could be closed.

The officers pushed him back and held him against the cell wall. The custody sergeant removed the cell mattress from the bed and placed it in the middle of the floor.

The man tried to get to the cell door when the officers released their grip. The custody sergeant told the officers to put the man on the floor. The man continued to struggle with the officers and tried to leave the cell.

The custody sergeant then told the officers for a second time to put the man on the floor. One of the officers then placed one hand on the man's head and another on his arm and walked in front of him and backwards into the cell, leading him inside and towards the centre of the cell as a result. Another officer held the man's back and pushed him forward into the cell. The DDO completed the chain of officers controlling the man by holding the back of one of the officers and pushing forward behind the man.

The man was then lowered on to the mattress. When he was on the floor one officer held his legs, one was bent over his torso, and one was bent over his head. The custody sergeant moved to the side and continued to tell the man to relax.

The man shouted at the officers "What are you doing?"



**National  
Autistic  
Society**

## **Autism: a guide for police officers and staff**

Developed by the National Autistic Society, this guide is designed to help police officers and staff who come into contact with people who have autism. It provides specific advice relevant to people working in a custody setting.

### **Dos and don'ts in custody**

- ✓ Remain alert to the possibility of undisclosed autism.
- ✓ Detain the person in the quietest area possible and try to be reassuring.
- ✓ Respond to any sensitivity that the person may have to particular textures such as police blankets or clothing.
- ✓ Make sure that adequate safety measures are in place to minimise risk of self-harm and other injury.
- ✓ Bear in mind that the signs of autism may fluctuate depending on levels of anxiety and stress.
- ✓ Let the person retain any comfort item they may have if it's not causing harm.
- ✓ Identify and appoint a suitable appropriate adult without delay.
- ✓ Consider seeking the advice of an autism professional if you are unable to appoint an appropriate adult who understands the person's particular needs and difficulties.
- ✓ Make sure the person understands why they are in custody, for how long and what they can expect to happen.
- ✓ Avoid being specific about timings if you don't have to be. "I will be with you in a minute" could be interpreted literally and cause anxiety if you don't then appear a minute later.
- ✓ Identify and meet any dietary requirements.
- ✗ Overcrowd the person. They may respond better to dealing with as few police officers and staff members as possible.
- ✗ Make loud, sudden noises. If an autistic person is kept in a cell, the noise of the door banging could be very distressing or shouting of other prisoners very frightening.

### **Find out more online:**

<https://www.autism.org.uk/Products/Core-NAS-publications/Autism-a-guide-for-criminal-justice-professionals.aspx>

The officers then moved slightly in their positions as the man continued to resist by moving underneath them.

The custody sergeant explained that force was being used as he would not listen to the officers who told him to get in the cell.

When the officers removed their restraint and one-by-one left the cell, the man immediately stood up and ran towards the cell door. However, it was shut before he could reach it.

From outside the cell the custody sergeant told the man to relax, but he became verbally abusive. The officers left the corridor and headed towards the custody desk area.

The CCTV showed that the process of getting the man into a cell took 13 minutes and 22 seconds from completing the custody arrival process to officers leaving the glass fronted cell. The time taken to get the man into the glass fronted cell from the point of arrival to when the officers exited the cell was nine minutes.

The custody record shows that the man was placed on observations every 30 minutes by custody staff.

The man's father came to the station around 6.50pm to act as an appropriate adult for the man's criminal interview. There is no entry on the custody log to record what time he was called and asked to go to the police station.

Around 7pm the man left his cell for a consultation with his father before being interviewed. His father was present during the interview and acted as his appropriate adult. The interview finished around 8.40pm.

The man was brought to the custody desk around 10pm and was told that he was being released from arrest on bail pending further enquiries. His father was also there. ●

### **Key questions for policy makers/managers:**

- What guidance or training does your force give to officers to help them understand more about autism?
- What steps has your force taken to make officers aware of the National Police Autism Association and the support that might be available to officers working locally?
- Does your force provide officers with clear guidance on how to respond to people who are reluctant to enter cells? Does this include responding to people who say they are claustrophobic?
- How does your force make sure that where people require appropriate adults, they are there before a strip search is carried out?

### **Key questions for police officers/staff:**

- If you found yourself in the same situation, would you have taken any other action to try to get the man into a cell?
- Do you know who your force National Police Autism Association coordinators are, and how to get in touch?

### **Outcomes for the officers/staff involved:**

- One of the two officers who initially dealt with the man was dealt with through unsatisfactory performance procedures. This was for failing to tell the custody sergeant before the strip search that the man had said that he had autism. The officer received a written improvement notice as a result of the proceedings.
- **Read full learning report**





## **National Police Autism Association**

**The National Police Autism Association (NPAA) supports members of the UK police and criminal justice community with an interest in autism and related conditions.**

Membership of the NPAA is free and open to all UK police officers and staff, including special constables, PCSOs and police volunteers. We welcome personnel from all territorial and national police forces, including the Civil Nuclear Constabulary, Ministry of Defence Police and the Police Service of Northern Ireland.

We provide personal support to police officers, staff and volunteers through our network of champions (NPAA Co-ordinators) in UK police forces. The role involves being a point of contact for any colleague needing confidential support, and helping to moderate our web forum. Forces may have a single coordinator, or a lead coordinator and a team of deputies.

We also host the Police Neurodiversity Forum, moderated by our team of co-ordinators. Members can discuss workplace, personal, family and public service delivery issues; share experiences; and offer mutual support in a supportive and confidential environment.

We welcome discussions and questions around neurodiverse conditions (autism, dyslexia, dyspaxia etc.) and anything else! The forum is searchable and also serves as a knowledge base, with information on the conditions we support and links to external resources.

### **Find out more online:**

<http://www.npaa.org.uk>





## Improving policing: HMICFRS custody inspection programme

By Norma Collicott, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS)

**The HMICFRS rolling custody inspection programme makes sure that custody facilities in all 43 forces in England and Wales (and the Border Force) are inspected at least once every six years. The programme began in 2008 and is a joint effort by HMICFRS and Her Majesty's Inspectorate of Prisons.**

The programme forms part of the joint work programme of the criminal justice inspectorates and the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – to monitor the treatment of and conditions for detainees.

Custody inspections assess how well each police force is fulfilling its responsibilities for the safe detention and respectful treatment of people detained in custody. Our judgements are made against the criteria set out in the *Expectations for police custody*. These criteria are underpinned by international human rights standards, the *Police and Criminal Evidence Act 1984 (PACE)* codes of practice, and College of Policing guidance. They were recently updated to reflect the recommendations of Dame Angiolini's *Review of Deaths and Serious Incidents in Custody*.

Inspections are unannounced and gather evidence from strategic interviews, officer focus groups, case reviews, custody record and data analysis, and operational observations in suites (including early morning, night time and weekend visits). Specialist healthcare inspectors are also involved, including representatives from the Care Quality Commission.

We carry out a follow-up visit one year after a force's inspection to look at the progress they have made in response to our findings.

## Key themes from recent joint inspections of custody

As in previous years, we have found that custody officers treat most detainees respectfully and provide good levels of care. Following changes to the *Police and Crime Act* in April 2017, the number of people taken into police custody as a 'place of safety' under the *Mental Health Act* has significantly reduced. Forces showed their commitment to reducing the number of vulnerable people (including children) brought into custody more widely. Some showed improvements in the information they collected about arrested children. This informed their work with local authorities to improve alternative secure and non-secure accommodation arrangements. Identifying initial risk factors when a detainee arrived in custody was usually good. Healthcare was also much improved, including better oversight and monitoring of contract services by forces.

However, several areas continue to require improvement. Too many children continue to be held in custody overnight, especially where secure accommodation is needed. This is despite several forces following the concordat on children in custody. This requires children who have been charged and refused bail to be moved to more suitable alternative accommodation by local authorities.

Although the use of custody as a 'place of safety' has reduced, police officers' access to mental health practitioner advice and support remains limited. Response officers often tell us that they spend a lot of time accompanying detainees waiting for ambulances or mental health facilities. It is increasingly common for delays in obtaining mental health assessments for people arrested and detained in custody and any subsequent transfers into hospital beds.

Forces are also regularly failing to consistently meet all the requirements of the PACE codes (C and/or G), particularly about the reviews of detainees' detention. These are often timed inappropriately or insufficiently focused on detainees' interests. The quality of detention records, particularly those about the use of force in custody, were also poor.

## HMICFRS custody inspections - examples of good practice

Some positive practices we found during our 2018/19 inspection programme include:

- > Emergency readiness exercises showed a partnership approach to life support in medical emergencies. This benefitted detainees in crisis (Cheshire).
- > Drug arrest referral workers screened all new detainees through the computer programme NICHE to make sure that they were aware of people with indicators of addiction (Derbyshire).
- > The force monitored response times and outcomes for all mental health assessments from the time of referral to the time that they left the suite. They used this information to improve outcomes for detainees (Merseyside).
- > The in-house training programme input for custody officers on mental health included service users' direct experiences of custody (MPS).

## Supporting forces to improve

We regularly review our expectations so that they achieve the best outcomes for detainees and reflect changes to custodial policy and practice. We will publish a thematic summary review of detainees' dignity and care in summer 2019 to help forces improve, and hold a learning event for force custody leads in late 2019.

We invite force representatives to shadow our inspections to better understand how we carry out inspections and encourage forces to learn from inspection reports. We are involved in various policy making and influencing groups, including the PACE strategy board, the National Police Chiefs Council (NPCC) national custody forum, and the Independent Custody Visiting Association to help improve custody across the country.

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**Norma Collicott is a retired Police Superintendent and served for 30 years in the City of London Police. She has been the inspection lead for the custody programme for HMICFRS since April 2016.**

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# CASE 2

## MONITORING DETAINEES DURING A HANDOVER

### III

A woman was arrested at her home for failing to appear at court. She was taken into custody.

The custody sergeant who booked the woman in asked her routine risk assessment questions. The woman said that she had mental health issues and had bipolar disorder and manic depression. The custody sergeant asked whether the woman had ever self-harmed. The woman replied that she had in the past but had not done so for a while.

The woman did not say that she had drunk three litres of cider that day. However, she told the IOPC that due to the high volumes of alcohol she drunk regularly, this quantity of cider would not have affected her. All custody staff said that the woman did not seem intoxicated.

The woman was searched by a custody detention officer (CDO). The CDO asked the woman to remove her coat, jewellery, and shoes, and used a metal detector to help the search. The woman later told the IOPC that she had concealed a cigarette lighter between her buttocks. The lighter was undetected by the metal detector. However, it would not have been necessary or proportionate for the CDO to carry out a strip search given the information that they had.

When the search was complete, the woman was taken to a CCTV monitored cell and placed on level two intermittent observations. She was also shown the cell communications button which she could use to call the custody desk from her cell.

### College of Policing Authorised Professional Practice

#### 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. It includes the following actions:

- > the detainee is visited and roused at least every 30 minutes
- > physical visits and checks must be carried out – CCTV and other technologies can be used in support of this
- > the detainee is positively communicated with at frequent and irregular intervals
- > visits to the detainee are conducted in accordance with PACE Code C Annex

#### Find out more online:

[https://www.app.college.police.uk/app-content..t/detention-and-custody-2/detainee-care/#levels-of-observation](https://www.app.college.police.uk/app-content/t/detention-and-custody-2/detainee-care/#levels-of-observation)



Approximately 30 minutes after arriving in custody, the woman could be seen on CCTV using the cigarette lighter to set fire to the left sleeve of her clothes. After doing this, the woman could be seen pressing the cell communications button. Around one minute later, the woman pressed the button again.

The CDO who carried out the search explained that when the button is pressed it emits a buzzing noise from a control panel at the custody desk and also lights up the control panel. CCTV with audio at the custody desk also showed a buzzing sound coming from the control panel which corresponded with the times that the woman was pressing the cell communications button. Shouting and screaming could also be heard coming from the cells on the custody desk CCTV.

A staff handover was taking place in a small room off of the custody desk at the time of the shouting and screaming.

The custody sergeant explained to the IOPC that handovers always take place in the office next to the custody desk. On the day of this incident, the door between the office and the custody desk was open.

The CCTV showed the CDO who was responsible for carrying out cell checks in the office while the handover was taking place. When the buzzing started, the CDO left the handover office, silenced the buzzer, and returned to the office. The CDO explained to the IOPC that she silenced the buzzer because this was normal working practice when a handover was taking place. All staff were required to attend the handover.

## **College of Policing Authorised Professional Practice**

### **Handover procedures**

It is essential that enough time is allowed for a full and effective briefing and debriefing between custody officers and staff when handing over responsibility for detainees, particularly at shift change over.

This ensures that all relevant information is passed on and understood by the person taking over responsibility. If handover has to take place in or around the booking-in desks, the custody suite should be cleared of other personnel. Custody officers and other custody staff should carry out the handover together.

### **Find out more online:**

<https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/#handover-procedures>

The custody sergeant also confirmed that there was no procedure in place about the monitoring of detainees during a handover. College of Policing APP does not state that all staff must attend handovers.

After approximately one minute from when the woman first pressed the buzzer, she pressed it again. The CDO responsible for carrying out welfare checks left the handover office, silenced the buzzer, and returned to the handover. The woman had been setting fire to her clothes throughout this time.

The CDO was asked whether her perception of the situation changed once the woman pressed the buzzer a second time. The CDO said that it did not, as she said that people often repeatedly press the buzzer when in custody.

Inside the handover office was a wall of television screens which stream live CCTV images of the cells. The CDO who carried out the search of the woman stated that during the handover she looked at the CCTV screens and saw the woman “dancing around her cell”. The CDO confirmed that this was during the handover, which indicated that CCTV images from inside the woman’s cell were available inside the handover office.

The on-duty medical professional heard a buzzing noise at the custody desk and heard screaming from one of the cells. He approached the custody desk and asked who was making the noise and what was wrong with them. He walked to the woman’s cell with the CDO responsible for carrying out checks. Halfway between the cell and the custody desk he recalled that the CDO asked him if he could smell smoke.

The on-call medical professional and two CDOs entered the woman’s cell. They could immediately see and smell smoke and could see that the woman’s top had melted.

One of the CDOs and the medical professional tried to put the woman’s arm under the tap in the cell, but the water ran warmer. They moved the woman to a sink in the cell corridor. The woman’s arm was placed under cold water, but again the water ran warm. She was moved to the medical room where cold water was applied.

An ambulance was called a few minutes later. The woman was taken to hospital. She was returned to custody around 10pm after receiving medical treatment. ●

### Key questions for policy makers/managers:

- What guidance does your force give to officers on responding to cell communications buzzers, including during handovers?
- How does your force make sure that detainees are monitored effectively while handovers are carried out?

### Action taken by this police force:

- The force has taken steps to remind staff about assessing risk before silencing a cell buzzer.
- The force has taken steps to make sure that at least one member of staff monitors the CCTV screens during staff briefings.
- Work is underway by the force to make sure that cell communication buttons are monitored and appropriate responses provided during shift handovers.

### Outcomes for the officers/staff involved:

- The CDO who was responsible for carrying out cell checks had a case to answer for misconduct. This was for silencing the cell communications buzzer and failing to monitor the CCTV of the cell. The CDO attended a misconduct hearing and received a written warning.
- **Read full learning report**

## College of Policing Authorised Professional Practice

### Cell Checks

Where practicable, the person who carried out the last visit should conduct the next check. Continuity in checking allows evaluation of any changes in the detainee's condition and potential risks involved.

Officers and staff undertaking visits or observations must:

- > be appropriately briefed about the detainee's situation, risk assessment and particular needs
- > take an active role in communicating with the detainee and establishing a rapport
- > be familiar with the custody suite emergency procedure and aware of equipment available
- > ensure that each check is recorded in the custody record and that relevant information is captured and applied as part of the ongoing risk assessment process
- > be in possession of a cell key and ligature cutter

When cell checks and visits are carried out, it is not sufficient to record 'visit correct' or 'checked in order' in the custody record. More detail is required. A check through the cell spyhole does not constitute an acceptable welfare check under any circumstances. Checks are required even where the detainee is awake and has been engaging in conversation.

If custody staff are unable to clearly see the face of a sleeping detainee because their view is obscured by a blanket, the blanket should be adjusted so as to allow an adequate welfare check.

Where a decision has been made to monitor the detainee's welfare using continual CCTV cell observation, officers should record the reasons for taking this measure in the custody record along with the name of the person(s) responsible for the monitoring. CCTV monitoring does not negate the need to make regular physical checks of the detainee and update the custody record accordingly. If it is decided that the detainee needs to be roused on each visit, officers must do so and record the detainee's responses in the custody record.

Accurate entries in the custody record are essential, including a record of who has conducted each check.

### Find out more online:

<https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/?highlight=cell%20checks?s=cell+checks#cell-checks>

# Key themes in the IOPC's work around deaths in custody



**Tom Milsom, Chair of the IOPC's deaths in custody subject matter network**

As described in this issue, we continue to feedback learning from our work to help make sure that detention is as safe an environment as possible.

After a recent near-miss investigation, we have drawn attention to a risk of emergency cords in disabled toilets being used as a ligature. This has implications for many custody suites and the National Police Chiefs Council (NPCC) has shared this knowledge widely through its custody portfolio forum. Find out more about this case on page 26.

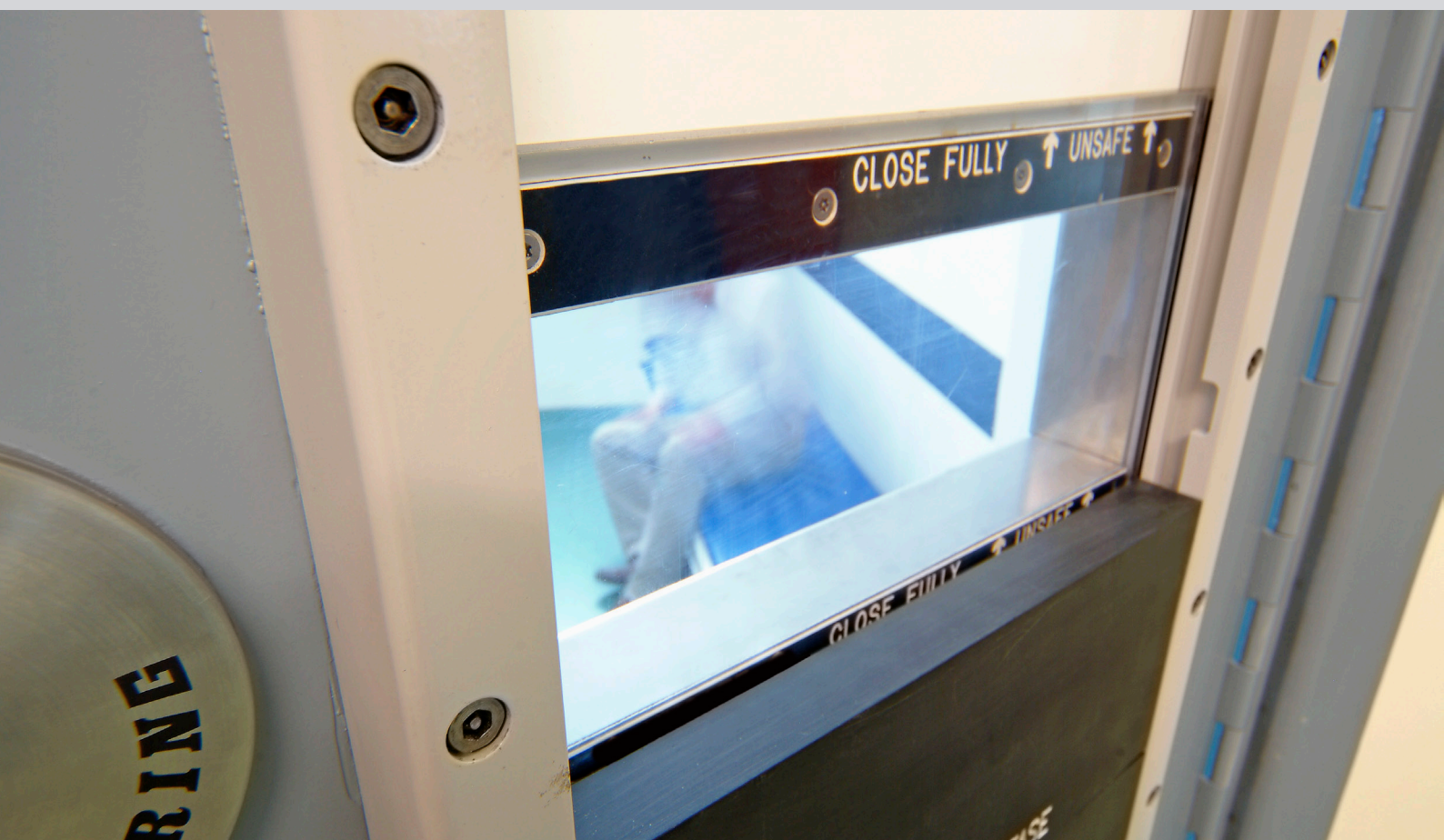
Long-standing themes that arise from our investigations include the quality of risk assessments and searches, the thoroughness of staff handovers and custody records, and the ability of staff to recognise vulnerability in all its various ways. Another issue we see is the adequacy of checks on detainees. In particular, when welfare checks are made through spyholes only, rather than by dropping hatches and communicating as required.

Custody is a difficult, dynamic workplace and staff play a key role in dealing with vulnerable people. Custody staff on the front-line face many challenges, including working with mental health concerns and substance mis-use among some of those in custody. We see the police dealing with people whose needs and risks have not been picked up or managed properly in the community. Those working in custody settings need good quality, ongoing training and support to develop their professional skills and keep pace with developments.

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**Tom Milsom** is an Operations Manager at the IOPC, and Chair of the IOPC's subject matter network on deaths in custody.

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# The ICVA and independent custody visitors



## Sherry Ralph, Chief Operating Officer, ICVA

**The Independent Custody Visiting Association (ICVA) is a Home Office, Policing Authority and Police and Crime Commissioner (PCC) funded membership organisation set up to lead, support and represent PCC and Policing Authority led independent custody visiting schemes.**

We work closely with the government and criminal justice organisations to:

- > Promote and support independent custody visiting in police forces in the UK. We provide guidance, training, advice and support to custody visiting schemes.
- > Create initiatives to improve conditions in police custody by supporting independent custody visitors across England and Wales.
- > We are members of the UK National Preventive Mechanism (UKNPM). This a requirement of the Optional Protocol against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) – an international human rights treaty designed to strengthen the protection of people deprived of their liberty.

## Who are independent custody visitors?

Independent custody visitors (ICVs) are local volunteers who unexpectedly visit police custody to check on the rights, entitlements, wellbeing and dignity of detainees held in police custody. They report to PCCs and policing authorities who hold chief constables to account.

There are around 1800 ICVs nationally and they are a vast resource for PCCs, policing authorities and the forces themselves. In 2017/18, ICVs made a staggering 8000 visits to custody across the UK, speaking to more than 26,000 detainees. One of the key drivers to visit custody is to reassure the public and provide public oversight of what can be quite a closed environment.

The ICVs complete visit forms once they have spoken to detainees (where possible) and checked any other areas of custody they may wish to see. They have a feedback meeting with a custody sergeant, detailing any problems during the visit that need immediate action. Reports are escalated where necessary.

The sheer scale of the work that ICVs undertake, in their own time and for free, is astonishing. We are very proud to support schemes that make sure that these fantastic volunteers are effectively trained and kept up-to-date with issues relevant to all areas of custody.

## What are the main issues that ICVs identify during their work?

ICVs identify a range of issues and areas of good practice across all of the suites that they visit. Some of the main issues frequently include but are not limited to:

- > Appropriate adult provision – problems are reported about wait times for both children and vulnerable adults, and extending the time that someone will need to stay in custody.
- > Wait times and access to healthcare services – these can be problematic for detainees.
- > Staffing – this is often reported, sometimes delaying ICVs accessing detainees.

Some areas of good practice that are reported include:

- > Really good relationships between custody staff and detainees.
- > Improvements in menstrual care available to detainees.

## Why are ICVs important?

We recently worked with the Home Office about menstrual protection and dignity of detainees after concerning ICV reports. We hear numerous reports of ICV feedback leading to improvements to suites and supplies. This includes the introduction of fridges, thicker mattresses, blankets in cold weather, menstrual products, equipment for detainees with disabilities, and appropriate food for diabetic detainees.

We think that ICVs can make a massive difference to detainees and custody suites across the UK, whether because reports have changed legislation or time spent chatting to an upset detainee about their wellbeing has helped. Both are important work. The impact that ICVs have can create a better environment for detainees and custody staff alike.

## What is coming up for the ICVA?

This year detainee dignity is the theme for our work and conferences for scheme managers and ICVs. We will produce resources on what dignity is, what this looks like in a custody context, and why detainee dignity is important. We will continue to work with schemes to embed findings from inspectorate reports into custody visiting. We also launched the first of our distance learning modules for scheme managers.

## How can people get involved and become an ICV?

Recruitment for volunteers is managed locally by the Office for the Police and Crime Commissioner (OPCC) or the policing authority (depending where you are in the UK). We have an interactive map on our website with the email addresses of your local office <https://icva.org.uk/purpose/>

## Read more

Read the full announcement from the Home Office on the upcoming changes to PACE Code C here: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/796951/2019-04-23-Post-Consulation-Response.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796951/2019-04-23-Post-Consulation-Response.pdf)

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**Sherry Ralph** is the Chief Operating Officer at the ICVA. Sherry has worked throughout the criminal justice sector including work in prisons, delivering contracts for prison leavers and gang-affected young people, housing allocations policy, and contract management for a domestic violence service. Follow Sherry on Twitter [@projectICVA](https://twitter.com/projectICVA)

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# CASE 3

## VULNERABLE WOMAN IN CUSTODY

### III

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

Two officers were made aware of the visit. They made a number of enquiries to find the woman, including checking local shops, searching the local area, and visiting her home.

The woman’s partner told officers that she had been drinking and was upset about the death of her grandmother.

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

The two officers were made aware of the incident and went to the hospital. They arrived around 11pm. When they arrived the woman was sprawled on the floor and was shouting and swearing at two security guards. She was arrested for drunk and disorderly behaviour.

The officers called for assistance from colleagues as a van was needed to take the woman to custody. The officers in the van took the woman into custody and the two attending officers resumed their normal duties.

The two officers who initially dealt with the woman did not explicitly tell their colleagues of the concern for safety incident. This was because they said the officers had been present when the initial report was made; numerous updates had been given to the control room over the previous hour while they were looking for the woman; and there had been a lengthy radio conversation while they had been trying to find the woman.

One of the officers who took the woman into custody told the IOPC that there had been no discussion between her and her colleagues about what options were available to them when dealing with the woman. She said on reflection that they could have considered taking her to the hospital’s accident and emergency department because she was so drunk.

On arrival at the custody suite the officers found it difficult to help the woman from the back of the police van into the custody suite because she could not walk unaided.

Officers tried to place the woman in an EVAC chair. EVAC chairs are typically used to move people in an emergency. However, this was unsuitable due to her size.

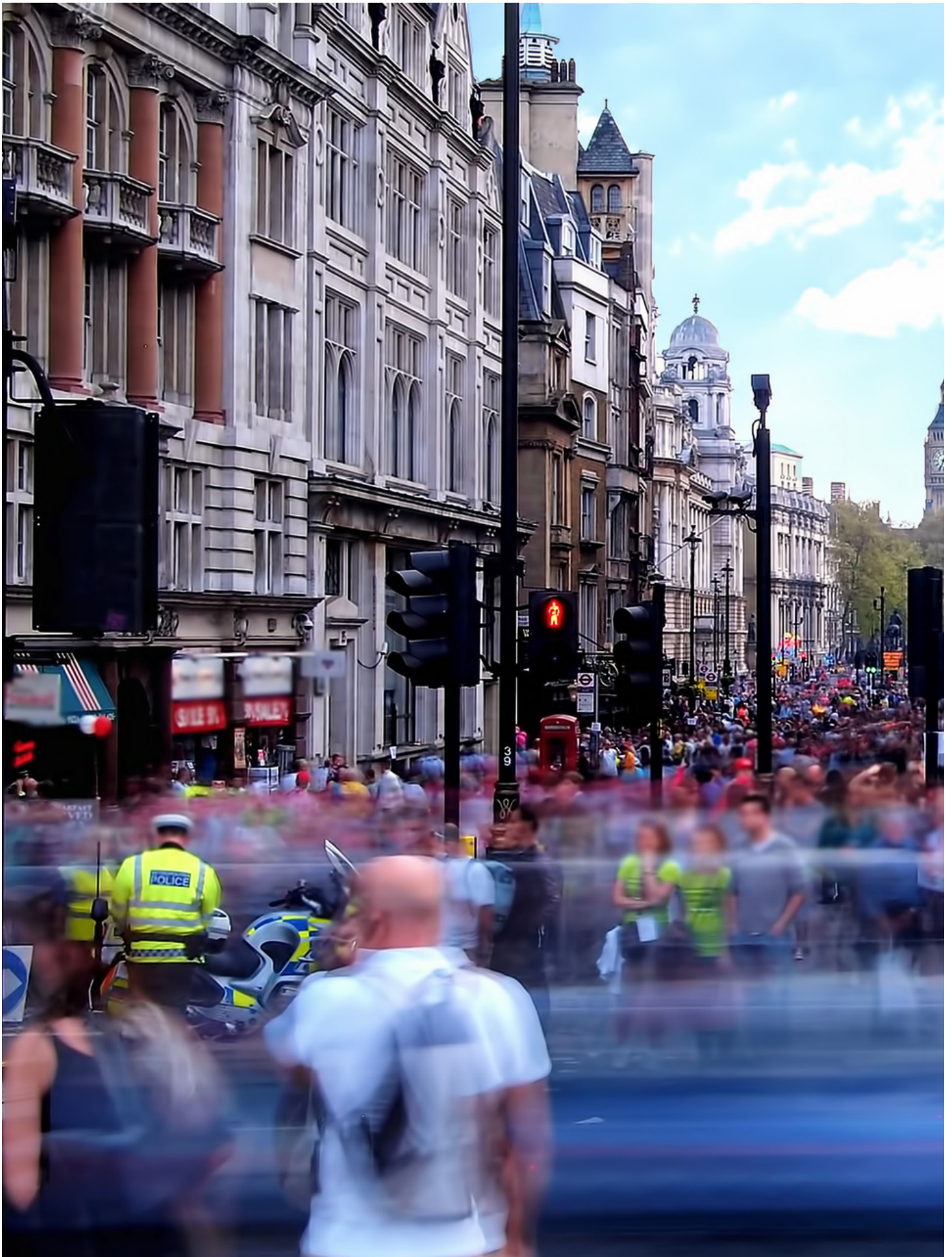
CCTV footage of the woman entering the custody suite shows that she walked to the custody desk with an officer supporting her under her right arm. She leant on the custody desk and three officers helped to steady her on her feet.

The woman removed her trousers at the custody desk and sat on the floor.

The custody sergeant allocated the woman to a life sign cell with a camera and a low bed. A life sign cell is equipped with a motion sensor which triggers an alarm if a person appears to stop breathing.

CCTV shows that officers pulled the woman to her feet and guided her towards the cell. The woman sat down on the floor before reaching the cell. She told officers that she could not get up because her knees and ankles were hurting.







The custody sergeant told the IOPC that he received limited information that the woman had been arrested at the hospital for being drunk and disorderly. He said that she was obviously drunk as her speech was slurred, she was not able to listen, and her hair was messy. He said that she lay down as officers tried to move her, and it was clear that she would not have been able to listen to the questions he needed to ask her during the booking-in process.

He noted that she was apologetic and upset, although he could not recall anything she said specifically. He added that he did not think she was incapable, and if he thought she was, he would have told the officers to return her to the hospital. He noted on the custody record that the woman was unfit to complete the risk assessment.

The woman crawled into the cell. Once in the cell the woman's jewellery was removed and she was placed in the recovery position.

The officers discussed placing the woman in an anti-rip suit but one was not available in a suitable size. The custody sergeant told the IOPC he was confident the woman did not require anti-rip clothing. He felt this could have made the situation worse.

He considered removing her clothes and providing her with an anti-rip blanket but thought this could have compromised her dignity. He also said he was aware that approximately six months before, the woman had tied a blanket around her neck to try to self-harm.

Around 12am the custody sergeant recorded on the custody record that:

- > A risk assessment was not completed as "the woman is extremely intoxicated and unable to understand at this time".
- > The woman needed to see a health care professional for "obs/alcohol/withdrawal".
- > The woman was to be searched and placed on level two observations in an observation and life sign cell, with a mattress moved to the floor.

He added that the woman should remain on her side to make sure that her airway was open. The custody sergeant was aware of a previous occasion in custody where she had rolled over and had breathing difficulties due to her size.

The custody nurse told the IOPC that because the woman was so intoxicated she was unable to carry out any observations in line with the custody sergeant's request. She went on to say that she was not allowed to assess a detainee in their cell unless it was an urgent case, and a detainee would not normally be assessed if they were very intoxicated.

Around 4.40am the duty inspector recorded on the custody record that the woman's continued detention was necessary until she was sober and a charging decision could be made. He recorded that he had been advised that she was extremely difficult to deal with. He told the IOPC that when he conducted his review the woman had been in custody for just over four hours. He did not wake her as she was drunk and resting. He explained there was sometimes no benefit in giving a detainee their rights and entitlements while drunk, as they would be unlikely to understand or remember.

Around 6.45am at the end of his shift, the custody sergeant updated the custody record to show that the two oncoming custody sergeants had taken over responsibility for the woman. He told the IOPC he noted that the woman was "needy" and that he had most likely received that information from the custody detention officers. He said that he had meant that she needed a lot of care. He also said that he meant that if she pressed her cell buzzer she should be treated more promptly and a relevant care plan should be implemented.

The woman was checked around 6.30am.

The buzzer in the woman's cell sounded while the handover was ongoing, and someone went to her cell to take her to the toilet.

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

Around 7.10am officers found the woman unresponsive in her cell.

The custody sergeant told the IOPC that when they found her, the woman was lying on her back, beginning to turn blue in the face, and her breathing was raspy. He said he immediately placed her in the recovery position, while the other custody sergeant removed the bra from her neck. The woman's breathing became easier, colour returned to her face, and she became fully conscious.

The second custody sergeant noted on the custody record that when the woman started to breathe normally she said that she wanted to kill herself. Around 7.25am he updated the custody record to reflect that she had been put on level four observations under constant supervision.

An ambulance was called and an officer went with the woman to hospital. The custody record noted that a person escort record (PER) form, care plan, and risk assessment were given to the officer accompanying the woman to hospital.

When a copy of the PER form was requested at the start of the investigation, the IOPC was told that it had not been kept. Two custody sergeants said they were unaware of the requirement to keep a copy.

During interview, one of the custody sergeants highlighted an issue with the NICHE risk assessment process.

If the person completing the assessment answered "no" to the question "is the detained person drunk or does the detained person appear drunk?", the user had no option to add additional notes about whether medical assistance was required.

When requesting radio and telephone recordings as part of the investigation, the IOPC was made aware that the contact centre had been temporarily relocated, leading to the loss of audio recordings.

Audio and visual footage from the custody suite had also not been kept due to a fault on the server. ●

### Key questions for policy makers/managers:

- How does your force make sure that PER forms can be stored and retrieved effectively?
- Do staff working in your custody suites have easy access to wheelchairs that can be used by people of all shapes and sizes?
- Do your force custody suites stock anti-rip clothing in a variety of sizes, including larger sizes?
- How does your force make sure that radio and telephone recordings are kept, particularly when upgrade work takes place?
- Does your force regularly check audio and video recording systems to make sure that footage is kept in accordance with force policy?
- How does your force make sure that any contracted medical staff working in custody are aware of any force specific practices which might differ to those within other force areas where they operate?
- Does your force set out expectations for when medical staff should visit people who are drunk and incapable?

### Key questions for police officers/staff:

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

### Action taken by this police force:

- Anti-rip suits up to size 4XL are now stocked in custody.
- Wheelchairs for people weighing up to 17st 9lbs are located behind custody desks.
- The force is exploring the issue with the NICHE risk assessment. Staff have been advised of an interim solution.
- Staff are conducting quality checks to make sure that calls into the communications centre are recorded and kept.
- All staff working in custody are now equipped with body worn video cameras.
- Training and working practices for all agency nursing staff have been reviewed. An induction is now in place.

### Outcomes for the officers/staff involved:

- The two officers who responded to the initial call about the woman, but failed to make sure that the custody officers were told about the woman's threat to self-harm, both received management action. The officers were reminded of the content of APP around making sure that arresting officers pass relevant information about risk factors to any escorting officers. This would ensure the details are passed to the custody officer when authorising detention.
- The custody sergeant who dealt with the woman when she was brought into custody received management action. This was for failing to carry out a review of the risk assessment, and for failing to make sure that the woman received sufficient medical care. He was reminded of responsibilities to observe APP guidance and comply with Code C of PACE.
- The nurse who was working in custody when the woman was brought into the custody suite, was found to have a case to answer for misconduct. This was for failing to assess the woman when she arrived in the custody unit in an intoxicated state. No further action could be taken as the nurse no longer worked for the police force.

**Read full learning report**



**Want to know more about the action taken by the force following this case?**

**You can download the full learning report from the [IOPC website](#).**

# Making good: key lessons for practice from the good police custody study



**Dr Layla Skinns, University of Sheffield**

Over the last five years, my research team and I have collected a range of data as part of an Economic and Social Research Council (ESRC)-funded project called 'Good' police custody? Theorising the 'is' and the 'ought'. The primary aim of the research was to robustly examine what is meant by 'good' police custody.

This data has been used to explore initial ideas about good police custody (Skinns et al., 2015), the delivery of police custody (Skinns et al., 2017a), staff-detainee interactions and the use of 'soft' power (Skinns et al., 2017b), detainees' emotional reactions to police custody (Wooff and Skinns, 2017), the pains of police detention (Skinns and Wooff, forthcoming), and police-academic partnerships during research on police custody (Greene and Skinns, 2017).

In 2016-17, we surveyed nearly 800 staff and detainees in 27 custody facilities in 13 police forces. These data have been used to create good practice recommendations (see [www.sheffield.ac.uk/law/research/projects/police](http://www.sheffield.ac.uk/law/research/projects/police)).

It is recommended that dignity – linked to equality, autonomy and decency – should be prioritised by police custody practitioners, managers, national leads and policy makers. They should prioritise this in relation to the operation and strategic direction of police custody, alongside existing priorities such as safety, security, risk, cost effectiveness and the demands of the law and the criminal justice process. This will be beneficial for detainees and staff. For example, through increased detainee cooperation. To achieve this, it is recommended that changes are made to police attitudes and behaviours; policies, training and line management procedures; detainee expectations; and the material conditions of police custody. For example, it is recommended that:

- > Staff should emphasise and encourage detainee autonomy wherever possible. Even in police custody, there are small things that detainees can do/have for themselves. For example, being able to tell the time, read, write and exercise their other rights and entitlements. Opportunities for autonomy may offset poor material conditions. This is particularly important where police forces may not have the resources to improve material conditions.
- > Police forces should design dignity into the fabric of the building. This could include maximising natural light, private spaces for staff-detainee interactions, clocks, adequate pixelation on computer screens around toilets, and art in communal areas.

**“ Dignified treatment and improved material conditions are at the heart of more ordered and forward-thinking police custody facilities. ”**



### Further reading (freely available online)

- Greene, A. and Skinns, L. (2018) Different ways of acting and different ways of knowing? The cultures of police-academic partnerships in a multi-site and multi-force study, *European Journal of Policing Studies*, 5(3), 55-75.
- Skinns, L. Rice, L., Sprawson, A. and Wooff, A. (2017b) Police legitimacy in context: An exploration of 'soft power' in police custody in England, *Policing: An international Journal of Police Strategies and Management*, 40 (3), 601-613.
- Skinns, L., Sprawson, A., Sorsby, A., Smith, R. and Wooff, A. (2017a) Police custody delivery in the twenty-first century in England and Wales: Current arrangements and their implications for patterns of policing, *European Journal of Policing Studies*, 4 (3), 325-349.
- Skinns, L., Wooff, A. and Sprawson, A. (2015) 'Preliminary findings on police custody delivery in the 21st century: Is it "good" enough?' Policing and Society, 27(4), 358-371.
- Wooff, A. and Skinns, L. (2017) The role of emotion, space and place in police custody in England: Towards a geography of police custody, *Punishment and Society*, DOI: 10.1177/1462474517722176



**Dr Layla Skinns** is a Reader in Criminology in the Centre for Criminological Research, University of Sheffield. A key focus of her research has been on police detention in England and Wales, but also in other parts of the English-speaking world. She is interested in police powers and their relationship with the law, police cultures and police discretion, and how this impacts on equality and state-citizen relations.



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## CASE 4

## SELF-HARM WITH A RAZOR BLADE



A man was arrested on suspicion of common assault and was taken to custody. He was booked in by the custody sergeant, who had dealt with him before.

The custody sergeant recalled that the shift was busy, the custody unit was operating with one less custody sergeant, and the other custody sergeant was involved in a matter which took a significant amount of time to resolve.

As a result, he was responsible for dealing with all detainees entering custody.

A risk assessment was completed and the custody record said that the man:

- > did not have any illness or injury
- > was not taking, or supposed to be taking, any tablets or medication
- > had unknown mental ill-health
- > refused to answer whether he had previously tried to harm himself
- > had drunk two glasses of wine
- > had no drug or alcohol dependencies
- > did not require police help and support with reading/writing or have any learning disabilities
- > refused to answer whether there was anything else regarding his welfare that he wished to make the custody sergeant aware of during his detention
- > was feeling “very nice”
- > did not want to speak to the custody nurse
- > was not in contact with any medical or support services

Force policy required officers to check both the Police National Computer (PNC) and NICHE during a risk assessment. The custody sergeant checked the PNC (which showed markers from two years before about self-harm and thoughts of suicide) but did not check NICHE (which showed a more recent suicide marker not contained on the PNC).

He requested an assessment by a healthcare professional (HCP) to determine the man’s fitness for detention (due to the possibility of diabetes, but not in relation to his mental health); recorded a care plan; and placed the man on level one observations with enhanced frequency of visits every 30 minutes until the HCP assessment could take place.

The custody sergeant had dealt with the man two months earlier, when he disclosed that he had taken 20 tablets and had tried to self-harm a week before coming into custody. He had indicated that he wanted to die when he left custody. No warning marker was created on either the PNC or NICHE about this.

The man was searched. During this he was asked to take off his shoes. His jeans and coat pockets were searched but his socks were not removed. A hand-held metal detector was not used, despite force policy requiring this. The officer carrying out the search told the custody sergeant that there was a rip inside the man’s coat, but that nothing could be felt inside. The custody sergeant confirmed that the man could keep his coat. The man was taken to a cell.

When questioned, the custody sergeant said that the rip in the coat did not concern him as a previous briefing to officers had said that leaving a detainee in their own clothing and increasing the observation levels may be more appropriate than seizing people’s clothing.

A detention officer (DO) entered the cell and placed toilet paper and a blanket on the bed. The DO had also dealt with the man before and voiced some concern to the custody sergeant about the man's demeanour. It is not known if the DO raised any specific concern about the man being allowed to keep his coat with him in the cell.

The HCP attended and recorded that the man was emotional and refusing assessment, stating that he wanted to be left alone. No concerns were noted about his fitness for detention. It was decided that he should remain on the same level of observation. No risks of self-harm were found but it was suggested that consideration be given to a Liaison and Diversion System (LADS) assessment if there was no change in his emotional state.

Shortly after the HCP spoke to the man, CCTV footage showed him moving the blanket from over his head and sitting up. He folded his left arm out in front of him (with the sleeve pulled up to his elbow) and moved it up to the left side of his head. His right forearm was placed on his right thigh. He then lay back down on his left side and pulled the blanket over his upper body.

A minute later, he sat up and walked to the toilet. Blood staining could be seen on the mattress. He stood over the toilet and pressed the flush button before returning to lie on the bed, holding his left arm over the side. Blood was seen to drip from his left arm onto the floor of the cell. Some minutes later, he sat up and walked to the toilet again. After bending over the toilet he pressed the flush button and washed his hands before returning to lie on the bed and pulling the blanket over his upper body. A privacy panel obscuring the CCTV footage of the toilet stops us from seeing what the man did.

While the man was lying on the bed, a second DO heard voices coming from his cell. They opened the vertical louvered cell door viewer and closed it again in under two seconds. They did not drop the cell hatch.

College of Policing Authorised Professional Practice (APP) on detention and custody states that checking through a cell spyhole is not an acceptable welfare check under any circumstances.

The DO recorded on the custody record that a welfare visit had been made: "Cell visit DP awake, no concerns at this time".

CCTV footage showed that when the louvered viewer was opened, there was blood staining on the cell floor below the man's left arm.

The DO told the investigation that she saw no visible signs of cuts on the man's wrist or hands, or blood on the floor. She therefore did not raise any alarm or seek medical assistance as she had no concerns regarding his welfare at that time.

Minutes later, the CCTV showed the man moving his right hand and making a number of slashing movements across his left forearm. CCTV showed him leaning towards the toilet before lying down on the floor.

The viewer and cell hatch were fully opened. Other staff, including an Arrest Intervention Referral Service (AIRS) worker, entered the cell and attended to the man in the presence of the HCP. An ambulance was called and the man was taken to hospital. He received treatment for his injuries and a mental health assessment before being returned to police custody.

After the man was taken to hospital, the custody sergeant spoke with the duty inspector about the next steps required in relation to an adverse incident. The inspector questioned whether the incident was an adverse incident but the custody sergeant completed the relevant form and submitted it anyway.

A small blade was found in the man's cell. The recovered blade had likely been used by the man to self-harm while in the cell, although it was not known where he had concealed it. The custody sergeant added warning markers for 'conceals' and 'self-harm' to the man's NICHE record for uploading onto the PNC. The incident was initially dealt with informally by the duty inspector before a detective superintendent referral was made by the force's Professional Standards Department (PSD). ●

**Key questions for policy makers/managers:**

- Does your force remind officers to check both the PNC and NICHE when completing risk assessments?
- What steps has your force taken to advise all officers and staff of the circumstances which constitute an adverse incident, and how these should be reported?
- Where your force requires officers to routinely use hand-held metal detectors, do you make sure that these are readily available to officers working in custody?

**Key questions for police officers and staff:**

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

**Action taken by this force:**

- The force has added a definition of 'adverse incident' to force policy. This has been shared with all operational custody staff.
- Custody staff have also been advised that NICHE does not always replicate information held on the PNC, and therefore both systems should be checked.

**Outcomes for the officers/staff involved:**

- The custody sergeant who booked the man into custody was found to have no case to answer and no further action was taken.
- The detention officer who opened the vertical louvered viewer of the cell door for less than two seconds to check on the man was found to have a case to answer for misconduct. The matter was dealt with through a misconduct meeting. She received a verbal warning which will remain for six months.
- **[Read full learning report](#)**



# CASE 5

## ACCESS TO AN APPROPRIATE ADULT



A woman was brought into custody around 8.40pm. In her custody record under risk assessment, it was recorded that:

- > detained person (DP) is intoxicated but can 'walk and talk'
- > DP has various warning signs (WS), including drugs and self-harm (DSH)
- > DP has risks of DSH/suicide
- > DP also had WS for conceals
- > DP has been strip searched – nothing found
- > DP has some mental and health problems
- > previous risk assessments have been reviewed and there is nothing further of note
- > DP will need to see the forensic nurse practitioner and clinical nurse practitioner

The custody sergeant placed the woman on level two observations, directed she was roused every visit, and that she be assessed by a custody nurse and referred to the community psychiatric nurse the next morning.

When asked by the IOPC about any consideration given to calling an appropriate adult, the custody sergeant stated “whilst [she] was intoxicated she understood the allegation against her and why she had been arrested. [She] was oriented to time, date, place and person. [She] had been in custody many times previously and was familiar with the processes. I was satisfied that there was nothing to suggest that [she] did not understand the significance of what was said to her or the situation in general. This was reinforced by [her] request for a solicitor of her choice. If there was any concern over [her] mental health or a requirement for an appropriate adult, the community psychiatric nurse would identify it”.

### » PACE Code C – Annex E

The role of the appropriate adult is to safeguard the rights, entitlements and welfare of juveniles and vulnerable persons to whom the provisions of this and any other Code of Practice apply. For this reason, the appropriate adult is expected, amongst other things, to:

- > support, advise and assist them when, in accordance with this Code or any other Code of Practice, they are given or asked to provide information or participate in any procedure;
- > observe whether the police are acting properly and fairly to respect their rights and entitlements, and inform an officer of the rank of inspector or above if they consider that they are not;
- > assist them to communicate with the police whilst respecting their right to say nothing unless they want to as set out in the terms of the caution and;
- > help them to understand their rights and ensure that those rights are protected and respected.

### Find out more online:

<https://www.gov.uk/government/publications/pace-code-c-2018>

He added “As [she] was not going to be interviewed until the next day even if I had deemed [her] vulnerable there was no purpose in requesting an appropriate adult at that time. My view was likely that [she] was likely to go to sleep”.

### » PACE Code C – Annex E

If the custody officer authorises the detention of a vulnerable person, the custody officer must as soon as practicable inform the appropriate adult of the grounds for detention and the person’s whereabouts, and secure the attendance of the appropriate adult at the police station to see the detainee.

#### Find out more online:

<https://www.gov.uk/government/publications/pace-code-c-2018>

As part of the IOPC investigation, it was found that the force policy on appropriate adults states that “if a detainee appears to be suffering from a mental disorder, [a force] forensic nurse practitioner (FNP) or a police surgeon must be called and their advice sought regarding the need for an appropriate adult” and that “only in exceptional circumstances must the services of the [appropriate adult service] be utilised between the hours of 2200hrs and 0700hrs.

In such circumstances the inspector responsible for the relevant custody suite must authorise the attendance of the appropriate adult] and their details must be provided when the request is made”. This position is currently contradictory to the guidance given in PACE about when an appropriate adult should be called.

Around 9.35pm the woman was taken to her cell and was given a hot meal, drink, blanket and tissue paper soon after.

The woman was checked in her cell around 10.05pm and was “sat up and eating”. Around 10.30pm she was given a hot drink before being taken out of her cell in order to complete a liveness scan, a method of taking fingerprints. She was returned to her cell around 10.45pm. She was visited again at 11pm and was sitting up and awake.

Around 11.20pm the FNP spoke to the woman. She recorded that the woman had anxiety/depression treated by her GP; had attempted suicide previously; had tied cord around her neck; had no suicidal thoughts at that time; denied drug use; and denied drinking alcohol. She also documented that “DP [detained person] denies any drug use or alcohol today but presents as intoxicated, I would suggest she has taken normal medication plus extra, she is on roused visits and will remain so for a few hours... not fit for interview.”

She endorsed the custody sergeant's care regime of 30 minute rousing visits.

The woman was checked around 11.35pm and was asleep on her left side and breathing. When she was visited around midnight officers were unable to get a response, although she was breathing. An ambulance was called and she was taken to hospital. It was later discovered that the woman had concealed a wrap of what was believed to be heroin in her vagina. ●

#### Key questions for policy makers/managers:

- Is your force’s policy on appropriate adults consistent with PACE?
- What advice does your force give to officers on making contact with appropriate adults out of hours, or recording where they have tried to do this, but been unsuccessful?

#### Action taken by this police force:

- The force has updated its policy on appropriate adults to reflect PACE.
- [Read full learning report](#)

# CASE 6

## DETAINEE SELF-HARMS WITH RED LIFELINE CORD FROM DISABLED TOILET



A man was arrested on suspicion of shoplifting and trespass upon a railway line and was taken into police custody. On arrival he was booked in by a custody sergeant.

The custody sergeant carried out a risk assessment in which it was revealed that the man had anxiety, post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD) and depression. He was receiving medication for these. The man had warning markers for self-harm but was noted to be calm and compliant at the time.

The custody sergeant had dealt with the man on a previous occasion in custody, and later told colleagues than the man appeared agitated and less calm than when he had dealt with him before. The man was placed on level one observations. This required cell checks every 30 minutes. All cords were removed from his clothing.

Anti-rip clothing was considered but was not thought to be necessary. This was reinforced by a recent inspection by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services which had recommended that anti-rip clothing should only be used as a last resort.

A healthcare professional (HCP) was requested.

While waiting for the HCP, responsibility for the man's detention was handed over to a different custody sergeant.

At this point, the man asked to use the disabled toilet which was located close to the custody desk. It had become common practice within the custody suite for recently arrested detainees who had been searched but not yet placed into a cell to be allowed to use this because of its proximity to the custody desk.

The custody sergeant who took over responsibility for the man allowed him to use the toilet. They asked the man to leave the door open while he used it. The custody sergeant did not watch the man use the toilet, but stood very close to the door.

While in the toilet, the man was able to remove a portion of the red lifeline cord, by biting through it, and hide this on his person. The custody sergeant was unaware of this.

The man was put into a cell because the HCP was delayed.

He was visited a few minutes later by a custody detention officer (CDO). He looked through the spy hole and saw the man lying on the bed with a blanket over him which came up to his chest/shoulder area.

He could see the man's chest moving up and down and believed he was asleep.

A few minutes later another CDO went to the man's cell to take him to the HCP. They found him unresponsive with a portion of the red lifeline cord from the disabled toilet wrapped around his neck. ●



**Key questions for policy makers/managers:**

- If your force uses red lifeline cords in disabled toilets, what action have you taken to reduce the risk of cords being used as a ligature when toilets are used by detainees?
- How does your force make sure that detainees are adequately supervised during toilet visits, particularly where the risk of self-harm has been identified?

**Key questions for police officers/staff:**

- How would you have handled this situation differently to make sure that the man did not have the opportunity to self-harm?

**Action taken by this police force:**

- The force immediately stopped allowing detainees who had not yet been put into a cell to use the disabled toilet.
- All lifeline cords were immediately removed from disabled toilets across the force area. They were replaced with a different product that removes the risk presented by the cord.
- The incident was brought to the attention of all custody staff through the departmental newsletter.
- The incident was discussed on the force's custody refresher training.
- The force worked with the National Police Chiefs Council (NPCC) to make sure that learning was shared quickly with heads of custody working in other forces.

**Action taken by the NPCC:**

- Learning from this case was shared with all force custody leads via the NPCC custody portfolio forum.
- All forces were advised to review their own custody facilities as a matter of urgency to make sure that any cords that could present a similar risk were replaced with alternative means of raising alarm which could not be used as a ligature.
- Learning has also been uploaded to the NPCC ChiefsNet to make sure that it can be accessed by a wider policing audience.

**Outcomes for the officers/staff involved:**

- The custody sergeant who first dealt with the man when he was brought into custody received management action. The force decided that while conducting the risk assessment and creating the care plan for the man, the custody sergeant failed to take into account that the man was a vulnerable detainee who was visibly agitated on arrival and had warning markers for recent self-harm attempts. Instead, the custody sergeant placed the man into a cell on a level one care plan, rather than on a level three or level four close proximity regime, and had chosen not to place him in anti-rip clothing.
- The CDO who visited the man after he was first placed in his cell, and checked on him by looking through the spyhole, was given advice on making appropriate checks.
- **[Read full learning report](#)**



# Heading to an event?

Would you like Learning the Lessons items to give out at an event? To order copies of magazines, leaflets, pens or tote bags, please email [learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk)





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

We are creating a new virtual panel, bringing together a range of stakeholders from the police, the community and voluntary sector, and academia, to support the development of future issues of Learning the Lessons.

If you are interested in joining the panel, please complete our [online registration form](#) to register your interest.

For more information email [learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk)

## Why I got involved...



**In November 2018 we launched a new panel to support the development of the magazine. In this issue we meet one of its members, DCI Jon Hull.**

I have been in policing, with Sussex Police, for almost 24 years. For the majority of my career I have been a detective, but more recently I have worked with our Professional Standards Department (PSD).

It is my work in the PSD that shows me how important it is to learn from things that go right and wrong. This strikes at the heart of our ability to keep the public safe. When I saw Learning the Lessons, it was not new to me. We would often get bulletins in custody about learning from the experiences of others.

I was really keen to get involved as a panel member.

This is about learning from each other rather than allowing the same mistakes to happen in different areas. The Code of Ethics says that objectivity, openness and accountability are key. Learning is something we should do day-in, day-out.

**“ I was really keen to get involved as a panel member. This is about learning from each other rather than allowing the same mistakes to happen in different areas. ”**

The Learning the Lessons magazine is published by the IOPC.

It is developed in collaboration with partners in policing.

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July 2019

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