



ASSOCIATION OF
CHIEF POLICE OFFICERS



Guidance on

THE SAFER DETENTION AND HANDLING OF PERSONS IN POLICE CUSTODY Second Edition

This has been published as an interim product due to the development of Authorised Professional Practice (APP) and will be published in an alternative format in the future as part of the APP programme.

2012

Produced on behalf of the Association of Chief Police Officers
by the National Policing Improvement Agency

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Guidance on **THE SAFER DETENTION AND HANDLING OF PERSONS IN POLICE CUSTODY**

Second Edition

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Produced on behalf of the Association of Chief Police Officers
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Preface

Dealing effectively, fairly and lawfully with people who come into contact with the police is a key element in:

- Building community confidence;
- Ensuring the successful outcome to the investigation of crime;
- Engaging support in building safer, more secure neighbourhoods;
- Promoting a safer working environment for staff;
- Ensuring that people who are arrested are treated fairly and that the wellbeing of detainees, especially those who are vulnerable, is safeguarded.

This guidance sets out the legal framework within which the police must operate to tackle crime, and the protections and safeguards for the public.

It focuses on practical issues and aims to provide a definitive guide on how police forces should put in place strategic and operational policies to help raise the standards of custodial care for those who come into contact with the police. The core task of the police is to uphold law and order and to tackle crime and disorder effectively. The evidence gathering process is essential to this. Ensuring that a detainee receives the appropriate level of care to determine their fitness to be detained and fitness to be interviewed is a key element in obtaining the best quality of evidence to assist in prosecuting offenders. There are three other elements to consider.

- Many people who come into custody or police contact do so with physical or mental vulnerabilities or both. There are also problems of alcohol or drug-related abuse or misuse. The police service often provides the gateway to healthcare services. A police station is not the most appropriate place for diagnostic assessment or healthcare treatment. The guidance, therefore strongly promotes and advises engaging the right healthcare professional at the right time and in the right place.
- The high level of contact police officers and police staff have with detainees, who may be violent or vulnerable or both, places significant risk and expectations on them. This guidance focuses on helping staff to identify warning signs and to carry out effective risk assessment. Identifying the risks and acting on them in the best way possible should help to minimise the risk to the detainee, to staff and others who come into contact

- with those in custody.
- The impact of a death in custody or following police contact is traumatic for the family and friends of the deceased. It also has a significant effect on the staff involved. This guidance has been compiled primarily to help minimise deaths and reduce the number of adverse incidents while people are in police custody. Lessons have been learned from deaths and adverse incidents in custody and this document sets out to ensure that these lessons are put into practice.

This guidance is produced by the National Policing Improvement Agency (NPIA) on behalf of the Association of Chief Police Officers (ACPO) who have worked closely with stakeholders and practitioners. This guidance will be re-formatted and published as ACPO Authorised Professional Practice (APP) and will be available publicly and to police forces in an electronic format in 2012. ACPO will continue to review and maintain the content of this guidance to ensure that it remains relevant, up to date and continues to make best use of the changing good practice and lessons learnt.

1

INTRODUCTION

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1.1 INTRODUCTION

ACPO 2006 Guidance on the Safer Detention and Handling of Persons in Police Custody identified the standards expected in the handling of persons who come into police contact. It has been established that these standards can only be delivered by having strategic policies which support and drive operational good practice and effective training. Recognition is given to the varying demands on individual police forces and the way in which they deal with the detention and handling of persons in their custody.

This guidance revises and brings up to date the 2006 document. In doing so, it incorporates and applies a wealth of learning from the implementation and practical use of original guidance since 2006. This document draws together legislative changes, Independent Police Complaints Commission (IPCC) recommendations, HM Coroner's recommendations, Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Prisons (HMI Prisons) report findings, and other ACPO Guidance that relates to and affects the way in which people may be detained and dealt with in police custody and during transportation. It also provides a level of flexibility needed to meet local requirements, while providing an overarching framework under which standards in custodial care may continually improve.

Work on this guidance has drawn on the collective experiences of policing practitioners, stakeholders, academics, and current literature to bring together the policies and principles that underpin the appropriate handling of persons in police custody. The guidance aims to assist the Police Service to achieve the delivery of targets, particularly regarding the detection of crime, reducing reoffending and increasing public confidence.

The Police and Criminal Evidence Act 1984 (PACE) and the associated Codes of Practice (including all 2011 and draft 2012 amendments) set out the legislative framework for dealing with people who come into police contact. This guidance complements PACE.

1.2 SENIOR MANAGEMENT CONSIDERATIONS

To achieve the adequate strategic level engagement that is necessary for the safe delivery of custody, senior management should consider the following controls¹:

- **There is a policy focus on custody issues at a chief officer level that covers**
 - developing and maintaining the custody estate
 - staffing of custody suites with trained staff
 - managing the risks of custody
 - meeting the mental and physical health and wellbeing needs of detainees
 - meeting the diverse needs of detainees – including vulnerable adults, and safeguarding children
 - working effectively with commissioners and providers of health services, immigration services, youth offending services, criminal justice teams, Crown Prosecution Service (CPS), courts and other law enforcement agencies.

- **There is an effective management structure that ensures**
 - appropriate policies and procedures for custody are in place and fully implemented
 - custody delivery is proactively monitored against agreed standards and performance measures
 - use of force, adverse incidents and complaints are proactively monitored locally and at force-wide level
 - there are partnership arrangements and constructive engagement, including at local criminal justice board level.

- **There is effective and proactive oversight by the Police Authority, Independent Custody Visitors (ICVs) and other mechanisms;**
- **Quality assurance procedures are in place;**
- **Effective procedures are in place for monitoring the use of force, and that the use of force is monitored by diversity, location and the officer involved.**

¹Developed from HM Inspectorate of Prisons and HM Inspectorate of Constabulary, Expectations for police custody Version 2 2012 © Crown Copyright 2010:
<http://www.hmic.gov.uk/publication/expectations-police-custody-criteria/>

1.3 PRINCIPLES OF SAFER DETENTION

1. There is a strategic focus, supported by the chief officer group, which promotes the safe and decent delivery of custody.
2. Detention is appropriate, authorised and lasts no longer than is necessary. All rights relating to PACE and the PACE Codes of Practice are adhered to.
3. While in police custody, detainees are treated in a way that is dignified and takes account of their human rights and diverse individual needs. Custody staff are respectful in their day-to-day working and are aware of and responsive to any particular risks and vulnerabilities relating to:
 - those who have consumed alcohol;
 - those who have consumed or packed drugs;
 - those with mental ill health or learning disabilities/difficulties;
 - women;
 - black and minority ethnic detainees;
 - children and young people;
 - those with disabilities;
 - foreign nationals;
 - immigration detainees;
 - those with specific religious requirements;
 - older detainees;
 - sexuality;
 - transsexual and transgendered detainees;
 - other factors.
4. Detainees have access to health and social care services appropriate to their physical and mental health needs. They receive emergency medical care where necessary and are provided with appropriate medication or support according to their needs.
5. Any force used within a custody suite is proportionate and lawful.
6. All custody officers and staff have undergone appropriate and adequate training. Police, contract and healthcare

professionals understand their role and their legal responsibilities, and are operationally competent.

7. All areas of the custody suite that are used by detainees are clean and safe. Custody facilities are kept in a good state of repair, are fit for purpose and meet fire safety standards.

Key Associated Guidance

- ACPO/NPIA Custody Officer Learning Programme
- ACPO (2010) Terrorism Act Custody Guidance
- ACPO Police First Aid Learning Programme (Modules 2 FASP and 3 FASC)
- ACPO (2007) Personal Safety Manual of Guidance
- Home Office (2010) Police Buildings Design Guide (HOPBDG)

1.4 DESIGNATION OF A POLICE STATION

It is the responsibility of the chief officer to designate a police station for the purposes of PACE.

Custody suites must be fit for purpose before a police station is designated under PACE and they must continue to be maintained at that standard. Designation of a police station for this purpose is covered under PACE, Part IV Detention, section 35.

1.5 CUSTODY OFFICER

The appointment of a custody officer by a chief officer of police (or other officer as directed by the chief officer) in a designated police station is a statutory requirement under section 36 of PACE. The legislation places specific responsibility on and authority with the custody officer in relation to the custody and protection of the detainee and the progress of the investigative process in the police station.

The custody officer must be of at least the rank of sergeant, however an officer of a lower rank can perform the functions of a custody officer in limited circumstances (section 36(4) PACE).

2

ARREST AND DETENTION

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2.1 THE DECISION TO ARREST

When the police approach a member of the public for any reason, they should first consider how their presence, attitude and demeanour may influence how a person will react. This reaction will have an impact on subsequent risks to officers, suspects and the public.

Officers are advised to be familiar with the National Decision Model (NDM) and to use risk assessment as appropriate during the contact and arrest phase. For further information see **Core APP 8 Decision Making Model** and **3.3 Condition of Detainee**.

Officers must always consider whether a person's arrest for an offence is necessary and proportionate, in accordance with PACE section 24 and Code G.

Elements of Arrest under section 24 PACE

A lawful arrest by a police constable requires two elements:

- A person's involvement or suspected involvement or attempted involvement in the commission of a criminal offence;
- and**
- Reasonable grounds for believing that the person's arrest is **necessary** (see **Necessity Criteria** below).

Both elements must be satisfied. Alternatives to police custody include: Voluntary Attendance, Penalty Notices for Disorder, Summons, or Charging by Post/Postal Charge and Requisition.

A person who is arrested, or further arrested, should be informed at the time, or as soon as practicable thereafter, that they are under arrest and of the grounds and reasons for their arrest, even if this fact is obvious, and of the relevant circumstances of the arrest in relation to both the above elements. The custody officer will be informed of these matters on arrival at the police station.

Necessity Criteria (PACE Code G)

The power of arrest is **only** exercisable if the constable has reasonable grounds for believing that it is necessary to arrest the person. The statutory criteria for what may constitute necessity are set out in PACE Code G, paragraph 2.9 and it remains an operational decision at the discretion of the constable to decide:

- Which one or more of the necessity criteria (if any) applies to the individual;
- and if any of the criteria do apply,
- Whether to arrest, grant street bail after arrest, report for summons or for charging by post, issue a penalty notice, or take any other action that is open to the officer.

Although a warning is not expressly required in law, officers should, if practicable, consider whether a warning which points out the offending behaviour of the individual, and explains why, if they do not stop, the resulting consequences may make their arrest necessary. Such a warning might:

- if heeded, avoid the need to arrest; or
- if it is ignored, support the need to arrest and also help prove the mental element of certain offences, for example, the person's intent or awareness, or help to rebut a defence that they were acting reasonably.

For detailed guidance relating to the information that is required to be given on arrest for an offence, the caution and records of arrest see PACE Code G.

2.1.1 DE-ARREST

Should further information come to light that indicates that a suspect is not responsible for the offence for which they were arrested, or the grounds for arrest otherwise cease to exist, officers must release the person. Where a person has been detained solely to prevent a breach of the peace, once the breach or potential breach has ended and is not likely to reoccur, the detainee must be released.

A custody record should be created for any detainee who is taken to a police station even if they are subsequently de-arrested. See **2.4.2 Detention Not Authorised.**

2.1.2 HOSPITAL

A detainee must be transported directly to hospital if they:

- Have had, or are showing the symptoms of having had, a head injury, see **3.3.6 Head Injuries**;
- Are, or have been, unconscious;
- Have suffered serious injury;
- Are drunk and incapable and treatment centres are not available;
- Are believed to have swallowed or packed drugs;
- Are believed to have taken a drugs overdose;
- Are suffering from any other medical condition requiring urgent attention;
- Are suffering any condition that the arresting officer or transporting staff believes requires treatment prior to detention in custody.

If a detainee has been arrested for a criminal offence and has been taken to hospital, a police officer or designated escort officer should remain with that detainee, except where bail has been granted, to ensure that they do not escape from detention, See also **6.3.5 Hospital.**

Where a person is detained under section 136 of the Mental Health Act 1983, consideration should be given to transporting them directly to a hospital, as a place of safety, where possible. A police station should only be used as a place of safety in exceptional circumstances. For further information see **8.4.1 Place of Safety.**

2.1.3 STREET BAIL

The use of street bail must be exercised reasonably according to the nature of the offence, the victim, the circumstances of the suspect and the needs of the investigation. Consideration should be given to the impact of the decision to grant street bail. Vulnerable persons in particular may not have access to the same level of safeguard and support as quickly as they would if they were to be transferred

directly to a police station, for example, the provision of an appropriate adult.

2.1.4 ALCOHOL TREATMENT CENTRES

Section 34 of the Criminal Justice Act 1972 gives a police officer the power to take a person to an alcohol treatment centre after they have been arrested for being drunk or drunk and disorderly (drunk contrary to section 12 of the Licensing Act 1872). The arrested person is deemed to be in lawful detention if taken to such a place.

For further information see **7.6 Diversion**.

2.2 PRE-CUSTODY RISK ASSESSMENT

All staff who come across incidents outside the custody suite must make an immediate risk assessment of the situation. The time available to do this will depend on the circumstances. When responding to an incident, the risk assessment should begin with gathering available information while travelling to the scene. Risk assessments carried out on the street do not need to be recorded.

Every planned operation should incorporate a detailed risk assessment and management plan that addresses the risks associated with the target suspects. The Intelligence, Intention, Methodology, Administration, Risk Assessment, Communication and Human Rights model (IIMARCH) provides a useful template for this.

Checklist 1 Risk Assessment

Risk assessment should take account of:

- What is known or believed to have happened;
- The number of persons involved or capable of becoming involved, see **3.3 Condition of Detainee**;
- Details provided about named individuals, including all intelligence and any warning or information markers recorded on the PNC, PND or other force or agency intelligence systems;
- Potential or known risks about the location;
- Concealed weapons or access to weapons within the contact environment;
- Community sensitivities.

The search of a detainee prior to arrival at the custody suite does not remove the need for a subsequent search at the police station.

For further information see **4.6.1 Search on Arrest** and **4.6.3 Search of a Detainee within Custody**, and **APP Core 8 Risk Management**.

All police officers and relevant police staff must be trained to comply with **ACPO (2007) Personal Safety Manual of Guidance**.

2.3 CUSTODY CAPACITY

Cell capacity is based on single cell occupancy in accordance with PACE Code C, paragraph 8.1, and the **Home Office (2010) Police Buildings Design Guide** (HOPBDG). The safe operating capacity of a custody suite depends on a number of factors:

- The number of detainees currently being held;
- The level of monitoring required for those detainees being held;
- Identified risks;
- The number of trained and competent staff available on duty;
- Operational commitments of the area;
- The actual number of cells in operation.

The safe operating capacity of a custody suite will fluctuate depending on the level and frequency of monitoring required for existing detainees. If the level of monitoring required places exceptional demands on custody staff, the custody officer may decide not to accept any further detainees so that the safety and welfare of the detainees and staff is not compromised.

Multi-occupancy of cells may be appropriate in some circumstances. If a custody suite has reached its safe operating capacity, arrangements must be made for additional detainees to be accommodated elsewhere. For further information see **6.4 Cell Occupancy** and **3 Risk Assessment**.

2.4 ARRIVAL AT THE STATION

All detainees must be seen by the custody officer as soon as practicable after arrival at the police station. The police station is defined as '...within the boundary of any building or enclosed yard

which forms part of that police station' (PACE Code C, paragraph 2.1A). Procedures should be established to ensure that detainees arriving at the police station are subject to a risk assessment should there be a delay in them seeing the custody officer.

The first risk assessment that occurs on arrival at the police station should fully consider the circumstances of the arrest and any relevant use of force and/or physical and mental health issues that the detainee may have. The custody officer is responsible for the risk assessment of all detainees. For further information see **3 Risk Assessment**.

Checklist 2 Detainee's Arrival at the Custody Suite

The following activities must be carried out for each detainee:

- Consider the grounds for detention/issuing of bail.
- Check that anyone who has had contact with the detainee has passed on any relevant information and risk-related information about the detainee to the custody staff.
- Check PNC, PND and local intelligence systems, recording relevant warning markers.
- Visually assess the detainee's general health and any injuries, recording and interpreting behaviour in the context of health and risk issues.
- Check that only approved restraint techniques and equipment have been used.
- Where there is doubt about the identity of a detainee, reasonable efforts should be made to identify the detainee.
- Authorise or refuse detention.
- Carry out risk assessment, (see. **3 Risk Assessment**).
- Establish a care plan for monitoring any risks to the detainee.
- If the detainee has been in custody before, check previous custody records and risk assessments and use any relevant information within the new risk assessment.
- Determine (in consultation with healthcare professionals, if necessary) if the person is fit to be detained and fit to be interviewed.
- Arrange for the attendance of an appropriate adult for juveniles (under the age of 17) Code C 1.5 requires anyone who 'appears' to be under 17 to be treated as a juvenile, unless there's clear evidence to the contrary.
- Consider the need for an appropriate adult. If a detainee appears to be mentally disordered or otherwise mentally

vulnerable, the custody officer should arrange attendance of an appropriate adult (see **8.6 Interview and Appropriate Adults** and PACE Code C, Para 11.15).

- If the detainee has been brought to the custody suite by Prisoner Escort and Custody Services staff from court or prison, or by police from another police station, check the PER assessment and take any action necessary. Make an entry on the custody record, review and update the risk assessment and detail all actions taken.
- Record and act on behaviour or information that may suggest a detainee is likely to harm themselves.
- Arrange for PNC warning markers to be added where appropriate.
- Search for and remove items in accordance with PACE section 54(1) and Code C.
- Cells or holding rooms should be checked for damage and objects that could be used to cause harm prior to placing a detainee in them, and also when a detainee is removed.
- Close the cell hatch.
- Ensure that information about a detainee's welfare and risk is accurately recorded and communicated to relevant staff and, where appropriate, other agencies.
- Ensure that the privacy of the detainee is managed. This is particularly important where detainees are under 17 years, are otherwise vulnerable, or have been arrested on suspicion of having committed serious or high-profile offences.
- When in doubt, consult a healthcare professional and monitor the detainee's condition.
- Ensure that detainees are checked at intervals dictated by their condition and the risk assessment.
- Check that the vehicle used to transport the detainee has been searched. The vehicle should be searched by the staff transporting the detainee, preferably in the presence of the detainee.

This checklist is not exhaustive and all relevant factors should be considered.

Exemptions for the Debriefing of Assisting Offenders under the Serious Crime and Police Act 2005

There may be occasions when a person is produced from prison establishments to be held in police custody for interview by specialist

debriefing teams. Detainees may be transferred from prison establishments under the Crime (Sentences) Act 2007 for the purposes of sections 71–74 of the Serious Organised Crime and Police Act 2005 (SOCPA) and the requirements of the relevant Her Majesty's Prisons Service (HMPS) Governor. The detention of that detainee, whilst in police custody, will not be governed by PACE.

The conditions in which these persons are required to be kept in police custody will require custody officers to consider certain departures from **ACPO (2012) Guidance on the Safer Detention and Handling of Persons in Police Custody**. In such circumstances, the custody officers or custody manager should meet the senior debrief officer and agree a memorandum of understanding regarding the persons care and custody. Prison Service Order 1801 (paragraph 5.1) requires that prisoners continue to be given the same rights they would be entitled to in prison; these rights are dictated by the Prison Rules 1999.

Custody officers and staff will be expected to ensure that they give priority to minimising the risk of harm to the person in custody, staff and others who come into contact with that person, taking into account the information that is made available to them. Provided the custody officer acts in good faith and in accordance with the information and risk assessment provided by the Prison Service and/or senior debriefing officer, the memorandum of understanding will act as a defense against criticism resulting from any departure from PACE and the standards recommended in this guidance.

2.4.1 VIOLENT DETAINEES

Officers transporting a violent detainee to the custody suite should inform custody staff of their impending arrival. People should be removed from reception areas to prevent them being involved with, or injured by, the detainee.

Custody areas must be kept free of trip hazards and weapons and should have sufficient space for officers to be able to deal safely with violent detainees. For further information see sections 2 and 3 of the Health and Safety at Work etc Act 1974.

Officers and staff should be aware that there may be an underlying medical reason for violent behaviour, see **3.3.3 Acute Behavioural Disturbance**.

2.4.2 DETENTION NOT AUTHORISED

A custody record must be opened for all detainees who arrive at the police station. If the custody officer believes that there are insufficient grounds for detention, or those grounds have ceased to apply, this must be recorded and the detainee released. Cases where detention is refused should be reviewed by the custody manager.

2.5 MEDICAL ATTENTION

The custody officer must ensure that **appropriate medical attention** is given as soon as practicable to any detainee who:

- Appears to be suffering from physical illness;
- Is injured;
- Appears to be suffering from mental ill health (or disablement, or difficulty that means that the detainee is likely to be mentally vulnerable or require additional support);
- Appears to have a drug or alcohol dependence or withdrawal likely to affect safety;
- Appears to need medical attention;
- Requests a medical examination.

For further information see PACE Code C, paragraph 9(b).

2.6 WELFARE AND SAFETY OF OTHERS

2.6.1 OTHER DETAINEES

The needs of other detainees should be considered at all stages in their detention. This should include:

- Clearing areas when a violent detainee is brought into custody;
- Ensuring the cleanliness of cells;
- Cleaning blankets and replacement clothing after use by an individual;
- Taking into account the possible consequences of cell sharing.

Custody officers should consider the overall risk assessment for the custody suite, other detainees and staff in accordance with **3 Risk Assessment**.

2.6.2 OTHER PROFESSIONALS

All visitors, including solicitors, healthcare professionals, appropriate adults, custody visitors, or interpreters, should be aware of their role and responsibilities prior to gaining access to custody. Custody areas should not become a gathering point and only those with legitimate reasons should be present. If an individual is denied access to a custody suite or particular cell, the reason for this must be recorded.

The content of any risk assessment is not required to be shown or provided to the detainee or any person acting on behalf of the detainee. However, information should not be withheld from any person acting on the detainee's behalf, for example, an appropriate adult, solicitor or interpreter, if to do so might put that person at risk.

Advice documentation is available for distribution to third parties who have a requirement to enter the custody area. See ***Home Office Circular (034/2007) Safety of Solicitors and Accredited and Probationary Representatives Working in Custody Suites at Police Stations*** and ***ACPO (2010) Terrorism Act Custody Guidance, Applicable to Persons arrested under section 41 of the Terrorism Act 2000.***

2.7 THE CUSTODY RECORD

The following information must be recorded in the custody record:

- Grounds for arrest.
- Grounds for authorising detention.
- Search (level of search and persons present).
- Items withheld from, or kept by, the detainee following search.
- Replacement clothing supplied to the detainee.
- Risks identified and control and/or support measures.
- Medical questionnaire.
- Time placed in cell, cell number, cell searched.
- That the cell call buzzer system within each cells has been checked to ensure is fully operational for each detainee. (This information should be entered onto the custody record immediately after the detainee is placed within the cell).
- The reasons for a juvenile being placed in a particular cell.
- Medical treatment and care plan.
- Use of any force and/or restraints that have been used and the justification.

- Other relevant information, (eg. details of the detainee's actions, mood and emotional state).

This list is not exhaustive, for more detail see PACE Code C.

It is a matter for the custody officer to determine whether a record should be made of the property a detained person has with them or had taken from them on arrest. For further information see PACE Code C, paragraph 4.4.

When information is recorded elsewhere a record should be made within the custody record of where that information is recorded.

3

RISK ASSESSMENT

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3.1 ASSESSMENT AND MONITORING

Risk assessment means assessing the risk and potential risk that each detainee presents to themselves, staff, other detainees, and to others coming into the custody suite.

Every detainee is an individual. Changing events and circumstances for the detainee, and within the custody suite, may affect the detainee's mood or behaviour and the risk that they pose to themselves and others.

The assessment must be ongoing and be reviewed throughout the period of detention. The risk that a detainee may pose to themselves and others may alter when a detainee is charged, refused bail or released on bail and, therefore, the custody officer must review the risk assessment at these stages and prior to release or transfer. A record must be kept in the custody record of each time that a risk assessment is carried out.

Risk assessment should be as objective as possible and assumptions should never be made when assessing risk. Police custody is stressful for most detainees and for some it is particularly traumatic. Simply being placed in a police cell may immediately raise the category of risk for a detainee.

The custody record provides the focal point for recording this information and the custody officer must be informed of identified risks or changing circumstances that may lead to additional risk. The custody officer must ensure that those risks are documented and managed.

The custody officer must ensure that all those responsible for the detainee's custody are briefed about the risks. In addition, staff other than the custody officer must make it their responsibility to ensure that they are aware of the current risks associated with each detainee in their care.

Accessing all available information is key to successfully managing risk. This can be obtained from the following:

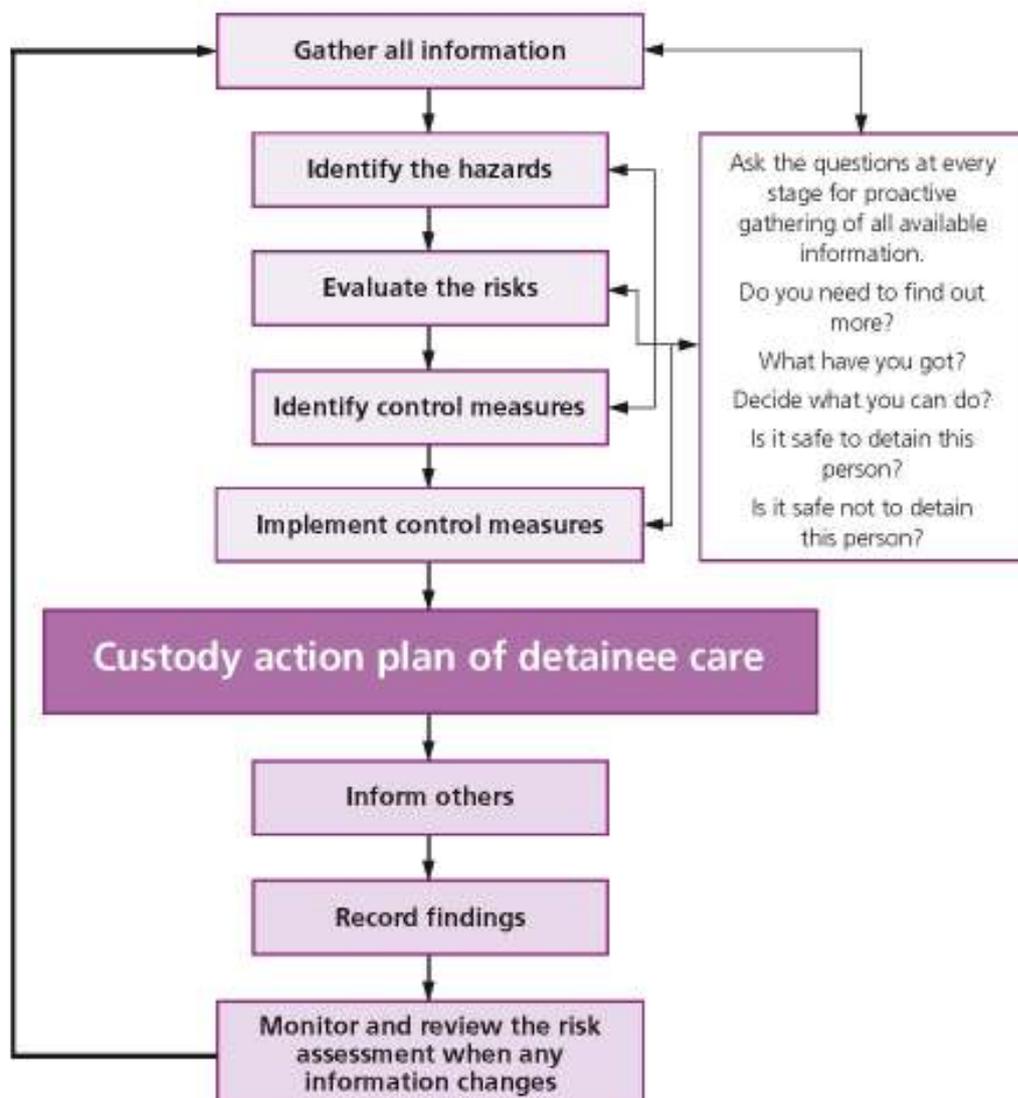
- The detainee;
- The detainee's friends or relatives;
- Witnesses;
- All staff involved in the person's arrest and detention;

- The Police National Computer (PNC), the Police National database (PND) and other local IT systems;
- Healthcare professionals (including GPs);
- Legal representatives;
- An appropriate adult;
- Other detainees;
- Other relevant bodies and organisations, eg, Youth Offending Team (YOT).

Additional guidance on risk management and use of the National Decision Model can be found in **APP Core 8 Risk Management**.

Figure 1 identifies a process which may be used when carrying out the risk assessment.

Figure 1 Detainee Risk Assessment Flowchart



The custody officer is responsible for the risk management process in accordance with PACE Code C, paragraphs 3.6 to 3.10.

The custody officer may consider that the current level of risk that may be posed by detainees within custody is such that accepting further detainees would impact on the safety of all those in the custody suite. If this happens, the custody officer should consider the need for additional staff to manage the risk or, if that is not practicable, whether further detainees should be directed to other custody accommodation in line with force contingency arrangements.

The custody officer is responsible for managing risk in the custody suite and must make that decision. Any challenge to the custody officer's decision by an officer of a higher rank must be referred to the superintendent responsible for the station, in accordance with PACE.

Forces should have a policy setting out the criteria for custody suite closure and have in place contingency arrangements for other accommodation. For further information see **12 Human Resources and Training** and **13 Contingency Planning**.

When a detainee has arrived at a custody suite but cannot be detained there because of a lack of resources or cell availability, a custody record should be opened and the reasons why they cannot be detained at that custody suite documented. If a detainee is identified as having medical needs, the custody officer must ensure that these needs are acted on as soon as practicable. For further information see **2.3 Custody Capacity**.

If a person is detained solely under the Mental Health Act 1983, their assessment and management will be in accordance with that Act. See **8.4 Mental Health Act Detainees** and **8.7 Custody Exit and Aftercare Strategies**.

For further information see ***Home Office Circular (32/2000) Detainee Risk Assessment and the Prisoner Escort Record (PER) Form***.

Checklist 3 Assessment of Detainees

Custody officers must ensure that the detainee is asked the following questions:

- How are you feeling in yourself now?
- Do you have any illness or injury?
- Are you suffering from any mental ill health or depression?
- Would you like to speak to the doctor/nurse/paramedic (as appropriate)?
- Have you seen a doctor or been to a hospital for this illness or injury?
- Are you taking or supposed to be taking any tablets or medication? If so
 - What are they?
 - What are they for?
- Are you in contact with any medical or support service, If so;
 - What is the name of your contact or support worker there?
- Do you have a card that tells you who to contact in a crisis?
- Have you ever tried to harm yourself? If so
 - How often?
 - How long ago?
 - How did you harm yourself?
 - Have you sought help?

If the detainee answers yes to any of the above, they should be asked further questions as appropriate:

- What is the name of your GP and GP's surgery?
- Do you have a family member who is aware of your health problems?
- Is there anything that I can do to help?

3.2 INFORMATION SOURCES

3.2.1 PNC, PND AND LOCAL FORCE SYSTEMS

Accurate and up-to-date recording of warning signs and information markers on PNC is necessary to assist colleagues and other agencies.

The PNC should be considered the primary reference for recording and accessing risk information. Custody staff should have direct access to PNC at all times.

Note: If a member of custody staff believes that an information marker or warning signal is out of date, they should make arrangements to have it modified. If the officer is not trained in PNC protocols, they should ensure that the information is passed on by a trained member of staff.

Staff should be mindful that information about a person, including warnings, may be held on a local force system but not on the PNC or PND. When a person comes into custody and is known to live or have lived in other police areas, checks should be made on the PND in the first instance. Where no information is available, officers and staff should directly contact relevant other forces directly for warnings and any other relevant information that might be recorded on their local systems. If this is not done, the reason for not doing so should be recorded on the custody record. Information on local systems should be added to PNC or PND as soon as possible.

Custody officers should be aware of the Violent Offender and Sex Offender Register (ViSOR), which can be accessed by both the police and the National Probation Service. Although access is only available to public protection officers, the database may hold relevant information regarding detainees who present a high risk. If the detainee has a ViSOR entry, a VS marker on the PNC will indicate this. Access is likely to be via specialist PNC unit/staff within each force .

It is advised that custody officers should read **ACPO (2010) Guidance on the Management of Police Information (MoPI)** and make themselves aware of the principles of the **ACPO (2005) Code of Practice on the Management of Police Information.**

3.2.2 PERSON ESCORT RECORD FORM

The purpose of the Person Escort Record (PER) form (previously known as the Prisoner Escort Record) is to ensure that all staff transporting and receiving detainees are provided with all necessary information about them, including any risks or vulnerabilities that the person may present. The identification of risk of suicide or self-harm is one of the

prime purposes of the form and staff should note that it is a requirement to indicate both a current risk and any known past risks. A PER form must be completed whenever a detainee is escorted from a police station to another location. This includes movement or transfer between separate custody suites (police stations) and other custody accommodation (courts, prisons and immigration detention facilities) and from custody to hospital.

Checklist 4 The PER Form

The PER form should be handled in the following way:

- Where the detainee is to be transferred away from a police station, the responsibility for the PER form lies with the first **custody officer** who becomes aware of the transfer.
- The form may be completed by a trained and competent custody detention officer, however, the responsibility for the content and sign off of the form will remain with the custody officer. This reduces the risk of important information being lost during any subsequent handovers between custody officers.
- It is the responsibility of the custody officer who transfers the detainee from the police station to the escort to ensure that the PER is up to date and contains details of any additional post-charge or other care requirements. (The PER form should provide details of the transfer of medication with the detainee, and the custody officer must ensure that a sufficient supply of medication is available to the detainee to allow for the onward transfer period. Consideration should be given to when an another prescription is likely to be available to the detainee.)
- Custody officers must provide supporting information when ticking a warning marker box.
- Copies of risk assessment forms and medical examination records that are not confidential should be attached to the PER, this information should also be completed on the PER in case any of the attached information is lost.
- Confidential medical information must be attached in a sealed envelope.
- A direct contact telephone number for the custody suite should be added to the PER so that escort, court, probation or prison staff can make prompt contact with the custody officer should they need to clarify any information.
- The escorting staff will be responsible for the maintenance of a record of the detainee's movements and any occurrences during transit.

Forces must ensure that custody officers are trained and competent in the completion of the PER form, and that procedures are established to audit and assess completed forms.

3.3 CONDITION OF DETAINEE

If it is believed that a detainee has a medical condition of a mental or physical nature, other than a minor ailment, advice must be sought from a healthcare professional. See PACE Code C, paragraph 9.5 and Notes for Guidance, Note 9C.

Detainees requiring urgent medical attention should not be taken to a police station.

If the detainee appears to have any medical condition requiring urgent attention an ambulance should be called. Consideration should be given to the urgent requirement for transfer directly to hospital, having regard to the potential impact of waiting for an ambulance to arrive and the potential risks associated with moving the person.

Medical direction should be sought wherever necessary. This may apply even if the detainee has already been medically assessed and their condition subsequently deteriorates on return to police custody.

Checklist 5 Immediate Transfer to Hospital

The detainee should be immediately transferred to hospital if he or she exhibits any of the following:

- **Unconsciousness** or **lack of full consciousness** (e.g. problems keeping their eyes open);
- Any **confusion** (not knowing where they are, getting things muddled up);
- Any apparent **drowsiness** or sleepiness which goes on for more than one hour when the detainee would normally be wide awake;
- **Difficulty waking;**
- Any problems **understanding** or **speaking;**
- Any **loss of balance** or **problems walking;**
- Any **weakness in one or more arms or legs;**
- Any **problems with vision;**
- Very **painful headache** that will not go away;

- Any **vomiting**;
- Any **fits (collapsing)** or passing out suddenly);
- **Clear fluid coming out of their ear or nose**;
- **Bleeding** from one or both ears;
- **New deafness** in one or both ears;
- **Abnormal breathing.**

The detainee should be wakened fully to be checked.

Detailed guidance on ACPO approved First-aid procedure and practices in response to a wide range of medical conditions can be found in the **ACPO Police First Aid Learning Programme**. See **12.4.4 First Aid** and **8 Mental Ill Health and Learning Disabilities**.

For guidance that is relevant to the management of violent behaviour of detainees requiring medical attention see **NHS NICE (2005) Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. Clinical Guideline 25.** available at: <https://www.nice.org.uk/CG025NICEguideline>

Healthcare professionals may refuse to transport or care for an individual who is violent. Forces and healthcare agencies should agree protocols to establish respective responsibilities for dealing with such occurrences.

NPIA (2011) Template Protocol For The Management Of Detainees That Require Hospital Treatment provides forces with a template for drawing up agreements with local healthcare providers.

Wherever possible, detainees must be asked about any current (or recent) mental health or medical conditions. Detainees should also be asked about any medication they are currently taking. Items in a detainee's possession should also be checked as they may indicate a medical condition, eg, insulin syringes, inhalers, medication. The presence of a health condition and its severity will affect decisions about how and where a person should be treated.

If a person will not communicate with staff, it may be because they have a mental health and/or medical condition (diagnosed or otherwise) which prevents them from doing so.

3.3.1 SUICIDE AND SELF-HARM

The risk of self-harm and suicide is particularly high during the early hours of detention. The following factors may indicate an increased risk:

- Mental illness including depression, personality disorder, anorexia and schizophrenia;
- People who have been arrested and detained for the first time;
- Drug, alcohol or substance abuse or withdrawal;
- Breakdown of social support and isolation – military service veterans, students, prisoners, homeless people, immigrants, old people and refugees are at particular risk;
- Being unemployed;
- Previous episodes of deliberate self-harm, especially if occurring within a custodial environment;
- People in certain professions who have easy access to a means of suicide, eg, poisons, drugs, or guns, have higher rates of suicide than the general population;
- Chronic disabling pain or illness;
- Family history of suicide and/or mental disorder;
- Recent loss such as bereavement, divorce, separation, redundancy;
- Adverse childhood experiences;
- People arrested in relation to violent or sexual offences, especially where they involve children, a close friend, or family.
- Added risk factors for young people include
 - impaired parent-child relationships (including poor family communication styles and extremes of high and low parental expectations and control)
 - parental separation or divorce
 - mental illness in parents (eg, depression)
 - history of parental substance use disorders and anti-social behaviour

Cutting the skin is probably the most common form of self-harm. In custodial settings, hanging or self-strangulation is the most common method of attempted suicide. Other forms of self-harm include burning the skin, especially with cigarettes, hitting, biting or punching themselves, hitting themselves with an object, swallowing tissue or other objects, picking at the skin, pulling out hair and

breaking bones. Self-harm is more common among women than men, often starting in adolescence at about 15 years of age. Fear of discovery and shame often cause people to conceal self-injury.

People may self-harm over many years or only at times of extreme stress. Some people only self-harm once, where as others have repeated episodes throughout their lives.

Increased vulnerability may arise:

- After interview;
- On being charged with an offence;
- After arrest for further offences;
- Following a visit by family, friends or others who have taken an interest in their welfare;
- After refusal of bail;
- While on bail.

For additional information see ***NICE Guidance on self harm and immediate treatment guidelines.***

3.3.2 POTENTIALLY VIOLENT INDIVIDUALS

Chief officers have a responsibility to establish a local protocol with social services, local authorities and health trusts for dealing with potentially violent individuals.

The following areas should be considered when developing such policies:

- A proactive approach to gathering information;
- Conducting intelligence systems checks;
- Sharing information with partners for safer detainee care;
- Observing the detainee during and after arrest for potential dangers;
- Identifying any impact factors;
- Effective allocation and use of resources;
- Extent of searching to be justified on an individual basis;
- Effective transport;
- Procedures for informing custody officers of the grounds for arrest, risks, intelligence, observation and other relevant information on persons detained in custody.

3.3.3 ACUTE BEHAVIOURAL DISTURBANCE

People who are violent and agitated pose an increased risk to the safety and welfare of themselves and those dealing with them. There may be an underlying medical reason for the behaviour. If there is any suspicion that the violence stems from a medical condition, the person must be treated as a medical emergency. Whenever possible, the person should be contained rather than restrained until medical assistance can be obtained.

The following medical conditions may cause violent, aggressive or changing behaviour and confusion:

- **Diabetes;**
- **Epilepsy;**
- **Stroke;**
- **Infections;**
- **Angina and other heart problems;**
- **Excited delirium;**
- **Head injury;**
- **Dehydration (and salt imbalance);**
- **Sickle Cell Anaemia;**
- **Acute mental illness such as paranoia, hearing voices;**
- **Neurological diseases such as dementia and brain injury;**
- **Learning difficulties.**

Note: Where an individual is well known or familiar to police officers and staff, there is an increased risk that symptoms of serious illness or injury may go unnoticed, eg, regular detainees associated with alcoholism or drug addiction.

Custody managers should ensure that:

- All custody staff are trained and competent in first aid and have completed the First Aid Skills for Custody (FASC) training according to the requirements of their role;
- All custody staff are trained and competent in the completion and management of risk assessment and understand the importance of this task;
- A local policy exists that sets the criteria for custody suite closure and contingency arrangements for that closure. It may also be necessary to plan for the need to access additional custody capacity if the risks associated with a detainee cannot be adequately managed within existing resources.

3.3.4 DEALING WITH DIABETES

When a diabetic person is detained, it should be established whether they are insulin dependent or not. If the detainee is insulin dependent, staff should ask whether the detainee has insulin with them or if it can be collected from home.

A diabetic detainee should be checked at least every thirty minutes throughout the duration of their stay. Custody officers should, during the initial risk assessment, decide if they feel that further assessment of the detainee by a health care professional is required. Custody staff should be aware that any individual with diabetes mellitus or 'sugar diabetes' can develop hypoglycaemia (low blood sugar).

In assessing the individual, should take into consideration whether they are displaying any symptoms that may indicate illness, eg, altered consciousness level, unusual thirst, visual disturbances, difficulty in speech and understanding, asking for something sweet or vomiting. **This is a medical emergency;** if a healthcare professional is not immediately available then the detainee should be transferred to hospital by ambulance.

If the detention of an insulin dependent diabetic person is likely to extend beyond the time in which they will need their next dose of medication, a healthcare professional should assess that individual and make the appropriate prescription as necessary.

The custody officer should discuss management of the detainee's health, and fitness of the detainee for interview with the healthcare professional. Information about any possible complications should be obtained from the detainee and the healthcare professional along with details of the appropriate dosage and type of insulin medication.

Once insulin has been prescribed, persons with diabetes may, subject to risk assessment, inject themselves. This should be after having food and under the supervision of custody staff. Doses of insulin taken by the detainee and times that it is taken should be recorded. Custody staff should establish in consultation with the healthcare professional when the next dose is due.

Where the detainee has an insulin infusion pump in situ, this should be left as it is and advice from a healthcare professional sought urgently.

The benefit of the meal, followed by insulin (to avoid hypoglycaemia) should be explained to the detainee. The detainee should be given regular meals.

Detailed guidance on ACPO approved first-aid procedure and practices in response to diabetes can be found in the **ACPO Police First Aid Learning Programme**, and the **Faculty of Forensic and Legal Medicine (FFLM) Guidance for the Management of Detainees with Diabetes in Police Custody**.

If a detainee refuses insulin, a healthcare professional should be informed immediately. The detainee may use their diabetes as a means to delay the investigative process. Insulin refusal alone, however, is not a medical emergency as deterioration in health may take hours or days.

3.3.5 EXCITED DELIRIUM

Of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life threatening. Excited delirium can be caused by heavy use of certain drugs, typically stimulants, of which cocaine is the most common.

The **symptoms** of excited delirium include:

- A state of high mental and physiological arousal -perceiving others as frightening and dangerous, 'fight or flight reaction';
- Breathing problems;
- Agitation;
- High body temperature and/or sweating – so may try to undress;
- Violence aggression and hostility;
- Insensitivity to pain and incapacitant sprays.

People who appear to have this condition should only be restrained in an emergency. They must be taken by ambulance to hospital as soon as the condition is suspected. If no ambulance is immediately available, the individual should be transported to hospital in a suitable police vehicle.

It is important that people experiencing excited delirium have their physical health needs assessed prior to any further mental health assessment.

3.3.6 HEAD INJURIES

Detainees who have suffered a head injury should be immediately transported to hospital for medical assessment and monitoring.

A blow to the head can result in bruising or bleeding inside the skull or inside the brain; not all head injuries are visible. Complications may occur at any time after the event. Staff must be aware of the risks associated with head injuries, particularly when dealing with detainees who may have been involved in a fight or a road traffic collision; a head injury may result in a rapid deterioration in the health of the detainee.

Custody officers and staff should be guided by the **FFLM Head Injury Advice Leaflet for Custody Officers, Gaolers & Detention officers** when dealing with a detainee who is exhibiting symptoms of a head injury. This may be the case even where there is no obvious sign of injury, or when/if the detainee denies that any injury has occurred.

3.3.7 INFECTIONS AND COMMUNICABLE DISEASES

Whenever a detainee is known or suspected to have an infection or communicable disease, advice must be sought from a healthcare professional. Some detainees will give information readily about a disease or infection, others will not. Information may be available on the PNC, PND or local force systems, and there may be visible signs such as discolouration of the skin or weeping sores. Information should be recorded on the risk assessment and the detained person's medical forms. If information is written on a whiteboard, it should not be visible to anyone other than custody staff.

Forces must have procedures to manage the potential risk of communicable diseases. PACE Code C, paragraph 9.7 permits the custody of a detainee and their property in isolation until medical directions have been obtained.

Where a person with a communicable disease has been in a cell, the cell must be cleaned before another detainee uses it. It is suggested that forces should seek to manage the risk of onward transmission of such diseases through thorough cleaning to a defined standard. This standard may be agreed locally via staff or private contract arrangement. Relevant information about communicable diseases

must be included on the PER form.

Common communicable diseases include the following:

- Hepatitis (A,B and C);
- Tuberculosis (TB);
- HIV and AIDS;
- Scabies;
- Methicillin-resistant staphylococcus aureus (MRSA);
- Norwalk virus (Norovirus);
- Fleas.

For more information see: <http://www.nhsdirect.nhs.uk> and the Health Protection Agency website for up-to-date information on infectious diseases: <http://www.hpa.org.uk/Publications/InfectiousDiseases/>

3.3.8 CLAUSTROPHOBIA

Claustrophobia is the extreme or irrational fear of confined places and can lead to intense anxiety accompanied by:

- Panic attacks;
- Shaking;
- Rapid heart beats;
- Intense sweating;
- Difficulty breathing;
- Feeling sick (nausea);
- Dizziness;
- Chest pain.

In extreme cases symptoms may be accompanied by the fear of:

- Losing control;
- Fainting;
- Dying.

Checklist 6 Dealing with Claustrophobia

When dealing with a claustrophobic detainee staff should:

- Be calm;
- Reassure them;
- Take them to a cool, quiet place;
- Encourage them to breathe more slowly;
- Stay with them until they have recovered;
- Call a healthcare professional.

Claustrophobia is a difficult condition to deal with in the custody environment. Detainees may say they are claustrophobic when they are not. There are generally no suitable areas within a custody suite to keep detainees who do suffer from claustrophobia. Each detainee must be risk assessed and then a decision made on where they should be detained. It may be necessary to keep them in a holding cell visible to the custody officer from the main desk, or to place them in a cell, on constant observation (Level 3) or within close proximity (Level 4), with a member of staff at the open door.

3.3.9 ASTHMA

Staff should ask a detainee whether they have asthma during the risk assessment process. In many cases the individual will have an inhaler with them, which they use to control the condition or alleviate their breathing during an asthma attack.

Attacks may be aggravated by stress, heavy exercise, infection or exposure to allergens such as dust or fumes. Many asthma attacks occur during the night.

Attacks can usually be dealt with quickly by using an inhaler, but there may be other occasions when an attack is so severe that it warrants urgent medical attention.

People with asthma can usually administer the inhaler without the assistance of others. Unless there is a risk of self-harm to the detainee, it is safe to allow them to retain their asthma inhaler. Where custody staff are in any doubt, they should seek the advice of a healthcare professional.

Detailed guidance on ACPO approved first-aid procedure and practices in response to asthma can be found in the **ACPO Police First Aid Learning Programme**.

3.3.10 HEART DISEASE

Chest pain should always be taken seriously and urgent advice sought from a healthcare professional, or an ambulance should be called.

People with heart disease present a significant risk of sudden death

in custody. Interview situations may cause stress and trigger an angina attack. Anxiety or claustrophobia may cause chest pain.

Consideration should be given to allowing angina sufferers to keep angina sprays with them unless the detainee presents a risk of self-harm.

If a detainee has heart disease do not interview them until a healthcare professional has been consulted.

If the detainee presents any symptoms of a heart attack or serious illness, they should be immediately transferred to hospital. For further details of symptoms of heart disease, see **ACPO Police First Aid Learning Programme**.

3.4 RELEASE FROM CUSTODY

When making the decision to release or transfer a detainee, it is recommended that custody officers are familiar with the **National Decision Model** and are able to carry out and justify their decision making.

The custody officer should complete a pre-release risk assessment. Pre-release risk assessment should not be left until the point of release, but should be an ongoing process throughout detention to be concluded at the point of release. Custody officers should refer to all existing risk assessment information for the detainee and will need to decide what action, if any, is appropriate to support vulnerable detainees.

A person **charged** with an offence can be refused bail and kept in custody under section 38(1)(a)(6) PACE if the custody officer has reasonable grounds to believe detention is necessary for his/her own protection.

Detention after charge can also be authorised (under PACE section 38(1)(iii)) if the custody officer believes it is necessary (in respect of a non-imprisonable offence):

- To prevent him/her from causing physical injury to any other person;
- To prevent him/her from causing loss of or damage to property;
- In the interest of the detainee, where the detainee is an arrested juvenile.

Additionally, detention after charge may be authorised in respect of an imprisonable offence:

- to prevent him/her from committing an offence, (preventing injury or damage caused by offences such as assault and criminal damage).

There are occasions when it may become apparent through pre-release risk assessment that a detainee is extremely vulnerable, and that there is a real and credible risk to that individual on release (including the risk of suicide). This risk may not always be apparent at the early stages and may, therefore, leave the custody officer very little time to make an urgent referral.

The custody officer will have no explicit powers to detain a high-risk detainee **before/without charge** once their detention can no longer be authorised in accordance with Part 4 of PACE or any other lawful power. The custody officer responsible for the duty of care for that detainee will need to make a decision on the best lawful course of action for the detainee on release and, under exceptional circumstances, the safest course of action to protect the life of that individual.

In some circumstances it may be appropriate to simply offer an individual appropriate advice and options to support their welfare on release. The options for onward referral of a detainee open to the police will vary according to local provision of services in:

- Social care;
- Healthcare;
- Hostels/refuges;
- Charity support organisations (eg, Royal British Legion);
- Other agencies.

Custody officers should take into consideration the duty of a police officer to preserve life. Under section 6 of the Human Rights Act 1998 (HRA), the Police Service is prohibited from acting in a manner incompatible with the European Convention on Human Rights (ECHR). One of the obligations under the ECHR is to take feasible operational steps (within the lawful powers of the officer) to avert any risk of death that the officer is aware of, or should have been aware of. As such, it may be appropriate in some circumstances to extend the detention period of the detainee for a minimal and limited period to allow for the transfer of care to other appropriate care

services, eg, transfer into social services or local hospital care facilities.

It is unlikely that a referral will be legally permitted without the explicit consent of the detainee unless there is a legal obligation to inform others. Where there is a legal requirement to make a referral but the referral has been made without the consent of the individual, the reason and justifications for this should be recorded in the custody record.

For further information see **6.12 Diversion and Referral** and **8.7 Custody Exit and Aftercare Strategies** (Mental Health).

3.5 TRANSFER OF DETENTION

Checklist 7 Transfer of Detention

Prior to transferring the detainee, the custody officer must:

- Review the risk assessment, custody record and attachments;
- Review medical notes;
- Complete a Person Escort Record (PER) Form (If the detainee is being transferred to hospital then the PER should be accompanied as a minimum by the Detainee Medical Assessment Form (450), and the Detainee Medication Form (450a), under confidential cover);
- Prepare the detainee;
- Check the detainee's property and consider authorising an additional search;
- Ensure the detainee has appropriate clothing;
- Check medication;
- Consider appropriate level of restraint;
- Consider the number of detainees being transferred.

Responsibility for the welfare of a detainee being transferred to court by PECS lies with PECS staff.

A detainee may be restrained while being transferred by the police if there are reasonable grounds to believe that an unrestrained detainee will use violence against escorts or bystanders, or that the detainee will try to escape from custody. Where restraint is to be applied, it is important to communicate to the detainee what is happening and why. When the detainee is passed to another agency

or service, responsibility for restraint no longer rests with the police.

For more guidance on restraint techniques and legal levels of restraint, see **ACPO (2007) Personal Safety Manual of Guidance**.

Transportation of multiple detainees may increase risk and should be subject to a joint risk assessment prior to transfer.

Custody staff may also receive detainees from prison. They must, therefore, be aware of the forms used by public and private prisons to deal with self-harm and risk. **Appendix 1** gives information on receiving a detainee who has an open Assessment, Care in Custody, and Teamwork (ACCT) Plan.

4

CONTROL, RESTRAINT AND SEARCHES

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4.1 INTRODUCTION

Police officers are frequently required to deal with potentially violent situations and may need to use control and restraint techniques. Officers must be aware of the potential risks the use of such techniques place on the suspect or detainee.

Detainees suffering from the effects of alcohol, drugs, a mental health condition or those who have a medical condition are particularly vulnerable to the impact of being restrained.

This section should be read in conjunction with **3 Risk Assessment**, which sets out symptoms deriving from medical or mental health conditions.

Staff must be trained in the use of restraints in accordance with **ACPO (2007) Personal Safety Manual of Guidance** and **ACPO (2009) Guidance on Personal Safety Training**.

4.2 LEGISLATION

The three main powers relating to the use of force are contained within:

- Common Law;
- Section 3 of the Criminal Law Act 1967;
- Section 117 of PACE.

Responsibility for the use of force rests with the police officer exercising that force. Officers must be able to show that the use of force was lawful, proportionate and necessary in the circumstances. The use of handcuffs, for example, may not always be a necessary or proportionate response.

There is additional legal provision within the Mental Capacity Act 2005 for police intervention to administer or assist in the medical treatment of a person without the mental capacity to know what they need. For more information see:

The Mental Capacity Act Code of Practice

<http://www.justice.gov.uk/guidance/protecting-the-vulnerable/mental-capacity-act/index.htm>

The Mental Capacity Act 2005: Deprivation of Liberty safeguards - Code of Practice

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

4.3 INITIAL CONTACT

In an operational environment, potentially violent incidents cannot always be as controlled as they can be within secure settings such as custody, prisons or mental health establishments. Events are spontaneous, and officers usually have little time in which to assess a situation and plan a response.

Upon receipt of a call requesting police officers for such duties, police telephone operator staff should ask for as much detail as there is available. Information that has been passed to officers on the condition of the detainee, and of other people on the premises prior to arrival at the scene will enable the responding officers to make a judgement on whether to use restraint techniques and how to do this safely.

When police officers are called to restrain potentially violent or disturbed detainees (for example at medical facilities), it is important that where possible they are properly briefed on the medical condition of the individual. It may be important, for example, to have prior knowledge of conditions such as asthma or a heart condition.

Detainees should not be left alone and unsupervised in vehicles; an officer must be able to observe and monitor the person and react to any situation which may arise.

Checklist 8 Warning Signs for Physical Violence

Warning signs indicating that the behaviour of a person or detainee may be escalating towards the use of physical violence can include:

- Facial expressions – tense and angry;
- Increased or prolonged restlessness, body tension, pacing;
- General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils);
- Increased volume of speech, erratic movements;
- Prolonged eye contact;
- Discontentment, refusal to communicate, withdrawal, fear, irritation;
- Unclear thought processes or poor concentration;
- Delusions or hallucinations with violent or aggressive content;
- Verbal threats or gestures;
- Reporting anger or violent feelings;
- Blocking escape routes.

Factors that may indicate an increased risk of physical violence include:

- A history of disturbed or violent behaviour;
- A history of substance or alcohol misuse;
- Any previous expression of intent to harm others;
- Evidence of rootlessness or social restlessness;
- Previous use of weapons;
- Previous dangerous and impulsive acts;
- Denial of previous dangerous acts which are known to have occurred;
- The severity of previous acts of violence or aggression;
- Verbal threats of violence;
- Evidence of recent severe stress, particularly personal loss or the threat of loss;
- One or more of the above in combination with cruelty to animals or reckless driving.

Close supervision of detainee health and welfare must be maintained during periods of prolonged restraint. Individuals may react differently to restraint, especially if restrained in the prone position.

When taking charge of an incident, the supervisor must ensure that the health of the detainee is monitored and that the degree of

restraint being applied is reasonable. Monitoring should include assessing the detainee's breathing and heart rate following the incident. The supervisor should ensure that details of the restraint are recorded.

Staff who may be required to use force in the course of their duties must be trained in accordance with **ACPO (2007) Personal Safety Manual of Guidance**. Staff whose training has lapsed must not be deployed in the custody area. See also **12.4.4 First Aid**.

4.3.1 METHOD

When a detainee is restrained in a prone position for any length of time, one team member should be responsible for protecting and supporting the head and neck. That person should lead the team through the physical intervention process and ensure that the airway and breathing are not compromised and that vital signs are monitored. Prolonged restraint and struggling can, particularly when the lungs are being squeezed while empty, result in exhaustion. This can be without the detainee being aware of it and can lead to sudden death.

The safest way of dealing with a violent person is by rapid initial restraint by those who have had proper training. A violent or restrained detainee must not be placed in a police vehicle unsupervised. Detainees who have struggled violently should not be placed in a vehicle unrestrained. In order to ensure appropriate control during any journey, the detainee should be seated upright where possible. For further information see **5.5.1 Placement of Detainee**.

4.4 POSITIONAL ASPHYXIA

There is a risk of positional asphyxia when restraining a person. The prone position should be avoided if at all possible, or the period for which it is used minimised.

It should be recognised that there is an increased risk of causing positional asphyxia when restraining children or small adults.

Body weight should not be used on the upper body to hold down the detainee.

Checklist 9 Factors that Can Contribute towards a Death during Restraint

Include situations where:

- The body position of a person results in a partial or complete obstruction of the airway and the subject is unable to escape from that position;
- Pressure is applied to the back of the neck, torso or abdomen of a person held in the prone position;
- Pressure is applied restricting the shoulder girdle or accessory muscles of respiration while the person is lying down in any position;
- The person is obese (particularly those with large stomachs and abdomens);
- The person is a child or small adult;
- The person has a heightened level of stress;
- The person may be suffering respiratory muscle failure related to earlier violent muscular activity (such as after a struggle);

4.5 CONTROL WITHIN CUSTODY

Staff working in a custody environment must be trained in the short-term management of violence. This should include tactical communications and the recognition and management of positional asphyxia, acute behavioural disturbance and excited delirium. Staff should also be trained in techniques for moving detainees and repositioning them from the prone position.

4.5.1 RISK ASSESSMENT AFTER RESTRAINT

As soon as possible after arriving at the police station, the escorting staff must inform the custody officer about any control methods or restraint techniques used. **The custody officer should, as part of the risk assessment, ask the arresting officer if any control measures or restraint techniques were used during arrest and transportation.** The custody officer should look for any injury or effect caused by restraint and any signs of behaviour or illness that may indicate a need for medical attention. Where necessary,

detainees requiring urgent medical attention should be taken to hospital by ambulance or police vehicle as appropriate to the circumstances. The custody record should be updated accordingly.

This information should be shared with healthcare professionals attending to the detainee; any concerns raised should be noted on the custody record by the healthcare professional.

A custody officer can require the removal of the handcuffs, although arresting or escort officers may remove handcuffs prior to or on arrival at the police station.

4.5.2 PLACING VIOLENT DETAINEES IN CELLS

It may be necessary to call a healthcare professional to assess and monitor a violent detainee's condition when the underlying reason for their violence is not apparent.

The initial risk assessment should be reviewed after the detainee has been placed in the cell. It should be repeated when and if the detainee has calmed down and is able to answer questions. These procedures must be recorded on the custody record.

When placing a violent detainee in a cell, only the approved techniques and methods described in **ACPO (2007) Personal Safety Manual of Guidance** should be used.

4.5.3 MONITORING DURING RESTRAINT

When restrained, the detainee should be under constant observation (Level 3) or in close proximity (Level 4) so that all vital signs can be monitored and appropriate intervention made if a medical emergency arises. For further information see **6.1.2 Monitoring, Observation and Engagement**.

This supervision may also involve:

- Being in the cell with the restrained detainee;
- Being in the cell with the detainee and physically restraining them;
- Being outside the cell and observing the detainee through the open cell door or a see-through door.

For additional information on the use of restraints in a cell, see PACE Code C, paragraphs 8.2 and 8.11.

4.5.4 USE OF TASER CONDUCTIVE ENERGY DEVICE

When a Taser Conductive Energy Device has been discharged on an individual prior to, or on, arrest and there is any sign of an adverse or unusual physical reaction, medical attention should be provided immediately. Where the need for medical attention is urgent, it will take precedence over transfer of the subject to a custody suite.

Local force policy will be clear about the areas in which officers are able to carry and use Taser Conductive Energy Devices. Officers who have been issued with the Taser Conductive Energy Device as part of their officer safety equipment may be permitted to carry the equipment within custody suites. There are, however, strict guidelines in relation to the carriage, security and deployment of the Taser Conductive Energy Device. Any use of the equipment must be fully justified by the officer.

Use of a Taser Conductive Energy Device in a hospital ward setting is not advised as there is likely to be an increased risk posed to:

- The subject (who is likely to be under existing medical care);
- Other patients (who may be dependent on electronic equipment);
- Members of staff; and
- The public.

All arrested persons who have been subjected to the discharge of a Taser Conductive Energy Device, must be examined by an Forensic Medical Examiner (FME) as soon as practicable.

At the earliest opportunity following arrival at the custody suite, a detainee who has been subjected to a Taser Conductive Energy Device discharge should be given an information leaflet describing the Taser Conductive Energy Device, its mode of operation and effects. This leaflet should be fully explained, and the fact that it has been provided should be recorded on the custody record. Any instance of the use of Taser Conductive Energy Device on an individual should be recorded on the custody record relating to their subsequent detention. See ***ACPO (2008) Operational use of Taser by Authorised Firearms Officers.***

Close monitoring of a subject throughout the period following discharge of the Taser Conductive Energy Device is of utmost importance. If the person is detained in a cell, they should be monitored and observed according to the risk assessment, ie at Level 3 Constant Supervision or Level 4 Close Proximity.

In instances where the detained person has sustained a head injury as a result of the secondary effect of the Taser Conductive Energy Device discharge, they should be transported to hospital for medical assessment and monitoring of the injury.

Experience from the use of Conductive Energy Devices (including Taser) in other countries, which is supported by medical assessment in the UK, has shown that the persons most likely to be at greatest risk from any harmful effects of the device are those also suffering from the effects of drugs, or those who have been struggling violently. There are cases where persons exposed to the effects of Taser Conductive Energy Devices have died some time after discharge where the cause of death is unlikely to have been the device itself.

Particular attention should be given to detained persons who have been subjected to the discharge of a Taser Conductive Energy Device and who are known to have, or are suspected to be suffering from, diabetes, asthma, heart disease, epilepsy or any other condition which may influence the individual's fitness to be detained, including the consumption of alcohol and/or drugs.

Where a detainee is taken directly to a hospital (under section 136 of the Mental Health Act 1983, or for any other medical reason), the fact that a Taser Conductive Energy Device has been discharged on the detainee must be brought to the attention of the doctor who takes charge of the patient at the hospital.

4.5.5 CELL RELOCATION

Moving violent detainees from place to place carries a high risk of injury and should be avoided. If, however, this becomes necessary the procedure must be carried out in line with **ACPO (2007) *Personal Safety Manual of Guidance***.

The custody officer should supervise all cell relocations and avoid becoming physically involved by ensuring sufficient staff are

available. Where an immediate relocation is necessary, it may be impractical to wait for additional staff. The supervisor is accountable for the way in which the incident is managed, but all staff involved have a responsibility to be aware of signs of distress and trauma.

In a pre-planned relocation using a specialist team, the team supervisor is responsible for the tactics of the procedure and team management, but the custody officer retains responsibility for the welfare of the detainee in accordance with section 39 PACE.

4.6 SEARCHES

4.6.1 SEARCH ON ARREST

When a person is arrested other than at a police station, a constable may search that person under section 32(1) of PACE if they have reasonable grounds for believing that they may present a danger to themselves or any other person. Under section 32(8) of PACE, a constable may seize and retain anything found if there are reasonable grounds to believe that the person may use it to cause physical injury to themselves or others. Reasonable force can be used if necessary.

Staff must always consider whether they should exercise their powers to search before placing a detainee in a vehicle. In large-scale public order situations it may be safer to remove the detainee away from the incident and then conduct the search.

Section 54 PACE provides a power to search an arrested person on arrival at a police station. There is a separate power to search at any other time, which is described in section 54 (6A)–(6C). After arrival and while at a police station both elements apply, but only to constables and designated detention officers by virtue of paragraph 26, Schedule 4 to the Police Reform Act 2002.

Paragraph 34(2), Schedule 4 to the Police Reform Act 2002 confers on designated escort officers a power to search and seize while in transit from the place of arrest to the police station. Paragraph 35(4) confers a power on designated escort officers to search persons being escorted from a police station to another station or from a police station to any place and then back to that station or onto another station.

For detailed guidance on intimate and strip searches, see PACE Code C Annex A.

4.6.2 SEARCH OF A VEHICLE

Vehicles used to transport detainees must be searched before and after use and, where practicable, in the presence of the detainee. In unmodified vehicles, attention should be given to the area down the back of the seats and the footwells as these are the most likely places for items to be secreted. Care should be taken when searching this area to avoid sharp objects including syringes. For further information see **ACPO (2007) Personal Safety Manual of Guidance**.

4.6.3 SEARCH OF A DETAINEE WITHIN CUSTODY

Where detainees have been searched on arrest, they should not be left unsupervised until they have been presented to the custody officer, who will decide whether a further search is necessary. Such decisions must comply with PACE and the Codes of Practice, whereby the search, the extent of the search and the subsequent retention of any article that the detainee has with them, depend on the custody officer believing that the article:

- May be used by the detainee to harm themselves or others;
- Is evidence of an offence;
- Could be used to interfere with evidence;
- May be used to aid an escape or cause damage.

Both the extent and location of a search are decided by the custody officer. There are three levels available:

- Standard search;
- Strip search;
- Intimate search (on the authority of an inspector).

The decision-making process must be documented on the custody record and include the reason for the search, those present during the search, those conducting the search and a record of any items found or seized. Custody officers should explain to the detainee why he or she is being searched. The custody officer is responsible for the safekeeping of property taken from a detainee which remains at the police station.

It is very important that staff explain to detainees why it is necessary to take unwelcome actions, for example in removing detainee's clothing.

For detailed guidance see PACE Code C, Annex A, **6.2.4 Religious and Cultural Needs**, and **6.2.6 Transsexual and Transvestite detainees**.

4.6.3.1 PROPERTY REMOVAL AND STORAGE

During the risk-assessment process, custody officers should be aware that items of clothing such as ties, belts, shoelaces and cords can be used as ligatures. All staff have a duty of care and must do all that is reasonably possible to protect the right to life under Article 2 ECHR.

The decision to withhold articles from the detainee must be based on a risk assessment of each individual and the guidance given in PACE Code C. Custody officers should, when deciding to remove property, balance the imperative to protect the right to life with the importance of ensuring detainees' dignity is respected. For example, detainees must be allowed to retain their spectacles if there is no significant indication that they may use them to self-harm.

Staff must bear in mind the potential impact that the detention and interview processes may have on an individual and how they may affect the changing level of risk assessment for that individual. The detainee should be given the opportunity to check and sign the custody record to confirm that the record of the items seized is correct. Adequate storage and security should be provided for a detainee's property. For further information see **6.7 Welfare and Safety**.

4.6.3.2 REPLACEMENT CLOTHING

All custody suites should retain an adequate supply of replacement clothing to issue to detainees as necessary. The detainee's dignity should be respected and their basic warmth and welfare needs must be met. A detainee must be provided with alternative clothing if their own clothing is wet as they will be at risk from hypothermia. It should be noted that paper suits are not generally considered to be adequate replacement clothing.

Detainees deemed to be at high risk of suicide by using their own clothing must be under constant observation (Level 3) or within close proximity (Level 4) depending on the risk assessment. Custody

officers should consider their power under section 54 of PACE to seize clothing on the grounds that they believe a detainee may use it to harm themselves (see also paragraph 4.2 of PACE Code C).

For further information see **6.1.2 Monitoring, Observation and Engagement** and **6.7 Welfare and Safety**.

4.6.4 SEARCHING DETAINEES IN CELLS

All custody staff must receive training and refresher training in accordance with the **ACPO (2007) Personal Safety Manual of Guidance** and the **National Custody Officer Learning Programme (COLP)**. Custody officers should also be trained to supervise the searching of detainees in cells, with specific regard to thoroughness, control and restraint, and diversity issues.

4.6.5 CELL SEARCHES

All cells and detention rooms must be visually inspected and searched, on release of a detainee and before new occupancy, to ensure that:

- Fresh damage is identified;
- Defects in cells are identified;
- Cell buzzers, intercoms and lights are working and fully functional;
- Alarm call systems are working and fully functional;
- The cell hatch fully closes;
- No ligature points are available;
- Previous occupants have left no items.

All cells and detention rooms should be checked periodically throughout the tour of duty and:

- On handover or at set times, if the cell is vacant;
- Immediately before a detainee is placed in the cell;
- By a trained search team as deemed fit by custody managers.

For further information see **11.1.2 Ligature Points** and **11.2 Maintenance of a Custody Suite**.

The following list details the actions to take when cells and detention rooms are inspected for defects and potential ligature points. This list

is not exhaustive.

- Work from the ceiling down to floor level.
- Start with the ventilation grilles through to light fittings, checking that the sealant has not been picked out and that holes are not too big.
- Check the light fittings and smoke detectors – are they fitted securely and is the sealant intact?
- Check toilet bowls where the filler between the bowl and seat might have been removed, enabling laces or belts to be pushed through. is the sealant intact?
- Check the bench underneath the mattress to see if any gaps would permit laces or belts to be threaded through.
- Check mattresses and blankets to ensure that they are not damaged. Damaged mattresses and blankets may be more easily torn by a detainee to make into a ligature (also check that they are not soiled or infested).
- Check the door and frame. Does it fit properly, are the welds secured, does the handle work correctly and is surrounding plasterwork undamaged?
- Check the cell hatch to ensure that it does not drop down if a detainee bangs on it while it is fully closed.
- Check the spy glass is not broken.

Custody staff should document within the custody record that the cell has been checked, that it meets the required standard, and that the cell call system is in full working order, immediately after placing a detained person into a cell.

Where the cell call system is found to be defective, the cell or detention room must be put out of service until it is fit for use. or a suitable control measure must be employed to ensure the detainee's welfare. Using this cell should be a last resort and, if appropriate control measures are not available/possible, then the cell should not be used.

Any cell found to be structurally defective or in need of cleaning must be closed for remedial action.

It is recommended as good practice that all cells are frequently searched by PoLSA trained search officers. This is most effective when it is carried out regularly with varying lengths of time between searches. Where this is in place, it has been seen to improve the practice of searching by custody staff and officers.

5

TRANSPORTATION

This section may be of particular interest to contractors and staff concerned with prisoner escort.

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5.1 INTRODUCTION

Only police officers and escort officers designated under section 38 (police authority employees) or 39 (contracted-out staff) of the Police Reform Act 2002 should be used to escort detainees in transit. When a custody officer transfers custody of a detainee to any of the above, the duty to ensure that the detainee continues to be treated in accordance with PACE and its Codes of Practice is also transferred to that person. For further information see section 38(1) and 39(2) PACE and Schedule 4 to the Police Reform Act 2002.

5.2 SEAT BELTS

The requirement to wear a seat belt does not apply where a vehicle is being used for police purposes or for carrying a person in lawful custody (See Regulation 6(1)(f) Motor Vehicles (Wearing of Seat Belts) Regulations 1993). The wearing of seat belts is encouraged and should be considered on a case-by-case basis.

5.3 POLICE STAFF AND OTHERS INVOLVED IN TRANSPORTATION

5.3.1 DESIGNATED ESCORT OFFICERS

Chief officers must be satisfied that all escort officers are suitable, trained and competent to carry out the powers and duties described in Schedule 4 to the Police Reform Act 2002 which are confirmed on them by their designation. For information on the search powers of designated escort officers, see **4.6.1 Search on Arrest**.

5.3.2 PRISONER ESCORT AND CUSTODY SERVICES

Prisoner Escort and Custody Service (PECS) is part of the National Offender Management Service (NOMS) and was established in accordance with arrangements made under the Criminal Justice Act 1991. It is responsible for the management of contracts awarded to the private sector for escorting prisoners to and from designated courts and police stations after charge and from prisons to court. It also deals with the transfer of prisoners between prison establishments.

If the contractors are unable to provide this service (in respect of persons refused bail after charge for court), the responsibility rests with the police to ensure that the detainee is transported to court, see section 46 PACE. Forces should establish contingency plans for escorting detainees to court should PECS contractors fail to deliver this service.

5.4 FLEET MANAGEMENT

Forces should establish policies and procedures for assessing the sufficiency and suitability of vehicles used for transporting detainees.

The assessment criteria should include:

- Reviewing the incidence of harm to detainees and escorting officers during transit to identify the level of risk;
- Pattern analysis of incidents of harm or successful interventions, see also Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995;
- Balance of vehicle fleet;
- Capability to transport detainees in a safe manner;
- Anticipated journey lengths and times;
- Availability of cells;
- Requirement for the segregation of detainees from escorting officers and other detainees;
- Ability to monitor detainees continuously;
- Ability to intervene in an emergency situation during transit, eg, fire;
- Suitability of cage or containment area for use;
- Size for intended occupancy;
- Ligature point protection, eg, a sliding internal door instead of standard hinged opening

The National Offender Management Service (NOMS) has a vehicle design specification for custody vans. This may provide useful direction in relation to policing needs.

5.4.1 VEHICLE SELECTION

The type of vehicle used for transportation will vary between forces and will be influenced by availability, whether the transport is planned or spontaneous, and by the risks associated with the

detainee. The risk assessment must be considered when determining the most appropriate form of transport. For further information see **3 Risk Assessment**.

For spontaneous incidents, the choice of vehicle may be influenced by the type of vehicle already at the scene. This could include:

- Unmodified car;
- Modified car eg, with clear screen dividing front and rear and/or plastic rear seats;
- Police carrier vehicles, eg, those used for public order;
- Unmodified van;
- Modified van (with a cage or containment area clearly marked with the maximum number of people it is designed to carry).

Checklist 10 Risk Assessment for Restraint and Escort

A risk assessment will determine the level of restraint and number of escorts required to convey the detainee and should include:

- Established actions of the person prior to police intervention;
- Actions after contact with police, particularly their level of violence;
- PNC warning markers;
- Local intelligence;
- Allegations by others about the detainee;
- Information from friends and family;
- Condition of the detainee, for further information see **5.5.3 Condition of the Detainee**;
- History of violence, in addition to the above sources;
- Extent and result of search of the detainee;
- Use of weapons by the detainee on this or previous occasions;
- Assessment of escape risk;
- Length of journey;
- Vehicles available;
- Physical disability.

This list is not exhaustive and all relevant factors should be considered so that the most appropriate control measures can be adopted.

While a detainee may appear to be compliant, staff must never be complacent. Depending on the risks identified and available

resources, it may be appropriate to call a different type of transport. The advantages of removing the detainee from the scene as quickly as possible may outweigh the benefits of waiting for the arrival of a more suitable vehicle.

For pre-planned operations, consideration should be given to selecting the most appropriate type of vehicle. Arrangements should be made to keep juvenile and adult detainees separate wherever possible.

Detainees can travel for a maximum of two and a half hours before they must be offered a comfort break; this may be reduced accordingly to meet individual needs.

All police vehicles used to convey detainees must be equipped with a first-aid kit. For further information see **ACPO Recommendations for Contents of First Aid Kits**.

5.5 DETAINEE AND STAFF SAFETY

Detainees should not be left alone and unsupervised in vehicles, an officer must be able to observe and monitor the person and react to any situation which may arise.

5.5.1 PLACEMENT OF DETAINEE

When placing a detainee in a vehicle, care should be taken with individuals who are restrained with handcuffs or leg restraints, as this can increase the risk of injury. In unmodified cars detainees must be placed in the rear of the vehicle in the seat furthest from the driver. If the vehicle has a cage or containment facility it should be used. When a cage that is designed for more than one detainee is already occupied, officers must consider whether placing a second detainee in the cage would present an increased risk. Detainees who are, or have been, violent and are assessed as presenting a continuing risk, and those suffering from mental health problems, must not be placed in a cage or containment area with another detainee.

5.5.2 CONTROL AND RESTRAINT

A detainee must never be handcuffed to a vehicle or restrained to it in any way. Extreme caution must be used where a detainee who is

already restrained by use of handcuffs and/or other limb restraints is considered to require further additional restraint. Owing to the risks of positional asphyxia, the prone position should not be used during transportation. If it is unavoidable, the detainee must be constantly monitored.

Where a detainee becomes violent, staff should, where practicable, stop the vehicle, regain control and only then resume the journey; it may be necessary to call for assistance and to change to a more suitable vehicle. For further information see **ACPO (2007) Personal Safety Manual of Guidance**.

5.5.3 CONDITION OF THE DETAINEE

Constant monitoring must be undertaken where the detainee is:

- Drunk and incapable;
- Believed or known to have consumed, swallowed or packed drugs;
- Violent or known to be violent;
- Believed or known to be at risk of suicide or self-harm;
- Has increased susceptibility to positional asphyxia, see **4.4 Positional Asphyxia**.

Staff may decide it is not appropriate to transport the detainee, and should consider calling medical assistance to the scene.

An ambulance must be called for any detainee who appears to be unconscious.

ACPO First Aid Forum Levels of Response

Level		Response	Action
A	Alert	Responds normally.	
V	Voice	Responds to voice, answers questions or obeys commands.	
P	Pain	Responds to painful stimulus such as squeezing/shaking the shoulders.	Individual should be treated as a medical emergency, medical assistance is required.
U	Unresponsive	Does not respond.	Individual should be treated as a medical emergency, medical assistance is required.

5.6 SUPERVISION AND ESCORT

5.6.1 RESPONSIBILITY FOR SUPERVISING AND MONITORING THE DETAINEE

The following principles should be applied:

- No more than one detainee must be conveyed in an unmodified police car;
- Modified vehicles should carry no more persons than they are designed for;
- High risk detainees will require more resources to monitor them.
- Every detainee must be supervised and monitored while in transit;
- Single crewed officers must be satisfied that they can perform this role. An escorting officer may be responsible for more than one detainee. Where appropriate, the escorting officer should accompany them in the rear of the vehicle or in the cage; the escort must be able to communicate with the driver at all times.

5.6.2 TRANSFER OF A DETAINEE WHILE IN CUSTODY

When a detainee is transferred from a custody suite, a PER must be completed and accompany them. This would include transfer to:

- Court;
- Hospital;
- Any other police station (in any force area);
- Prison;
- Prisoner Escort and Custody Services (PECS) contractor;
- Military police;
- The United Kingdom Borders Agency (UKBA) or agent.

When using other means of transport including aircraft, trains, boats or other public transport, control measures must be sufficient to protect the public from harm, ensure the safety of the detainee, and comply with individual carriers' own requirements.

Special arrangements may be necessary for high-risk detainees. Where there is an identified risk requiring special security measures, advice should be sought. Use of armed officers to support movement must be carried out in accordance with the **ACPO (2011) Manual of Guidance on the Management, Command and Deployment of Armed Officers**.

5.7 INSPECTION OF VEHICLES USED FOR TRANSPORTATION

Vehicles should be checked by the driver prior to and after use. Detailed inspections should be carried out weekly as part of the normal maintenance regime, and findings should be recorded for audit purposes. In addition to routine maintenance and servicing, the inspection must include the following:

- Serviceability and the general condition of the vehicle;
- Condition of any modifications made for the conveyance of detainees;
- Containment areas/cages;
- Checking for ligature points (for further information see **11.1.2 Ligature Points**);
- Doors/windows;
- Integrity of reinforced material.

6

DETAINEE CARE

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6.1 MANAGEMENT AND SUPERVISION

PACE and Code C set out the statutory framework for custodial care and the rights and entitlements of a detainee in police custody.

Clear lines of responsibility and accountability must be established for the supervision and management of custody staff, custody suites and detainees. Furthermore, with the enactment of the Corporate Manslaughter and Corporate Homicide Act 2007 and its application to police custody (2011) has meant that forces will need to ensure that there are clear lines of accountability in contracts for employment and services to custody. Contracts that apply to police staff, contract staff and other professionals working within the custody environment are required to detail appropriate actions and liabilities in the event of an untoward incident.

The duty inspector or custody inspector should undertake the supervision and support of all custody staff. At the beginning of each shift, custody officers and, where practicable, the inspector should visit and check:

- Welfare of all custody staff;
- Numbers of detainees;
- Custody records;
- Detainees in cells;
- That all risks, vulnerabilities and welfare needs of detainees are being adequately managed;
- Control measures against identified risks to ensure that they are both proportionate and effective;
- Review times;
- Whether staffing levels are sufficient;
- On any emerging issues;
- The physical condition of the custody suite.

PACE Code C, section 15 and PACE sections 40, 40A, 45a provide detailed guidance on the review of detention.

Custody officers must perform a check on each detainee under their supervision during or following the handover process with the outgoing custody officer.

Where multiple custody officers are on duty, it is essential that each is aware of their individual respective duties and responsibilities and

that this information is recorded and kept up to date. Local force policy will need to ensure that it is clear who is acting as the designated custody officer for each detainee at any given time.

6.1.1 MAINTAINING CUSTODY RECORDS

For the list of information required within a custody record see **2.7 The Custody Record.**

Audit and inspection regimes should be implemented for custody records and should include checking:

- The legibility, accuracy and appropriateness of entries;
- Compliance with PACE and its Codes of Practice;
- That all entries are signed, timed and dated;
- That the condition of the detainee on arrival, at each check and on release or transfer is accurately recorded;
- That the waiting time for examination of detainee by a healthcare professional had been within acceptable timeframes;
- That medical needs had been identified and met;
- The administration of medication and that it had been in accordance with instructions;
- The quality of risk assessment;
- That control strategies were commensurate with identified risks, for example, constant observation, CCTV monitoring;
- Compliance with risk management measures;
- That the detainee's intelligence records reflected any vulnerability identified in the risk assessment;
- That dietary or religious and cultural needs were identified and met;
- The timing of cell visits;
- The quality and frequency of rousing visits to detainees, particularly for detainees who have consumed alcohol or drugs;
- The needs of vulnerable or 'at-risk' detainees are considered and appropriate support is made available, eg, appropriate adults, interpreters, healthcare professionals;
- That details of the detainee's actions, mood and emotional state are recorded on the custody record;
- The level of detailed information provided on the PER Form, where applicable.

6.1.2 MONITORING, OBSERVATION AND ENGAGEMENT

Four levels of observation should be used:

- Level 1 – General observation;
- Level 2 – Intermittent observation;
- Level 3 – Constant observation;
- Level 4 – Close proximity.

The level of observation will depend on the circumstances of the individual.

It is the responsibility of the custody officer to effectively manage the supervision of each detainee, taking into consideration a detailed and up to date assessment of the risk that the detainee poses to themselves and others, and any recommendations made by a healthcare professional following medical assessment. The custody officer may mitigate identified risks by using appropriate and considered control measures, eg, CCTV monitoring, replacement clothing, supervised meals.

Custody staff are directly responsible for carrying out the observation and supervision of detainees should be aware of the risks that have been identified, and the purpose of the allocated level of supervision that is deemed necessary. All custody staff must receive **ACPO Police First Aid Learning Programme** training on at least Module 2 First Aid Skills – Police (FASP) and Module 3 First Aid Skills – Custody (FASC) prior to taking up a post in custody. Refresher training must be completed at least every twelve months. Custody staff should be familiar with the signs or behaviours of a detainee that may indicate that there is an increased level of risk and/or requirement for a higher level of monitoring. An increased level of risk, illness or change in behaviour should always be brought to the attention of the custody officer.

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 take the decision to switch off the cell call system for that cell for a short and limited time period. Where this course of action has been taken the custody officer must mitigate this increased risk by implementing control measures, eg, moving the detainee to a cell with CCTV where they can be continuously monitored, or by increasing the level at which they are being monitored. All such actions and justifications for those actions should

be detailed within the custody record.

A written record must be made within the custody record following each and every check carried out on detainees, and in all cases where a detainee has been roused.

Healthcare professionals may work across different forces and be familiar with different categories or levels of observation (eg, Metropolitan Police Standard Operating Procedures differ from those in this document). Custody managers should ensure that healthcare professionals working within their force are aware of local procedures.

Figure 3 provides a guide to determine the appropriate level of observation.

Figure 3 Levels of Observation

Level 1 General Observation

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

- Detainees are checked at least every hour (risk assessment is updated where necessary);
- Checks are carried out sensitively in order to cause as little intrusion as possible;
- If no reasonable foreseeable risk is identified, staff need not wake a sleeping detainee (checks of the sleeping detainee must continue and, where change in the condition of a detainee presents a new risk, the detainee should be roused);
- If the detainee is awake, the officer should communicate with the detainee;
- Visits and observations, including the detainee's behaviour/condition, are recorded in the custody record;
- Any changes in behaviour/condition must be reported to the custody officer immediately and added to the custody record and risk assessment as appropriate.

Level 2 Intermittent Observation

This is, subject to medical direction, the minimum acceptable level for those who are under the influence of alcohol or drugs, or whose level of consciousness causes concern. It requires the following:

- The detainee is visited and roused at least every thirty minutes;
- Physical visits and checks must be carried out – CCTV and other technologies can be used **in addition**;
- The detainee is positively communicated with at frequent and irregular intervals;
- Visits to the detainee are conducted in accordance with PACE Code C, Annex H;
- Visits and observations, including the detainee's behaviour/condition are recorded in the custody record and the risk assessment is reviewed and updated as appropriate;

Any changes in behaviour/condition must be reported to the custody officer. The use of technology does not remove the need for physical checks and visits.

Level 3 Constant Observation

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

- The detainee is under constant observation and accessible at all times;
- Physical checks and visits must be carried out at least every thirty minutes;
- Constantly monitored CCTV and other technologies can be used (see **11.4.4 Use and Monitoring of CCTV**);
- Any possible ligatures are removed;
- The detainee is positively communicated with at frequent and irregular intervals;
- Visits and observations, including the detainee's behaviour/condition, are recorded in the custody record;
- Any changes in behaviour/condition must be reported to the custody officer immediately (risk assessment will be reviewed and updated as appropriate);
- Review by the healthcare professional.

The purpose of CCTV cell monitoring should be recorded in the custody record together with the name of the designated member of custody staff who will be responsible for the monitoring.

(Issues of privacy, dignity and gender must be considered.)

Level 4 Close Proximity

Detainees at the highest risk of self-harm should be observed at this level. It requires the following:

- The detainee is physically supervised in close proximity (to enable immediate physical intervention to take place if necessary);
- CCTV and other technologies do not meet the criteria of close proximity but may complement this level of observation;
- Issues of privacy, dignity and gender are taken into consideration;
- Any possible ligatures are removed;
- The detainee is positively communicated with at frequent and irregular intervals;

- Observations, including the detainee's behaviour/condition, are recorded in the custody record;
- Any changes in behaviour/condition must be reported to the custody officer immediately (risk assessment will be reviewed and updated as appropriate);
- Review by the healthcare professional.

The custody officer should record the following in the custody record:

- The level of observation required for a detainee;
- The reasons for the decision;
- Clear directions that specify the name and title of the persons carrying out the observations;
- The name of the person responsible for carrying out the review of the required observation level.

Healthcare professionals should ensure that their directions for custody staff on the frequency of checks and/or any recommendations on the rousing of a detainee are written in the custody record, in addition to being verbally passed on.

Where there is evidence that risk to the detainee has reduced, the level of monitoring should be reduced appropriately. This change should be carefully considered and applied: detainees should not go straight from Level 4 observations to Level 1.

6.1.3 VISITS TO CELLS

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

Checklist 11 Visits to Cells

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 building a rapport;
- Be familiar with the custody suite emergency procedure and aware of equipment available.

When cell checks and visits are carried out, it is not sufficient to record 'visit correct' or 'checked in order' on the custody record. More detail is required, for example, 'detainee awake, reading, spoken to, offered drink, drink refused'. A spy-hole check 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.

Where a decision has been taken to monitor the welfare of the detainee using continual CCTV cell observation, the purpose of this control should be recorded on the custody record with the name of the person(s) responsible for the monitoring.

If it is decided that the detainee needs to be roused on each visit, this must be done and the responses recorded on the custody record.

6.1.4 ROUSING

Police forces should adopt procedures to ensure that custody officers and staff adhere to Police And Criminal Evidence Act (PACE) Code C, Annex H with respect to risk assessing, checking and rousing. Rousing involves the use of a stimulus designed to elicit a response from the detainee, the detainee will be considered as having been adequately roused only when a comprehensible verbal response has been heard.

It should be emphasised that when dealing with individuals who have consumed alcohol or drugs:

- All detainees should be risk assessed on arrival to the custody suite and throughout their detention, regardless of their level of intoxication;
- A detainee's unwillingness or inability to participate in a risk assessment should be viewed as a possible warning of risk;
- Cell visits and checks must be completed at appropriate intervals (as per the appropriate level of observation, see **6.1.2 Monitoring, Observation and Engagement**) and recorded in a timely and accurate manner;

The frequency of rousing advised by a healthcare professional must be adhered to unless the custody officer directs that rousing should be more frequent.

If a detainee cannot be roused, they should be immediately treated as a medical emergency. See **3.3 Condition of Detainee**.

Checklist 12 The Rousing Procedure

If any detainee fails to meet any of the following criteria, an appropriate health care professional or an ambulance must be called.

- Can they be woken?
- Go into the Cell.
- Call their name.
- Shake them gently.
- Response to questions –and can they give appropriate answers to questions such as:
 - What is your name?
 - Where do you live?
 - Where do you think you are?
- Response to commands – can they respond appropriately to commands such as:
 - Open your eyes;
 - Lift one arm, now the other arm.
- Remember to take into account the possibility or presence of other illnesses, injury or mental ill health/learning disabilities.
- A person who is drowsy or who smells of alcohol may be suffering from the following:
 - Diabetes;
 - Epilepsy;
 - Head Injury;
 - Drug use or overdose;
 - Stroke.

PACE Code C, Annex H

There is a risk of death in custody where alcohol or substance misuse masks another condition. For further information see **7 Alcohol and Drugs**.

If a healthcare professional is working in a custody suite, and where it is practicable, they should accompany custody staff on cell visits to those detainees presenting any risk or identified vulnerability.

6.2 EQUALITY AND INDIVIDUAL NEEDS

It is the nature of custody that detainees will be drawn from all areas of the community. All individuals have their own particular needs and vulnerabilities, some obvious and others less so.

It is fair and right that forces should take all reasonable steps to ensure that these needs and vulnerabilities are identified. Controls must be put in place to help mitigate any risks and meet the basic rights and needs of the community they serve.

When police forces are carrying out their functions, they also have a duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, and to promote equality of opportunity and to foster good relations between people with different protected characteristics, as defined under section 149(7) of the Equality Act 2010.

Detainees may have additional concerns which will increase the risk associated with their detention, and release, which must be recognised. Staff should try to be aware of these additional factors and realise that, while they may appear trivial to staff, they may have a high impact on the detainee and how well they are able to cope in police detention. While detention in custody is likely to affect the employment and home circumstances of all individuals, some detainees may have circumstances that increase their levels of anxiety.

The list of circumstances is extensive but may include:

- Being a prominent or responsible member of the community, eg, an MP or councillor;
- Being a religious leader;
- Having employment in a notifiable occupation;
- Being suspected of committing a publicly prominent offence, eg, with TV coverage;
- Being suspected of committing an offence against a vulnerable victim;
- Being suspected of committing an offence which carries significant public outrage.

6.2.1 FEMALE DETAINEES

The Corston Report (2007) A review of women with particular vulnerabilities in the criminal justice system found that owing to the high level of complex needs, socioeconomic and family consequences of imprisonment, and the different range of offences committed by women, there are fundamental differences between male and female offenders. It indicates that a different and distinct approach is needed for women.

Under the provisions of the Equality Act 2010, there exists a need to eliminate unlawful discrimination and harassment and to promote equality of opportunity between men and women. Her Majesty's Prison Service (HMPS) has developed and implemented gender-specific standards for the detention of women prisoners (***HMI Prisons (2008) Prison Service Order (PSO) 4800 Women Prisoners***); which have been in effect since April 2009. Gender is also covered in the National Offender Management Service (NOMS) single equality scheme. Although these standards are written to apply to prisons, it may be useful for custody managers to consider these standards when looking at health and safety matters for female detainees.

Girls under the age of 17 years must be under the care of a woman while being detained, conveyed or waiting to be so. This requirement comes from section 31 Children and Young Persons Act 1933.
See **9.4 Girls under the Age of 17 Years.**

Female detainees aged 17 years old and over should be given access to a female member of custody staff whose responsibility is to check on their welfare needs. This access should be provided promptly and as soon as practicable. If no female is working in custody, a female police officer or police staff (preferably designated as a detention officer) who is on duty at the station or unit will be assigned this role.

It is particularly important when identifying additional needs and vulnerabilities of female detainees to consider:

- Physical and medical welfare needs (all female detainees should be offered sufficient sanitary/hygiene pack(s) for use while in police custody);
- The need to identify child/dependent welfare issues (particularly for lone parents and foreign nationals);
- Access to female staff;

- Conditions under which women are searched (with respect for privacy and dignity);
- Adequacy of clean replacement clothing;
- Pregnancy, known or potential (particularly when considering modes of restraint, transportation, and the potential requirement for additional food or drinks);
- Mental health (in particular vulnerabilities around depression, and suicidal thoughts);
- Increased risk of self-harm;
- Domestic violence and abuse issues;
- Increased likelihood of drug addiction and/or alcoholism;
- The effects of child separation (where the detainee has a baby or infant).

Studies have reported that as many as half of women who have passed through the criminal justice system and then entered prison have experienced domestic violence, and up to a third have been victims of sexual abuse. Previous abuse often contributes to drug and alcohol problems, mental health problems and self-harm.

Women prisoners have also been found to have poorer physical and mental health than women in the general population. An Office for National Statistics study by **O'Brien, M., Mortimer, L., Singleton, N. and Meltzer, H. on Psychiatric morbidity among women prisoners in England and Wales**, carried out in 2001 reported that sixty-six per cent of women prisoners had symptoms of neurotic disorders, compared with sixteen per cent of the general household population.

The **Social Exclusion Unit (2002) Reducing reoffending by ex-prisoners**, found that fifteen per cent of sentenced women had previously been admitted to a psychiatric hospital and that over a third (thirty-seven) of women sent to prison had attempted suicide before imprisonment.

6.2.2 CARING RESPONSIBILITIES

Any person who comes into custody may have caring responsibilities for another person. The level of caring can vary considerably, however, and staff must be aware of the potential implications of detention for each detainee and their dependants.

Detainees should be asked about any caring responsibilities during the booking-in process. This information must be recorded in the risk assessment or other appropriate place in the custody record. **If a detainee is identified as having dependants for whom arrangements are required then appropriate arrangements should be made as necessary to find alternative care. This should be attended to without delay.**

The most effective method to obtain information and assess the risk such information presents is to ask questions. Staff are encouraged to be proactive in their enquiries. A few minutes during the booking-in process to resolve issues then can reduce the time taken later when the person is in detention.

Although it is a generalisation, adult females are more likely to have active caring responsibilities than other detainees.

Usually, caring responsibilities will relate to:

- Children;
- Parents (who may be disabled or otherwise vulnerable);
- Elderly relatives;
- Partners;
- Neighbours or associates;
- People for whom the detainee cares for professionally (eg, as a home carer, nurse or child minder).

Detainees may have a formal or informal relationship with the dependants. Carers may support any individual whether they are related or not. It should be recognised that children and young people in custody may themselves have caring responsibilities for a sibling, parent or family member.

Detainees may be reluctant to identify themselves as carers because of the embarrassment of arrest. They may have concerns about how the detention will appear to those they care for, or others associated with them.

Detainees with caring responsibilities will worry more as the time in detention increases. Staff should be careful to ensure the accuracy of any information when passing updates to them about their detention.

A detainee may wish to make multiple phone calls to arrange alternative care arrangements and where there is no investigative impediment, these calls should be facilitated.

Dependants or family members may ring custody seeking an update, staff should be mindful that both data protection and PACE limit the information that can be given without the detainee's consent. Some form of agreement should, therefore, be made with the detainee about these calls.

Dependant and family members may be able to provide further information on a detainee's risk assessment and staff should consider asking them appropriate questions. Similarly, information may be provided without prompting. In these cases it is essential that this information is recorded and the risk assessment of a detainee amended accordingly.

It is important to acknowledge when a detainee has concerns for a third party. Failure to acknowledge such concerns will increase the stress associated with a detention. Even if no action is possible, or efforts to resolve the concerns have failed it is still important to respond. For example, a parent may be convinced that they must be released to care for a child, if however the seriousness of the case prevents this, staff should acknowledge that there are concerns and take time to appropriately explain the police response.

Offences which involve an allegation by one family member against another can create additional strain for a detainee. They may have concerns about the reception they may receive on release and the effect the allegation will have on a continued relationship. Staff must be aware of these additional risks and consider them within the initial and ongoing risk assessments.

6.2.3 DISABLED DETAINEES

Forces must have a policy to ensure compliance with the Equality Act 2010 and take measures within custody suites to meet the requirements of the Act (This Act repeals, encompasses the requirements of, and replaces the Disability Discrimination Act 1995.) The needs of **all** custody users must be considered to ensure compliance, including detainees, legal professionals, appropriate adults and visitors.

A person has a disability under the Equality Act 2010 if they have a physical or mental impairment, which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. The term 'long-term' is defined as: for at least 12 months or the rest of the person's life).

A wide range of disabilities, conditions and illnesses are classed as impairments. Physical impairments cover a wide range of physical conditions, including those which affect sight or hearing. Mental impairments include mental health conditions (such as schizophrenia, bipolar affective disorders, and alcohol and drug dependence) and impairments relating to mental functioning including learning difficulties such as dyslexia. See **8 Mental Ill Health and Learning Disabilities**.

A substantial adverse effect is something which is more than a minor or trivial effect. The requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people.

Individuals do not have a duty to declare a disability. However, staff should be mindful of the possibility and react accordingly, as a failure to make reasonable adjustments (as required by the Equality Act 2010) constitutes discrimination.

PACE Code C paragraph 13.2 places a specific responsibility on the custody officer to ensure that interpreting support is provided for blind, deaf or otherwise vulnerable detainees who may have difficulty understanding procedures or completing documentation. Whenever a custody officer considers or has been told in good faith that a suspect may be 'mentally disordered or otherwise mentally vulnerable', they must request an appropriate adult to support the detainee. See PACE Code C, paragraphs 1.6 and 11.15 and **8.6 Interview and Appropriate Adults**.

Consideration of the impact of a physical disability will form part of the initial and ongoing risk assessment. The response or control measure implemented should be documented within the custody record. Where staff are uncertain of the needs of a detainee, it is appropriate to ask the detainee what additional needs or requirements they have. Additional advice may be available from healthcare professionals, family or friends (the detainee will need to give consent for communication with their family and/or friends).

All reasonable adjustments should be made to accommodate the additional needs of a disabled person, for example, any additional access requirements that they may have. These adjustments should not impact upon the overall safety and security of the custody suite.

It is helpful to ensure that people with dyslexia are supported to understand any documents, as they may find reading difficult and will need to have the information communicated verbally.

It may be possible to facilitate communication with people who appear to be deaf, or if there is doubt about their ability to hear, by using a suitably qualified interpreter as set out in PACE Code C paragraph 13.1 (eg. British Sign Language interpreter).

If a person is blind, seriously visually impaired or for other reasons unable to read, an independent person must be made available to help check any documentation regarding the detainee. See PACE Code C paragraph 3.20.

Particular care should be taken to consider the additional needs of detainees with disabilities during any possible evacuation.

Custody managers should refer to the **Home Office (2010) Police Buildings Design Guide** (HOPBDG) Chapter 10 Custody, when designing new, or updating existing, custody suite facilities, and the **National Police Estate Group (NPEG) (forthcoming) Custody Best Practice Document** in respect of the recommended requirements for cells and custody areas.

6.2.4 RELIGIOUS AND CULTURAL NEEDS

It is not permissible to treat a person less favourably because of their faith, belief or culture. The specific needs of a person are best determined by effective and respectful questioning. Responses should be recorded in the custody record and mentioned as part of any handover process.

Where it is not possible to meet a detainee's needs, an explanation should be given to the detainee and also recorded on the custody record.

Religion, culture or nationality should never be assumed. Decisions not to disclose a religion must be respected.

Each person who comes into custody should be asked whether they have any particular religious or dietary requirements.

Appropriate food should be offered at meal times, and forces should make appropriate arrangements for halal, kosher, vegetarian and vegan meal alternatives to be available for detainees.

Note: Someone who is vegetarian on ethical grounds should have this belief respected in the same way as if they were vegetarian on religious grounds.

Arrangements should be made for the provision of the following:

- Copies of the Koran, the Bible and the Torah available for use; (Islam requires that copies of the Koran be kept neat and wrapped securely away from contamination);
- Advice to Islamic detainees on the direction of Mecca (eg, a compass or mark applied to the eastern cell wall of one or more cells);
- Appropriate food and clothing.

Wherever possible, custody staff should facilitate any reasonable requests in respect of religious considerations, particularly in respect of:

- Facilitating times of prayer, including the requirement of some faiths that various parts of the body are washed prior to doing so;
- Asking the person for their prayer times and informing them when they are due;
- The reading of religious texts;
- Food and drink (food type and timing with regard to fasting);
- Visits from local faith leaders;
- Members of the Islamic faith are required to pray five times daily, at times which vary according to the season. Custody officers should ensure that enquiries are made (eg, with a local faith leader) to establish those times in advance, so that interviews and meal times may be organised around them.

Custody managers should give consideration to providing a separate room which can be used as a prayer room, or for detainees to receive official visitors, such as local faith leaders.

Due respect should be given to all religious artefacts retained in custody offices for the use of detainees.

6.2.5 FOREIGN NATIONAL DETAINEES

Foreign nationals may often require additional support and information to enable them to understand why they are being detained, and make informed decisions while in custody. Custody officers should consider that confusion and lack of familiarity with the UK criminal justice system may influence the behaviour of foreign nationals in custody.

Care should be taken to ensure that all rights and entitlements are provided according to individual needs of each detainee. The specific needs of an individual are best determined by effective questioning. Relevant responses should be recorded in the custody record and communicated as part of the handover process.

If a detainee is unable to speak or understand English, the custody officer should try to establish what language they are able to use and should make arrangements for an interpreter.

Further information on the identification and management of foreign national detainees is provided by the ***ACPO and NPIA (2011) Briefing Note on Foreign Nationals.***

It should be noted that:

A detainee who is a citizen of an independent Commonwealth country or a national of a foreign country, including the Republic of Ireland, has the right, upon request, to communicate at any time with the appropriate High Commission, Embassy or Consulate.

The detainee must be informed as soon as practicable of this right and asked if they want to have their High Commission, Embassy or Consulate told of their whereabouts and the grounds for their detention. Such a request should be acted upon as soon as practicable and cannot be delayed.

Consular officers may, if the detainee agrees, visit one of their nationals in police detention to talk to them and, if required, to arrange for legal advice. Such visits shall take place in private.

If a citizen of a country **with which the UK shares a bilateral consular convention or agreement** is arrested, the appropriate High Commission, Embassy or Consulate must be notified as soon as practicable. The **United Kingdom Borders Agency (UKBA)** is able to determine whether compliance with relevant international obligations requires notification of arrest to be sent and will inform the custody officer on what action the police need to take. The exceptions to this rule are where:

- The detainee is a political refugee, (whether for reasons of race, nationality, political opinion or religion); or
- Is seeking political asylum.

In these circumstances notification should not be made and no access should be permitted or information about the detainee provided to those bodies (except where the detainee has specifically requested that this happens). The custody officer must ensure that the UKBA are informed as soon as practicable of the claim.

Foreign nationals who are arrested and detained in the UK may have formed a view of the police in their own or other countries where law enforcement authorities may have been more aggressive or used corrupt methods.

Language and cultural differences may also induce anxiety in a detainee as their perceptions of custody may be influenced by their particular background or experience.

Foreign national women make up a disproportionate twenty per cent of the women's prison population. Many are single mothers. Female detainees held outside their own country will have increased vulnerability while detained, eg, mental health and wellbeing, and on release, eg, returning to exploitation.

Custody officers and staff must be aware of the potential increased vulnerability of individuals who may themselves be victims of human trafficking, extortion and/or abuse (often within the illegal sex trade). Additionally, custody officers should consider that a foreign national person entering custody may be less likely to have established

support networks that are able to help with care of dependants, or support them with housing and healthcare on release.

A foreign national may be held in custody by the UKBA, under a force agreement for short-term use of police cells for failed asylum seekers or immigration offenders.

Detainees who have been found (by the UKBA or police) trying to enter the UK via clandestine means should be assessed by a healthcare professional and monitored according to medical advice. A detainee who has been smuggled into the UK may be physically and/or mentally frail or unwell following a long journey in cramped and dangerous conditions. Detainees may require additional food or drinks, clothing and blankets.

6.2.6 TRANSSEXUAL AND TRANSVESTITE DETAINEES

It is important that transsexual and transvestite detainees receive the same respect and dignity as any other member of the public. The Equality Act 2010 makes it unlawful for a public authority (and therefore a police officer/police staff member) to discriminate against another person due to them having the protected characteristic of gender reassignment and treating them less favourably than they treat or would treat others.

It must be recognised that in carrying out some police procedures, such as strip searches, there is also a requirement to be sensitive to the dignity of police officers called upon to perform the task.

For the purposes of this guidance the following definitions will apply:

Transsexual is a reference to a person who has the protected characteristic of gender reassignment (see Section 7 Equality Act 2010). A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of that sex. That person is not required to be under medical care to satisfy this definition.

Transvestite is the adoption, fully or partially, of clothes normally identified as belonging to the opposite gender.

Sex refers to biological differences, chromosomes, hormonal profiles, internal and external sex organs of a male and female.

Gender describes the characteristics that a society or culture delineates as masculine or feminine.

Legally, the sex of a person is that which was registered at the time of birth, unless Section 9 of the Gender Recognition Act 2004 applies. However, a rigid adherence to this principle has been found to be too inflexible and can lead to unnecessary distress and confrontation. Dealing with all transsexual and transvestite detainees with respect and consideration will increase the likelihood of cooperation and decrease the level of risk and vulnerability posed.

The Gender Recognition Act 2004

Section 9 of the Gender Recognition Act 2004 (GRA) provides that where a full Gender Recognition Certificate is issued to a person, for all purposes that person's gender becomes their acquired gender.

In practical terms, legal recognition under the GRA has the effect that, for example, a male-to-female transsexual person will be legally recognised as a woman in English law. On the issue of a full Gender Recognition Certificate, the person will be entitled to a new birth certificate reflecting the acquired gender (provided a UK birth register entry already exists for the person) and will be able to marry someone of the opposite gender to his or her acquired gender.

Section 22 of the GRA defines any information relating to a person's application for a Gender Recognition Certificate or to a successful applicant's original gender as 'protected information'.

It is not authorised or permitted for any police officer or any member of police staff who has acquired information relating to a person's gender reassignment or proposed gender reassignment, whilst performing their official duties, to disclose that information to any other person (unless the exceptions listed below apply). To do so will constitute an offence in contravention of the GRA. Disclosure will have occurred if a record of this protected information is read by others, therefore custody records for transsexual detainees must be secured against disclosure.

An example of an illegal disclosure would be; if the existence of a Gender Recognition Certificate (that states that the detainee is transgendered) is noted on the relevant custody record, and that custody record is later viewed by an Independent Custody Visitor. This would constitute a disclosure and an offence will have been committed contrary to Section 22 of the GRA.

It is not an offence to disclose protected information relating to a person if:

- (a) The information does not enable that person to be identified.
- (b) That person has agreed to the disclosure of the information.
- (c) The information is protected information by virtue of subsection (2) (b) and the person by whom the disclosure is made do not know or believe that a full GRC has been issued.
- (d) The disclosure is in accordance with an order of a court or tribunal.
- (e) The disclosure is for the purpose of instituting, or otherwise for the purposes of, proceedings before a court or tribunal.
- (f) The disclosure is for the purpose of preventing or investigating crime.
- (g) The disclosure is made to the Registrar General for England and Wales, the Registrar General for Scotland or the Registrar General for Northern Ireland.
- (h) The disclosure is made for the purposes of the social security system or a pension scheme.
- (i) The disclosure is in accordance with provision made by an order by the Secretary of State under subsection 5, or
- j) the disclosure is in accordance with any provision of, or made by virtue of, an enactment other than this section.

When establishing whether the person concerned should be treated as being male or female for the purposes of strip searches and procedures, the following approach, which is designed to minimise embarrassment and promote cooperation, should be followed.

- (a) If there is no doubt about whether the person concerned should be treated as being male or female, they should be dealt with as being of that sex.
- (b) If at any time there is doubt about whether the person should be treated, or continue to be treated, as being male or female:
 1. The person should be asked what gender they consider themselves to be. If they express a preference to be dealt with as a particular gender, they should be asked to indicate and confirm their preference by signing the custody record or, if a custody record has not been opened, the search record or the officer's notebook. Subject to 2 below, the person should be treated according to their preference. (The person **must not** be asked whether they have a Gender Recognition Certificate.)
 2. If there are grounds to doubt that the preference in 1 accurately reflects the person's predominant lifestyle, for example, if they ask to be treated as woman but documents and other information make it clear that they live predominantly as a man, or vice versa, they should be treated according to what appears to be their predominant lifestyle and not their stated preference.
 3. If the person is unwilling to express a preference as in 1 above, efforts should be made to determine their predominant lifestyle and they should be treated in accordance with this. For example, if they appear to live predominantly as a woman, they should be treated as being female.
 4. If none of the above apply, the person should be dealt with according to what reasonably appears to have been their sex as registered at birth.

Transsexual and transvestite detainees must always be accommodated in a cell or detention room on their own.

Once a decision has been made about which sex a transvestite or transsexual is to be treated as, the officer or staff member who will carry out the search should be advised of that decision, and the

reasons supporting it, prior to the search of that person being carried out. This is important in order to maintain the dignity of the officer or staff member concerned.

In dealing with such circumstances there is potential for conflict and embarrassment. Sensible application of the above principles should minimise the risk of such action and protect officers.

6.3 HEALTHCARE PROVISION

Chief officers have a statutory responsibility under section 3 of the Health and Safety at Work etc Act 1974 to ensure that detainees have access to appropriate healthcare while in custody. This must be provided in a timely and effective manner.

There are three main reasons why a detainee may require medical attention:

- Physical and mental health;
- Welfare;
- Forensic examination.

All medical examinations must be carried out by an appropriate healthcare professional.

Responsibilities of the Custody Officer in relation to Healthcare Provision

The custody officer must make sure that a detainee receives appropriate medical attention as soon as is reasonably practicable if the person:

- (a) Appears to be suffering from physical illness; or
- (b) Is injured; or
- (c) Appears to be suffering from a mental disorder;
- (d) Appears to need clinical attention.

PACE Code C, paragraph 9.5

Custody managers and officers should familiarise themselves with and understand the contracts held with healthcare providers. This is essential if the police are going to be able to adequately hold

providers and individuals to account. The custody officer needs to understand the roles and responsibilities of all staff that provide a service to detainees and the force in the custody environment.

Healthcare Models

Forces should develop a healthcare model that best suits their requirements and enables them to deliver effective healthcare. The agencies and individuals providing this service must have the legal authority, qualifications, experience, capability and capacity to deliver a continuous quality service, within set timeframes. For example, it may be appropriate to use a contracted time limit (for non-urgent cases) of two hours between the request being made and the healthcare professional performing an assessment on a detainee. Forces must keep records, for audit purposes, which detail each healthcare professional's qualifications, their job description and role profile. Medical professionals must provide evidence of appropriate re-validation.

Models for the provision of custody healthcare include:

- Protocols with local hospital trusts and healthcare facilities;
- Paramedics on call;
- Forensic physicians/GPs on call;
- Forensic physicians/GPs employed by external suppliers;
- Nurses or paramedics employed as police staff, under contract, through agencies or on call-out from the NHS.

For further information see **6.3.1 Healthcare Professional**, which details the relevant qualifications for healthcare professionals working in police custody and the procedures and duties which may be undertaken by healthcare professionals, and **8.5 Mental Health Professionals** for details of Approved Mental Health Professionals (AMHP).

Factors to Consider When Deciding on a Model for Healthcare Provision

- The healthcare professional needs to be allocated resources to enable them to do their job efficiently. This includes providing suitable equipment to allow procedures such as suturing to be done at the custody suite, removing the need for detainees to

- be escorted to hospital for routine procedures.
- Where resources are allocated to specific sites and shared between sites, where practicable, they should not be more than twenty minutes apart and there should be a mix of main and smaller sites.
- Healthcare professionals should be based in busy custody suites at times of high demand to minimise the need to call them out.
- All risk assessment documentation must be retained by the police for internal and external inspection, and for monitoring the services provided.
- The presence of healthcare professionals in custody suites increases the chances of identifying detainees who may be at risk and improves the coordination of care for vulnerable persons.

Healthcare professionals should ensure, where practicable, that detainees sign a declaration form (**DH/HO Agreement to Sharing of Information Form**) to give consent for the sharing of information relevant to their care and welfare. The healthcare professional should record their findings on the **Detained Persons Medical Forms, Form 450**.

6.3.1 HEALTHCARE PROFESSIONALS

A healthcare professional means a clinically qualified person working within the scope of practice as determined by their relevant professional body. Whether a healthcare professional is 'appropriate' depends on the circumstances of the duties they carry out at the time.

The following qualified professionals may provide medical attention to detainees in different ways and to differing degrees:

- Forensic physicians (Forensic Medical Examiners);
- Nurses and psychiatric nurses;
- Occupational Therapists;
- Chartered Psychologists;
- Paramedics;
- Emergency Care Practitioners.

Until a new model for NHS commissioning of healthcare services comes into being, police forces should determine and make arrangements for the most appropriate model of healthcare

provision. This must be considered taking account of quality of service provision and best value.

Qualifications for Custody Healthcare Professionals

Forensic physicians

Forensic physicians (FPs) must be qualified medical practitioners who have achieved additional competencies and qualifications, such as obtaining Section 12 Approval under the Mental Health Act 1983, which allows the individual to carry out formal Mental Health Assessments for purposes including compulsory admission to hospital.

Nursing schemes

The following criteria are essential when recruiting custody nurses:

- An NHS Level 6 (minimum) registered General Nurse. Nurses qualified to lower grades cannot diagnose and this can lead to delays before the detainee is seen by an FP.
- Four years' post-qualification experience.
- Three years' Accident and Emergency, or prison, or custody, or mental health experience.
- Completed the yearly Resuscitation Council (UK) immediate life support course.

Further desirable criteria are qualifications in:

- Substance Misuse;
- Mental Health;
- Minor Injuries;
- First Contact Care Practitioner.

Paramedic schemes

Essential criteria when recruiting paramedics are:

- Paramedic qualifications;
- Two years' post-qualification experience;
- Custody or mental health experience.

A further desirable criterion is:

- Emergency Care Practitioner qualification.

Following the examination of a detainee, the healthcare professional should record any clinical findings and directions in the custody

record, unless there is information that must remain confidential and is not relevant to the effective ongoing care and wellbeing of the detainee. In such cases an entry must be made in the custody record indicating where the clinical findings are recorded. See PACE Codes of Practice Code C, paragraph 9.16 and Annex G, paragraph 7.

Directions concerning the frequency of visits and any concerns must be clear and precise. The custody officer must ask for clarification if any oral or written clinical directions given by a healthcare professional are unclear.

The risk assessment remains the responsibility of the custody officer and should be completed in consultation with the healthcare professional, reflecting the findings of each medical assessment. The custody officer and healthcare professional should agree an action plan for the care of the detainee. Any disagreement, along with the decision-making process, should be recorded in the custody record. Custody officers are advised to comply with clinical directions where possible, and if they cannot do so, to work with the healthcare professional to develop an action plan both parties are happy to endorse. Doing so will:

- 1) Offer more protection to the custody officer in the event of harm resulting to the detainee;
- 2) Ensure the action plan better meets the detainee's welfare needs.

For further information about the provision of medical attention, see **12 Human Resources and Training, 6.3 Healthcare Provision, 8.5 Mental Health Professionals** and *Home Office Circular (20/2003) Healthcare professionals in custody suites – guidance to supplement revisions to the Codes of Practice under the Police and Criminal Evidence Act 1984 on the roles and responsibilities of healthcare professionals in custody suites.*

6.3.2 FIT TO BE DETAINED

The custody officer may decide that medical attention is needed before a decision can be made about a person's fitness to be detained; this is irrespective of whether the person has already received treatment elsewhere, for example, at hospital. They should also be aware that the effects of alcohol or drugs may mask other

illnesses or injuries.

British Medical Association (2009) Healthcare of Detainees in Police Stations, Third Edition (paragraph 1.4), specifies the issues to be addressed when assessing fitness for detention:

- Assessment of illness, injuries and drug and alcohol problems;
- Advice to the custody officer on general care while in custody;
- Provision of necessary medication;
- Referral to hospital;
- Admission under mental health legislation.

The custody officer must ensure that all relevant information is made available to the healthcare professional, and that the healthcare professional makes available all relevant information to the custody officer. For further information see **6.3.7 Medical Documentation**.

It is the responsibility of the custody officer under PACE Code C, to seek medical treatment (or assessment) of any person who they suspect may be, or have been told may be, mentally disordered or otherwise mentally vulnerable.

As the thresholds for fitness for detention and fitness to plead are different, prosecution may still be appropriate if a person is assessed as not fit for detention.

For further information see **8 Mental Ill Health and Learning Disabilities** and **ACPO/DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities, Sections 7.3 and 7.5**.

6.3.3 FIT TO BE INTERVIEWED

Before an interview takes place, the custody officer must assess whether the detainee is fit to be interviewed. If doubts are raised about their medical fitness for interview, the detainee must be assessed by a healthcare professional before the interview takes place as failure to do this may prejudice subsequent proceedings.

The assessment should identify the risks to the detainee's physical and mental wellbeing, and determine safeguards that may be required during the interview process.

PACE Code C (11.18) states:

The following persons may not be interviewed unless an officer of superintendent rank or above considers delay will lead to the consequences in *paragraph 11.1(a) to (c)*², and is satisfied the interview would not significantly harm the person's physical or mental state:

- (a) a juvenile or person who is mentally disordered or otherwise mentally vulnerable if at the time of the interview the appropriate adult is not present;
- (b) anyone other than in (a) who at the time of the interview appears unable to:
 - appreciate the significance of questions and their answers; or
 - understand what is happening because of the effects of drink, drugs or any illness, ailment or condition;
- (c) a person who has difficulty understanding English or has a hearing disability, if at the time of the interview an interpreter is not present.

PACE Code C paragraph 11.20 requires that a record must be made of the grounds for any decision to interview a person under paragraph 11.18. For additional information see also PACE Code C, Annex G.

Custody records should record whether fitness to be detained or interviewed has been assessed, the reason for doubting a person's fitness for interview, and the result of any healthcare professional's assessment. Where this detail cannot be added fully to the custody record, reference to where the information is recorded should be made in the custody record.

These records should be made available to the CPS so that they are

² (a) lead to: interference with, or harm to, evidence connected with an offence; interference with, or physical harm to, other people; or serious loss of, or damage to, property; (b) lead to alerting other people suspected of committing an offence but not yet arrested for it; or (c) hinder the recovery of property obtained in consequence of the commission of an offence.

Interviewing in any of these circumstances shall cease once the relevant risk has been averted or the necessary questions have been put in order to attempt to avert that risk.

aware of any potential mental ill health and/or learning disability. For more details see ***British Medical Association (2009) Healthcare of Detainees in Police Stations, Second Edition.***

In a case where an individual is not fit for interview and is in the care of a hospital, local protocols should be in place to ensure that medical staff inform the police as soon as the individual is deemed fit for interview or charge. Appropriate arrangements can then be made to interview the person at the hospital, or for the person to be brought to the police station for further interview and/or further investigation.

6.3.4 MEDICATION

The custody officer may distribute, or authorise other custody staff to distribute, medication for self-administration if the officer has consulted the appropriate healthcare professional authorising their use and both are satisfied self-administration will not expose the detainee, police officers or anyone else to the risk of harm or injury. This consultation may be by telephone.

No police officer may administer or supervise the self-administration of medically prescribed 'controlled drugs' (of the types and forms listed in the Misuse of Drugs Regulations 2001, Schedule 2 or 3). A detainee may only self-administer such drugs under the personal supervision of the appropriate healthcare professional authorising their use.

Where it is known that a detainee requires medication, the custody officer is responsible for:

- The safekeeping of the medication, which should be held in a locked receptacle to prevent unauthorised access;
- Appropriate storage of medication, eg, some insulin and other drugs must be stored in a fridge;
- Providing the detainee with the opportunity to self-administer the medication at the prescribed intervals;
- Ensuring that the correct medication is available to the detainee and at the right dosage;
- Recording information in the custody record (Including a record of all consultations with healthcare professionals, see PACE Code C Paragraph 9.9).

Medication may have been brought in by the following means:

- By a detainee, friend, relative or by the police when detaining

the person. It may not be what the detainee, friends or family say it is, or what is recorded on the packaging, and it can be used to conceal other items. The medication should never be distributed to the detainee for self-administration prior to it being checked by an appropriate healthcare professional.

- Provided by the police in accordance with directions from the healthcare professional.
- Provided by a healthcare professional.
- Collected by the police via a private prescription.
- Provided by hospital staff when a detainee has been to hospital for treatment while in police detention.

Clear written instructions must be provided for custody staff. These should be recorded on the **Detained Persons Medication Form, Form 450a**.

Instructions should include:

- The name of the detainee, the prescribing healthcare professional, medication name, strength and quantity (number of tablets or capsules) required at stated times;
- Special instructions, eg, to be taken with or without food;
- disposal of unused medication, eg, when released or transferred from custody.

Depending on the risk assessment, it may be appropriate to allow detainees who have asthma to keep their inhalers (see **3.3.9 Asthma**) and angina sufferers to keep their angina sprays (see **3.3.10 Heart Disease**) so they can administer them as necessary. A detainee may, in certain circumstances, self-administer drugs under the personal supervision of the healthcare professional authorising their use.

Forces must establish procedures for the safe storage and handling of medication. This should include systems for auditing, management, and appropriate reporting of near misses, errors and adverse events. All custody staff must be trained in these procedures.

Custody staff must check that the correct medication is given in the correct dosage to the right detainee at the appropriate time; two custody staff should undertake this task where practicable. This should be recorded on the custody record and medication form. Care should be taken to prevent the detainee hoarding medication. If a detainee refuses medication, a healthcare professional should be informed.

Adequate quantities of medication should be available to cover the likely length of detention in police custody and any known transfer time. Details concerning this provision should be recorded on the PER or medication form as appropriate.

Where the detainee is released, custody staff should dispose of unused medication in accordance with the instructions provided, recording the method of disposal on either the custody record or medication form. Medication prescribed during the period of detention might be:

- Given to the detainee on release (only on the authority of the prescribing healthcare professional);
- Given to the escort service (travel with detainee);
- Returned to an appropriate healthcare professional;
- Disposed of in a suitable receptacle for disposal of unused medication. These must be kept secure to prevent detainees from gaining access to them.

For further information see PACE Code C, paragraphs 9.9 to 9.12 and Note 9A.

6.3.5 HOSPITAL

In medical emergencies an ambulance should be called and the detainee taken to hospital as soon as possible. If there is an appropriate healthcare professional available at the police station, they should be called to attend while awaiting the ambulance.

Note: It is advised that the custody officer ensures that local ambulance services are able to park a vehicle and gain access to the police station site(s) and custody suite in an emergency.

In exceptional circumstances it may be appropriate to transport the person to hospital by police vehicle. The detainee may require first aid, which should be given by suitably qualified staff.

The custody officer must ensure that a PER Form is completed to accompany the detainee to hospital. In emergencies there may not be sufficient time to complete the PER form. In this case the escorting officers should be verbally informed and the PER Form passed to them at the hospital as soon as practicable. For further information see **6.3 Healthcare Provision.**

On returning to police detention from hospital, the detainee must be searched again to ensure that they have not acquired items that could be used to cause harm to themselves or others, or to damage property. For further information see **4.6.3 Search of a Detainee within Custody.**

Any case notes or items of information from hospital medical staff relevant to the continuing treatment of the detainee should be passed to the healthcare professional at the police station. This should include the results of any tests such as CT scans in the case of a head injury, information on how to care for the detainee and any care plan. This should be obtained in writing. The escorting officers should return the PER to the custody officer and inform them of any additional risks identified.

The police retain a duty of care for detainees who are refused admission to hospital or treatment by ambulance staff. Efforts should be made to have the detainee examined and assessed, but if healthcare services still refuse to accept the detainee they should be taken into custody at the police station. Clear instructions about their care, ongoing treatment and transportation should be requested from healthcare staff. Preferably, this should be in writing, including the reasons for refusal of admission or treatment.

If the custody officer has any doubt about a detainee's fitness to be detained or interviewed following their return from hospital, a healthcare professional should re-assess the detainee.

If the escorting officers do not agree with hospital staff that a detainee should be released from hospital, the following options can be taken:

- Discussion with an appropriate healthcare professional;
- Request a second opinion;
- Request that an appropriate healthcare professional discusses the issue with the Accident and Emergency consultant;
- If an appropriate healthcare professional is not available, the detainee should be taken to another hospital for a second opinion.

Where it has been necessary to take the detainee to another hospital for a second opinion, the matter should be raised with the force custody management so that the issues can be discussed at strategic

level between the organisations.

6.3.6 SUPERVISION AND SECURITY

Staff undertaking hospital supervision duties must be briefed about their role. This should include:

- The individual they are guarding;
- The known risks associated with the detainee (including any medical conditions they may have) and the risk management plan;
- Actions to be taken to prevent the detainee's escape;
- Actions to be taken to preserve evidence;
- Actions to be taken to prevent the acquisition or retention of items that may cause harm to the detained person or others;
- Actions to be taken in the event of an incident involving the detainee or affecting the detainee;
- Any available and relevant information on the medical condition of other patients on the premises who may be located nearby or are likely to be affected by any actions of the police officers or detainee;
- The requirement to fully brief staff who take over the role from them;
- The use of handcuffs.

Staff engaged on hospital supervision should be contacted by a supervisor at least once during each tour of duty to ensure:

- The safety and welfare of the member of staff;
- The safety and welfare of the detainee;
- Consultation with the hospital and medical staff;
- Compliance with instructions and guidance given on the detention and care of the detainee.

Forces should establish local protocols with hospital trust managers, that specify how responsibility for security will be assigned between police officers and hospital trust security staff. For further information see **3 Risk Assessment**.

6.3.7 MEDICAL DOCUMENTATION

Medical notes are not part of the custody record. Care must be taken to ensure they are not disclosed to solicitors and Independent Custody Visitors (ICVs) while they are examining a custody record.

Forces may adopt the **Detained Persons Medical Form (450)** and **Detained Persons Medication Form (450a)**. These forms have been produced to provide a minimum acceptable standard and forces may decide to use a locally agreed version with additional detail.

Detained Persons Medical Form (DPMF/Form 450)

The purpose of this form is to focus awareness on areas of medical concern to custody staff, and to provide, where necessary, a chronological medical report relating to a detainee's period of detention.

The information contained in the form will only be disclosed, for the purpose of the detained person's welfare, to hospital and ambulance staff. If, however, the detainee has been assessed as being at risk of suicide or self-harm, the DPMF should accompany the detainee as they are transferred to court, hospital or prison.

Detained persons are not obliged to submit to an examination or to supply information. However, if the detainee chooses not to fully cooperate, or there is any suspicion that they are not being truthful in their responses to questioning, this should be recorded on the DPMF and on the custody record. This particularly concerns assessment, when the detainee may wish to conceal potential injuries (self-harm or other) and/or may be at risk of suicide.

The DPMF will be completed for any person who is detained or brought to a station who:

- Answers 'yes' to any of the medical history questions;
- Is otherwise apparently suffering from any physical or mental medical illness;
- Suffers from any physical or mental illness or injury while at a police station;
- Requires any non-urgent first-aid treatment;
- Is seen, or will be seen by a healthcare professional.

Where none of the above conditions apply, a form need not be used.

The DPMF will be made immediately available to the healthcare professional on arrival. It should be available at all times to all custody officers, staff and healthcare professionals involved with the care of the detainee while they are in police custody. This is

particularly important at shift handover. A copy will be provided to ambulance or hospital staff if a detained person is being transferred to hospital.

Healthcare professionals should endorse the form as required in clear and unambiguous writing and bring the content and detail of their report to the attention of the custody officer before leaving the police station. Any requests made by the healthcare professional (eg, collection of prescribed drugs) should be recorded on the custody record. Custody officers should record subsequent actions or decisions taken as a result of the request on the custody record, (and PER and/or Detained Persons Medication Form 450a as appropriate).

The recommendations section (12) of the form deals with the healthcare professional's overall assessment of fitness of the detainee to be detained and interviewed, and provides for an estimate of when such fitness may be expected, where appropriate. It also allows for medical opinion as to whether an appropriate adult may be required and is intended to aid the custody officer in taking this decision.

Note: In order to assess the 'fitness for interview' of a detainee the healthcare professional must be an FME or have received relevant prior training.

Where, through assessment, it has become apparent that the detainee has recent self-inflicted injuries; these should be noted on the body map section of the form. This information may aid identification of any new injuries that are occur after the form has been completed, at a later assessment, or on transfer to hospital, court or prison. The time the review has been completed should be provided on the form.

Where the healthcare professional believes further examination or assessment will be required again at a later time, this should be written on the form (including the proposed time) and noted on the custody record (and PER if appropriate). In this case the healthcare professional who completes the reassessment should read and consider the original DPMF and complete a new DPMF that relates to the later assessment. The unique reference number of the new form should be recorded on the original form and the custody record.

The DPMF should not include any confidential observations or notes. Such notes or observations should be recorded separately and kept by the healthcare professional.

Detained Persons Medication Form (Form 450a)

The purpose of the Detained Persons Medication Form is to clarify the prescribing and administering of medication to detainees. The form itself is self-explanatory and includes sections for single 'once only' prescriptions and sections for repeated or regular administration of prescribed drugs. In addition, the final section allows for explanation of reasons why prescribed drugs were not administered as required.

The form allows for more specific instructions to custody staff regarding the general provision of drugs and includes the healthcare professional's authority to transfer prescribed drugs to PECS escort service providers or to the detained person on release.

The information contained in the form must only be disclosed for the purpose of the detained person's welfare to hospital and ambulance staff.

Detained persons are not obliged to submit to an examination or to supply information.

6.4 CELL OCCUPANCY

Home Office approved cells and detention rooms are designed for single occupancy. Cell sharing should only occur on an exceptional basis and is not appropriate where:

- A detainee requires special provisions for any reason, eg, disability;
- There are diversity issues that would make cell sharing inappropriate, eg, religious beliefs and the inability to meet religious obligations;
- Detainees are not the same gender;
- The detainee is a juvenile.

The decision to multi-occupy cells rests with the custody officer. If there is any dispute with the custody officer's decision, the matter must be referred to the superintendent responsible for the station, in accordance with PACE. Multi-occupancy must be justified and recorded using a joint risk assessment on the relevant custody records.

The joint risk assessment must consider the following:

- Any warning markers that the detainees may have;
- Medical conditions;
- Demeanour on arrival;
- Current demeanour;
- Known or suspected racist or homophobic attitudes;
- Other discriminatory attitudes;
- Both detainees' views on sharing.

A detainee should not share a cell with another person if any of the above risks have been identified with either of them.

Consideration should be given to using a CCTV-equipped cell. Private toilet facilities must be made available. Expecting detainees to share open toilet facilities may breach Article 8 ECHR (the right to respect for private and family life).

Monitoring regimes must be reviewed when cells are being shared. The custody officer should increase the frequency of checking detainees in multi-occupancy cells.

Detainees' reactions to being held in a cell with another person cannot be precisely gauged in advance, but the risk of one person harming another must always be considered. Custody staff, including healthcare professionals, must keep the custody officer informed of any noticeable changes in behaviour which could alter the risk assessment.

6.5 OUT OF CELL

Custody staff must always observe the detainee through the spy hole or cell hatch prior to opening the cell door. Whenever a detainee is allowed out of a cell, they must be adequately supervised at all times to prevent them from obtaining an item or doing anything that could:

- Harm themselves or others;
- Interfere with evidence;
- Damage property;
- Affect an escape.

If there are concerns that a detainee has not been adequately supervised outside a cell, for example, during consultation with a

solicitor, the detainee should be thoroughly searched before being returned to the cell. For further information see **4.6.3 Search of a Detainee within Custody**.

6.5.1 EXERCISE

Detainees are entitled to brief daily outdoor exercise where practicable. Exercise should be provided individually and be adequately supervised. Exercise areas should be thoroughly searched for any potential hazards prior to use. Depending on the design of the exercise area, the nature of the exercise and the detainee's risk assessment, constant supervision may be necessary.

For further information see **11.1.1 Health and Safety**.

6.5.2 INTERVIEW

Investigating staff are responsible under PACE for the supervision of detainees when they are being interviewed.

The period immediately following an interview has been identified as a time when detainees are at a higher risk of inflicting self-harm, particularly if they have been arrested for a serious offence or re-arrested for further offences. All staff must be aware of this and watch for changes in a detainee's demeanour, such as their becoming quiet and withdrawn. Similar changes are often seen in detainees when bail is refused.

The custody officer must be informed by the investigating staff of any noticeable changes in the detainee's behaviour which could alter the risk assessment.

6.5.3 INVESTIGATION

All staff involved in investigating offences have a duty to inform the custody officer of any further information they discover which may affect the detainee's risk assessment. This includes any statements made by the detainee during interview, while on escorted visits outside the police station or made about the detainee by others who know them. See PACE Code C 11.13.

If for any reason a detainee is taken out of the police station by investigating staff, they must supervise the detainee at all times. They must also monitor their welfare and ensure that the detainee does not gain access to items that could be used as weapons.

When a decision has been taken to charge a person and bail has not been granted, the detainee will be kept in custody until the next available court sitting. The risk assessment must be reviewed when such a decision is made as they are at a higher risk of suicide or self-harm at this time. Detainees should be monitored for changes in behaviour that may indicate an increased risk of self-harm or suicide. Access to external support, such as calling the Samaritans, can be effective at this stage. For further information see **6.12 Diversion and Referral**.

6.6 USE OF TECHNOLOGY

Monitoring vulnerable detainees can be improved by using technology, however, physical checks and visits must be made irrespective of the use of technology.

Overreliance on CCTV monitoring will create a high risk to the health and safety of detainees. Technology must only be used to enhance the monitoring of a detainee's welfare. CCTV and monitoring devices installed within cells may be effective in alerting staff to self-harm or suicide attempts, however, a small CCTV monitor screen picture can not be relied upon to monitor a detainee's medical condition.

For further information see **11.4 CCTV**.

6.7 WELFARE AND SAFETY

Meeting the welfare needs of detainees involves providing various items, some of which are routinely taken into cells but which can be used to self-harm. Detainees who are determined to self-harm have been known to adapt items in unusual ways. For further information see **3 Risk Assessment**.

6.7.1 CLOTHING

Any item of clothing can be used as a ligature. Belts, ties, cords and shoelaces are obvious and more readily available as ligatures. The

decision to remove these items should be made after conducting a risk assessment, and the custody officer must balance any risk with the need to treat detainees with dignity.

If a detainee is believed to be at risk of suicide or self-harm, the seizure and exchange of clothing may not remove the risk but may increase the distress caused to the detainee and, therefore, increase the risk of them self-harming. Leaving a detainee in their own clothing may help to normalise their situation. Constant observation or within close proximity (Level 3 or 4) may be a more appropriate control measure in these circumstances.

Clothing is often taken from a detainee in the course of an investigation as evidence or for hygiene purposes. In all cases replacement clothing must be provided. For further information see **4.6.3 Search of a Detainee within Custody.**

There are various alternatives to the paper suit that are marketed as being safe for 'at risk' detainees. It should be noted that no suit is totally safe, although some are more difficult to use in self-harm attempts than others.

Removal of clothing must be justified and recorded on the risk assessment and custody record. Forces should ensure that alternative clothing is readily available within their custody suites.

6.7.2 BLANKETS

Blankets should be supplied to a detainee in a clean and sanitary condition. They should be checked and cleaned prior to being used by another detainee. No blanket is totally anti-tear and must be checked when being issued to prevent it being used as a ligature. Blankets should be collected when the detainee no longer requires them and should never be left in a cell when a detainee is moved or released.

6.7.3 MATTRESSES

When a cell is vacated, mattresses should be checked for damage and cleaned as required. A worn or damaged mattress can be torn into strips for use as a ligature or could be used to conceal items. Worn and damaged mattresses must be removed from use

immediately.

6.7.4 TOILET PAPER

The provision of toilet paper to detainees should be on a risk assessed basis. The default position should be that detainees are supplied with toilet paper unless there is evidence that they may try to harm themselves.

The use of toilet paper is a potential risk for detainees who may either plait long rolls of paper to make a strong ligature, or soak the paper and force it down the throat causing death by choking. A decision to withhold toilet paper must be made in accordance with the risk assessment. Risk can be minimised by:

- Supplying a number of single sheets of toilet paper when required;
- Ensuring that toilet paper is not left in cells;
- Not supplying rolls of toilet paper.

The additional needs of detainees who, for example, are menstruating or have an additional medical need should be taken into consideration on an individual basis.

Female detainees should be routinely informed that sanitary items are available on request.

6.8 FOOD AND DRINK

Adequate food should be offered to detainees as required in a timely fashion. The calorific value of meals should be reasonable and sufficient to meet the dietary requirements of detainees, including those held for over twenty-four hours.

The temperature of food provided should be carefully managed. Providing very hot food and drinks to detainees will present the risk of scalding to the detainee and can cause severe injury if thrown at staff. The design of most custody suites will involve the delivery of food and drinks to cells via the custody area.

Forces should consider banning food being passed on to a detainee from an external source (except when sourced by the police). Drugs are commonly smuggled in by these means and items such as

cigarettes, matches and lighters can also be concealed in this way. Where a decision has been taken to allow foodstuffs or drinks to be brought into the custody suite by relatives or friends of a detainee, it should be thoroughly searched prior to it being offered to the detainee. See to PACE Code C paragraph 8.6 and note 8A.

Technology is widely available to reseal food packaging. On this basis, consideration should be given to banning any food being passed on to a detainee from an external source other than for strict dietary or religious requirements.

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.

Kitchen areas must be kept secure. Staff should also be reminded that items of crockery brought into the custody suite for personal use should be kept secure to prevent detainees using them as weapons.

Forces should establish a policy on the provision and preparation of food to detainees from external sources.

6.8.1 CHOKING

Choking on foodstuffs can occur by accident or it can be a deliberate attempt to self-harm. This condition can be difficult to diagnose and may not always be observed until it is too late. Where practicable, visiting the detainee when they are eating may reduce the risk of them choking to death.

For further information see ***FFLM (2010) Management of Choking in Police Care & Custody – Recommendations for Police Personnel*** <http://www.fflm.ac.uk>

6.8.2 CUTLERY AND CROCKERY

Crockery must be safe for hot food but provide the least risk of being misused. All cutlery and crockery must be removed as soon as a meal is finished to prevent it being used for self-harm, to choke on, as a weapon or to cause damage.

6.8.3 HYGIENE AND COMMUNITY HEALTH ISSUES

The preparation and supply of food to detainees can carry the risk of food poisoning. Custody staff should ensure that all appropriate measures are taken to eliminate these risks. Care must be taken to ensure that all hot meals are properly heated through. Care must also be taken with hot food to prevent scalding. Additionally, the food container should not provide an easy source for self-harm.

For further information see **12.4.7 Food Hygiene.**

6.9 SMOKING

Forces should legally apply a no smoking policy to custody areas. Local force policy and procedure will need to direct custody officers and staff on the use of appropriate nicotine substitutes.

Where a decision has been taken to allow smoking within a designated area of the custody suite (eg, the exercise yard) then detainees should be monitored in line with their risk assessment. The safety and welfare of custody officers, staff and other detainees must be considered at all times and any such decision must meet with the requirements of the Health Act 2006.

6.10 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 the 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.

Communication of information should be done verbally. Where CCTV exists within the custody area, handover should be undertaken within sight and sound of an appropriate camera/microphone. If CCTV is not available, written acknowledgement that all custody officers and staff

have been fully briefed on the risks and needs should be made on the custody record.

The information transferred should include the risks, vulnerabilities, emerging issues, control strategies and welfare needs of each detainee. It should also cover the status of the investigation, including the actions required to achieve effective and lawful resolution of the matter for which they have been detained.

The incoming shift of custody officers and staff should ensure they are fully aware of any risks, medical needs and relevant personal circumstances for all detainees.

Where multiple custody officers are on duty, it is essential that each is aware of their individual respective duties and responsibilities and that this information is recorded and kept up to date. Local force policy should provide clarity about who is acting as the designated custody officer for each detainee at any given time.

Note: Medical notes should not be made directly on the custody record; see **6.3.7 Medical Documentation** for more information.

The use of whiteboards can assist in the handover process, but to comply with data protection legislation must be out of sight of non-custody staff.

The use of smaller wipe-boards on or close to cell doors that display private details, including the name of the detainee and any risk-related information, is not advised. This is in order to protect the privacy and dignity of the detainee from the view of other detainees moving around the custody suite.

Consideration should also be given to replicating the whiteboard information in force communication or control rooms to enable force-wide custody capacity to be actively managed and controlled.

6.11 INDEPENDENT CUSTODY VISITORS

Independent Custody Visitors (ICVs) are volunteers whose role is to attend police stations to check on the treatment of detainees and the conditions in which they are held, and to establish that their rights are being observed. This protects both detainees and the custody staff, and provides reassurance to the community at large.

Responsibility for organising and overseeing the delivery of independent custody visiting lies with police authorities (to be replaced by Police and Crime Commissioners) in consultation with chief constables.

ICVs can visit police stations at any time and must be given immediate access to all custody areas unless doing so would place them in danger. A custody officer can delay but not deny access. A full explanation must be given for the delay and the explanation recorded by the ICV in their report. Where there is a reasonable belief that there is a danger to the visitor or that access could interfere with the process of justice, an officer of the rank of inspector or above can limit or deny access to a specific detainee. Such a decision must be recorded in the detainee's custody record and by the ICV in their report of the visit.

During a visit, the custody officer or member of custody staff must escort the ICVs and advise them of any specific health and safety risks they may encounter. ICVs may have access to all parts of the custody area and associated facilities, eg, food preparation areas and medical rooms. They may also, subject to the consent of the detainee, speak to them about the adequacy of the detention facilities, the detainee's rights and entitlements, and the health and wellbeing of the detainee. It is the responsibility of the custody officer to ensure that:

- The detainee is informed of the function of the ICV;
- The detainee is prepared to speak to the ICV.

This may be established by self-introduction by the ICV (in the presence of the custody officer/staff) or by the custody officer or custody staff member. An ICV may review a detainee's custody record, but they may not view their medical notes.

At the conclusion of every visit, a copy of the ICV's report is left for the attention of the officer in charge of the station. The findings from visits should be discussed by ICV groups and reported to the police at local, area and force level. There must also be regular feedback to the police authority.

For further information about the obligations of custody visitors, see PACE Code C and Notes for Guidance 1F, **Code of Practice (2010) Independent Custody Visiting** at [http:// www.icva.org.uk](http://www.icva.org.uk) and **11.4 CCTV**.

6.12 DIVERSION AND REFERRAL

This guidance supports the definition of diversion from **Bradley (2009) *The Bradley Report***:

'Diversion' is a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence.

The Bradley Report, 2009, p 16

The term diversion is predominantly used in the context of those suspected or convicted of criminal offences and can apply at different stages in the criminal justice response. For example:

- Diversion from the criminal justice system altogether by: a decision not to invoke the criminal law (for example, by concluding that a criminal offence has not occurred); by recording a criminal offence according to the National Crime Recording Standard (NCRS) but not taking any further criminal justice action; or by discontinuing a prosecution (for example, following a decision by the CPS that charging is not in the public interest);
- Diversion from prosecution by use of a fixed penalty notice, caution or conditional caution, reprimand, final warning or other 'Restorative Justice' resolution;
- Diversion from prison by a hospital order, guardianship order, non-custodial sentence, fine or discharge.

Diversion at the first two stages involves decisions by the police and CPS, but may involve other agencies at various points depending on the circumstances. Diversion from prison involves decisions by the court, which should be supported by information from the police, CPS and other relevant agencies.

The duty to act on foreseeable risks can extend beyond release. Referral to another agency following the issue of a conditional caution, release, or transfer from police custody may prevent deaths

following police contact or incidents of self-harm. It can also help to break the reoffending cycle.

Agency referral is possible through the use of conditional cautions, where arrangements have been made between forces and local agencies to provide alcohol and drug awareness or support programmes, and via a simple referral mechanism to a relevant agency on release. Both of these methods require consent and a level of commitment on the part of the detainee for success.

There are a number of agencies which assist people needing help or support on release from police custody. These may include statutory agencies such as Community Mental Health Teams and General Practitioners, or voluntary agencies such as the Samaritans and local alcohol and drug diversion workers.

The main triggers for referral may include:

- Risk of deliberate self-harm;
- Risk of suicide;
- Drug abuse;
- Alcohol or other substance abuse;
- Risk to others, including domestic violence;
- Request by detainee;
- Risk of attack by others.

Others include: mental health, physical health, family problems or relationship difficulties, housing, financial or employment problems, bereavement or bullying.

Forces should consider facilitating access to external support workers for detainees who have been remanded in custody.

Forces should consider developing policies and protocols for sharing information with other agencies. The use of the templates and the provision of directories of suitable agencies for referral, (eg, local NHS directories) is recommended. Directories should be made readily available in custody suites.

The use of templates for agency referral should:

- Ensure appropriate information is captured;
- Ensure information pertaining to identified risks is appropriately communicated to agencies;
- Act as an aide-memoire, with regard to the rules;
- Offer a method for capturing consent in a structured manner;

- Provide the opportunity for electronic exchange.

Information obtained by the police while dealing with a detainee is confidential. Recording, retention and deletion of this information must be in accordance with the principles of the **ACPO (2005) Code of Practice on the Management of Police Information..** For further information see PACE Code C, paragraphs 3.8 to 3.10 and the Data Protection Act 1998 and **ACPO (2010) Manual of Guidance on the Management of Police Information, 2nd edition.** Provisions are made for sharing information in specific situations in the Crime and Disorder Act 1998.

For more information on forms of diversion for detainees suffering mental ill health, see **8 Mental Ill Health and Learning Disabilities.**

7

ALCOHOL AND DRUGS

Contents

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7.1 DRUNK AND INCAPABLE

There is no legal definition of 'intoxicated'. It is recommended that this term is interpreted in the ordinary sense, ie, 'under the influence'. Police officers are expert witnesses in presenting evidence of drunkenness and should apply the same process used at operational incidents to this custodial process.

Custody staff considering the risk assessment and care plan for a detainee should differentiate between a detainee who has had a drink containing alcohol and is therefore under the influence and a detainee who is 'drunk and incapable'.

In the case of *R v Tagg* [2001] EWCA Crim 1230, CA, the Court of Appeal determined that the everyday meaning of 'drunk' should be used, as it is not defined by statute.

They were happy to accept that the Collins English Dictionary or Oxford Dictionary interpretations were materially the same in that respect. They define 'drunk' as:

- Intoxicated with alcohol to the extent of losing control over normal physical and mental functions (Collins);
- Having drunk intoxicating liquor to an extent which affects steady self-control (Oxford).

For the purposes of this guidance, the following definition will be used:

Drunk and incapable means that an individual has consumed alcohol to the point of being unable to either:

- Walk unaided; or
 - Stand unaided;
- or is
- Unaware of their own actions; or
 - Unable to fully understand what is said to them.

As a guide, it is suggested that if someone appears to be drunk and showing any 'aspect' of incapability which is perceived to result from that drunkenness, then that person should be treated as drunk and incapable.

A person found to be drunk and incapable should be treated as being in need of medical assistance at hospital and an

ambulance should be called.

If a drunk and incapable person who is under arrest declines or is refused medical treatment, they should, only as a last resort, be taken into custody at a police station. The fact that a person has declined or has been refused treatment does not absolve the police or the medical services of their responsibility.

A protocol should be agreed with local healthcare agencies for dealing with people who are drunk and incapable. This protocol should include escalation procedures for quickly resolving issues of responsibility for drunk and incapable people.

7.2 UNDER THE INFLUENCE OF ALCOHOL

All detainees should be risk assessed on arrival to the custody suite and throughout their detention. Detainees who have consumed any amount of alcohol (or drugs, or both) should be treated as being under the influence. The amount of alcohol and/or drugs that have been taken and the detainee's reaction to them cannot be absolutely confirmed or predicted.

Custody officers and staff must adhere to PACE Code C with respect to risk assessing, checking and rousing detainees. Rousing involves the use of a stimulus designed to elicit a response from the detainee (PACE Code C, Annex H). In managing the detention of individuals who have consumed alcohol (and/or drugs) in this way, the possibility of missing a more serious underlying medical condition, such as a head injury, is minimised. A detainee's unwillingness or inability to participate in a risk assessment should be viewed as a possible warning of risk.

Where necessary, a healthcare professional should be consulted as soon as practicable. A healthcare professional must always be consulted if:

- The risk assessment indicates that constant observation (Level 3) or close proximity (Level 4) monitoring is required. For further information see **6.1.2 Monitoring, Observation and Engagement.**
- A detainee registers more than 150 micrograms of alcohol on the evidential breath-test machine. (There is no power to test a detained person for alcohol other than in cases of suspected drink-driving.)
- A custody officer has particular concerns about any person who

is believed to have consumed alcohol and/or drugs and has been physically restrained (eg, potential symptoms of injury or acute behavioural disturbance).

- An epileptic fit occurs.
- The detainee shows symptoms of alcohol withdrawal, especially delirium tremens (DTs).

Custody staff will have to carry out health-related activity in the custody suite when a healthcare professional is not immediately available. This may include initial care for detainees with the following conditions:

- **Hypothermia;**
- **Vomiting** (if the detainee has an impaired level of consciousness, they should be transferred to hospital as they will not be able to protect their airway and are at risk of choking);
- **Hypoglycaemia** (low blood sugar) untreated this may result in brain damage.

Under these circumstances an ambulance should be called and, where available, the immediate assistance of a healthcare professional should be sought.

If a person appears to have collapsed, their airway, breathing and circulation (ABC) should be checked. They should then be rolled into the recovery position if safe to do so. Any debris should be removed from the mouth and throat before attempting further resuscitation.

Juveniles who display any symptoms of being drunk and incapable should always be transferred to hospital. Hypoglycaemia is more likely to occur in the young.

For detailed information on the procedure for the handling of drunk and incapable persons, see **NPIA (2011) *Template Protocol for the Management of Detainees that are Intoxicated and Incapable in a Public Place.***

7.3 ADDITIONAL RISKS ASSOCIATED WITH ALCOHOL

Alcohol-related offending accounts for a significant proportion of all arrests. A study in 2010 by Payne-James et al found that twenty-five

per cent of detainees in police custody were dependent on alcohol. Between 1998/9 and 2008/9 there was known to be a total of 188 deaths in or following police custody, where consumption of alcohol or a combination of alcohol and drugs was a factor³.

Staff tend to take longer to identify a health problem where detainees are suffering from the effects of alcohol. In over half (seventy-one) of those deaths mentioned above, the detainee was in police custody up to six hours prior to death⁴. The health of a detainee who has consumed alcohol is likely to deteriorate more quickly than that of a detainee who has not.

When dealing with persons believed to have consumed alcohol, staff must pay attention to these key risks:

- Alcohol is a poison in its own right and **detainees can die of alcohol poisoning;**
- **Head injuries** are often masked by drunkenness, symptoms of a serious injury to the head are the same as common signs of drunkenness (eg. slurred speech, drowsiness and vomiting);
- **Diabetics** may behave in such a way that they appear to be drunk and/or aggressive;
- **Drug** misusers may appear to be drunk when they have overdosed;
- Detainees should be able to walk to the cell and say a few words. if not, they should not be put in a cell but transferred to hospital;
- Where an individual is well known or familiar to police officers and staff, there is an increased risk that symptoms of serious illness or injury may go unnoticed, eg, regular detainees associated with alcoholism or drug addiction;
- The **PNC** may show that other serious medical conditions are present;
- Detainees who have consumed alcohol, are problematic users, or are **withdrawing from alcohol, are at an elevated risk of suicide or self-harm.**

³ IPCC Deaths in or Following Police Custody: An examination of the cases 1998/9–2008/9

⁴ IPCC Deaths in or Following Police Custody: An examination of the cases 1998/9–2008/9

7.4 ADDITIONAL RISKS ASSOCIATED WITH DRUGS

Between 1998/9 and 2008/9, there were fifty-six deaths in or following police custody linked to drug taking, swallowing or packing. There were a further sixty-four deaths in or following police custody where both alcohol and drugs were a factor⁵.

All detainees believed to be under the influence of drugs should be medically assessed by a healthcare professional. The detainee may also have consumed alcohol or may be suffering from alcohol withdrawal which, in addition to complicating other presenting signs and symptoms, carries a significantly increased risk of morbidity and mortality if left untreated.

Drugs pose the following serious risks to detainees:

- Overdose – including later onset, where the symptoms are not immediately obvious on arrival in police custody;
- Swallowing or packing;
- Complications linked with alcohol;
- Drug withdrawal;
- Mental health problems;
- Heightened risk of self-harm.

This list is not exhaustive.

Features of toxicity include:

- **Cocaine** – agitation, dilated pupils, seizures, raised body temperature, fast pulse and chest pains. Irregular heartbeats may occur.
- **Heroin** – nausea, vomiting, pinpoint pupils, eyelids closing, respiratory depression (not breathing enough), lethargy, drowsiness and difficulty to rouse, and loss of consciousness.
- **Cannabis** – anxiety, hallucinations and loss of consciousness.
- **Amphetamines** – nausea, vomiting, dilated pupils, fast pulse, sweating and seizures.

Note: Drugs are often taken in combination, which may alter the features of toxicity seen.

⁵ IPCC Deaths in or Following Police Custody: An examination of the cases 1998/9–2008/9

7.4.1 SWALLOWED OR PACKED DRUGS PACKAGES

The concealment of illicit drugs such as heroin, cocaine and cannabis in the body has become increasingly prevalent among drug couriers, known as mules or body packers. Drug packages may also be hidden in this way around the time of arrest or during transportation. Wrapped packages of drugs are either swallowed or concealed in body orifices. It is common practice for persons to swallow drugs to avoid detection by the police.

If it is known or suspected that a detainee has swallowed or packed drugs, either for the purpose of trafficking or to avoid imminent arrest or detention by the police, the person must be treated as being in need of urgent medical attention and taken straight to the nearest hospital. Leakage from a package can prove fatal. If a package is swallowed to avoid detection, it is likely to have been prepared hastily and there is an imminent risk that it may come open or burst inside the person. If this happens, death can quickly follow, particularly when crack cocaine has been swallowed.

The risk from swallowing or packing drugs depends on the type of drug, the number of packages and the type of packaging used.

Forces, in partnership with healthcare trusts, should develop local policy for the assessment, treatment and observation of cases where drugs have been swallowed or packed. If the detainee has been brought to a custody suite, an ambulance must be called immediately. A custody record must be opened, but this should not delay transfer to hospital.

See **NPIA (2011) *Template Protocol for the Management of Detainees that are Suspected of Swallowing or Having Packed Drugs or Foreign Objects into Body Orifices or Cavities.***

Section 55A of PACE allows, subject to certain conditions, a person who has been arrested and is in police detention to have an X-ray taken of them or an ultrasound to be carried out. For further guidance see PACE Code C, Annex K.

When drug swallows are returned to custody from hospital, the following should be considered:

- Before accepting a detainee to return to custody, the escorting officers should request that the doctor immediately in charge of

the detainee or the A&E manager provides clear written advice to inform the detainee's care plan;

- Detainees may still have drug packages in their bodies and hospital tests and observation will not always detect them;
- The detainee will continue to be at risk of deterioration, which may be either slow or sudden.

7.4.2 RESTRAINT AND DRUG USE

Restraint is significantly more likely to have been used in a drug-related arrest than during a non-drug-related case. The IPCC study on Deaths in or Following Police Custody (1998/99–2008/9) found that of the fifty-six drug-related cases of death in or following custody, forty-three per cent had involved restraint of the individual. The most common restraint technique used in these cases involved the individual being held down by officers.

As soon as possible after arriving at the police station, escorting staff must inform the custody officer about any restraint techniques that have been used so that these may be considered in the risk assessment.

For more information on ACPO authorised restraint techniques and directions on use see, **4.3 Initial Contact** and **ACPO (2007) Personal Safety Manual of Guidance**.

The custody officer should, as part of the risk assessment, ask the arresting officer if any restraint techniques were used during arrest and transportation. The custody officer must look for any injury or effect caused by restraint and any signs of behaviour or illness that may indicate a need for medical attention.

This information should be shared with healthcare professionals attending to the detainee; any concerns should be noted on the custody record by the healthcare professional.

7.5 ROUSING AND CONSCIOUSNESS

Custody staff are required to rouse and speak to any detainee whom they suspect to have consumed alcohol or drugs, or both, at a

minimum level of every **thirty minutes (Level 2)**. There are particular conditions to look for when rousing and checking detainees who have consumed alcohol. Where a person becomes harder to rouse, the change may be due to a serious unidentified medical condition such as:

- Head injury;
- Drug intoxication or overdose;
- Stroke.

Where detainees are unusually quiet or snoring, this can be a significant indicator of risk. Detainees who are snoring may have an upper airway obstruction; they should be roused and checked at least every thirty minutes (Level 2) until they are able to talk coherently.

Where a detainee fails to respond to rousing at the appropriate level, or if there is a decline in the condition of the detainee or their level of consciousness (for example, if speech becomes incoherent), a healthcare professional should be immediately informed or the detainee should be transferred directly to hospital. Details of the condition of the detainee and their level of responsiveness should be recorded on the custody record following each check.

Custody staff should have a plan of action for a sudden collapse of a detainee.

For further information see **13 Contingency Planning**.

Checklist 13 Dealing with Sudden Collapse

The vital actions are:

- Call an ambulance, clearly state that there has been a collapse and that it is an emergency;
 - Put the detainee in the recovery position;
 - Monitor breathing and pulse.
-
- If either breathing or pulse stops, turn the detainee onto their back and lift the chin to open an airway.
 - If breathing stops give mouth-to-mouth resuscitation.
 - If heart stops begin cardiac massage.

7.6 DIVERSION

As an alternative to charging, the CPS has the option of issuing a conditional caution, to which restorative or rehabilitative conditions are attached. For example, a condition may be imposed for the detainee to attend an alcohol or drug awareness course or similar with a local agency. Such referrals are most effective when directed for the use of offenders who have committed minor offences where alcohol or drug use was a contributing factor, rather than for alcohol or drug dependent people.

Youth conditional cautions can be given under s.66A of the Crime and Disorder Act 1998. CPS guidance on these is available at http://www.cps.gov.uk/publications/directors_guidance/youth_conditional_cautions.html

Police can liaise with local health and social care services for the purpose of diverting the detained person with alcohol and drug dependency into treatment or support, taking into account their particular psychological or psychiatric needs. For further information see **6.12 Diversion and Referral**.

8

People with Mental Ill Health and Learning Disabilities

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- 8.1 Mental Ill Health Definitions**
- 8.2 Learning Disabilities or Difficulties**
- 8.3 Risk Assessment**
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- 8.5 Mental Health Professionals**
- 8.6 Interview and Appropriate Adults**
- 8.7 Custody Exit and Aftercare Strategies**
 - 8.7.1 Home Office Circular 66/1990
Provision for Mentally
Disordered Offenders**

This section should be read in conjunction with the Mental Health Act 1983 and amendments under the Mental Health Act 2007 and ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities. NCALT has a Mental Ill Health and Learning Disability Awareness E-learning package available for officers and staff.

8.1 MENTAL ILL HEALTH DEFINITIONS

The term mental ill health is used broadly in this guidance to refer to all those matters relating to mental health problems. These include mental disorders, mental illness and mental health needs, and many of the issues that fall within the Mental Health Act 1983 (MHA 1983) definition of mental disorder and the PACE Code C definition of mentally vulnerable. It also covers people who are experiencing mental distress at the time they come into contact with the police, whether or not they have been formally diagnosed or are accessing mental health services.

The term 'mentally vulnerable' applies to detainees who, because of their mental state or capacity, may not understand the significance of what is said to them (for example, in the form of questions) or of their replies.

It should be noted that where a detainee meets with the definition of being mentally vulnerable under PACE, it is possible that they may not be considered to be suffering from a mental illness by a healthcare professional. The detainee will still require the support mechanisms that they are entitled to under PACE - the presence of an appropriate adult.

If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as such for the purposes of this code.

(PACE Code C, Paragraph 1.4)

For further information on recognising signs of possible mental ill health or learning disabilities see:

ACPO and DH (2010) Guidance on Responding to People with

Mental Ill Health or Learning Disabilities

- **3.1 Recognising Mental Ill Health or Learning Disabilities;**
- **7.5.7 Recognising Mental Ill Health or Learning Disabilities in Suspects.**

Paragraph 11.15 of the PACE Code C refers to a person who is 'mentally disordered or otherwise mentally vulnerable'. When suspected of committing a criminal offence, such a person must not be interviewed other than in the presence of an appropriate adult except in certain circumstances (see **8.6 Interview and Appropriate Adults**).

Being in a police cell can have an adverse effect on a person's condition if they are already suffering from mental illness. In particular, isolation and the noise in a busy custody suite can be aggravating factors. Mental ill health and alcohol/drug misuse often coexist and a person's impulsivity may make it more likely that they will self-harm or consider suicide.

People with mental ill health can experience an adverse reaction to being touched and this can sometimes escalate a threatening situation into a violent one. An individual may be more likely to respond positively to being talked to, with restraint only being used in situations where this approach is not possible or a real danger of harm is present to the individual or another.

8.2 LEARNING DISABILITIES OR DIFFICULTIES

Section 1(4) of the MHA 1983 defines a learning disability as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'.

A learning disability may be mild, moderate or severe and affects the way a person learns and communicates. It results in a reduced ability to learn new skills, adapt to and cope with everyday demands, understand complex information or, in some cases, to live independently. Most people with a learning disability look physically the same as the general population although some may have clear physical characteristics, for example, people with Down's Syndrome (which is classed as a learning disability).

Those with mild learning disabilities may not receive any formal support or may not have had their disability identified before contact with the police. Also their needs and disability may not be obvious. Other people have profound and multiple learning disabilities and their needs will be considerable. When in contact with people with learning disabilities, the police need to be aware that individuals may be extremely vulnerable and suggestible. They may have difficulty with many everyday tasks, such as filling in forms, understanding information (written or spoken), concentrating and remembering, telling the time, knowing dates and using public transport. For more information see <http://www.mencap.org.uk>

For additional guidance on interviewing people with Learning disabilities see **MoJ (2011) *Achieving Best Evidence in Criminal Proceedings***.

8.3 RISK ASSESSMENT

When carrying out the risk assessment as covered in **3 Risk Assessment**, consideration should be given to any additional risk of short and longer-term harm for those detainees experiencing mental ill health. It is also important to identify specific areas which could adversely affect those who are vulnerable because of learning disabilities and difficulties. For example, people who have Autism or Asperger's Syndrome can be highly sensitive to their environment, and loud noises or bright lights may in some cases cause distress and possibly even aggressive behaviour.

The risks that a detainee with mental ill health or learning disabilities may pose to themselves or others will be individual to each case and cannot be generalised.

Assessing the level of illness, disability and vulnerability of an individual is complex, partly due to the multiple factors underlying a person's behaviour and the way these may interrelate. For example, the risk of violence can depend on a medical diagnosis, the nature and severity of symptoms, whether the person has been receiving treatment and/or care and whether there is a history of violence.

Aggression can also be associated with the side effects of medication. It is crucial, therefore, that decisions relating to the risk of harm should be made with other agencies wherever possible.

If the detainee appears to have a mental disorder, the custody officer must make sure the person receives appropriate medical attention as soon as reasonably practicable. This applies even if the detainee makes no request for medical attention. Medical examinations must be carried out by an appropriate healthcare professional.

8.4 MENTAL HEALTH ACT DETAINEES

Forces should have and maintain a policy giving advice and guidance on dealing with individuals detained under the Mental Health Act 1983 (MHA 1983).

Under section 135 of the MHA, the police can, on the authority of a magistrate, enter premises and remove to a place of safety a person who is thought to have a mental disorder and who has been or is being ill-treated or neglected or kept otherwise than under proper control or, if living alone, is unable to care for themselves.

Under section 136 of the 1983 Act, the police can remove from a public place to a place of safety a person who appears to have a mental disorder and to need immediate care or control.

In both instances, the person can be detained for assessment at the place of safety for up to seventy-two hours. A place of safety is defined in 8.4.1 Place of Safety. Assessments that take place at the place of safety will be carried out by a Section 12 registered doctor (See **6.3.1 Healthcare Professionals**) and the AMHP.

Note: There is additional legal provision made within the Mental Capacity Act 2005 for the police to administer or assist in the medical treatment of a person without the mental capacity to know what they need.

Following Assessment

If the registered medical practitioner is able to conclude, following clinical assessment, that the individual:

- Is not mentally disordered within the terms of the MHA 1983, then the detainee may no longer be detained under this section and will be immediately discharged from detention. (See MHA 1983 Code of Practice 10.31 and 10.33 for additional detail on

making any necessary arrangements for onward treatment and care.)

- Should be subject to detention under the MHA 1983 (sections 2, 3 and 4), then section 6 of the MHA 1983 provides a power for an applicant (usually the AMHP) to take and convey that individual to hospital.

For further information see **ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities.**

- 6.4 Section 136 of the Mental Health Act 1983 and Places of Safety
- 6.5 Transfers between Places of Safety
- 6.6.2 Protocol for Taking and Conveying

8.4.1 PLACE OF SAFETY

Section 135 of the Mental Health Act 1983 defines a place of safety as:

- Residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948;
- A hospital (as defined by the Act⁶);
- A police station;
- An independent hospital or care home for persons with a mental disorder, specialist residential or nursing home for people with mental health needs;
- Any other suitable place, the occupier of which is willing temporarily to receive the patient.

However, the MHA 1983 Codes of Practice indicate that for both England and Wales, a police station should be used as a place of safety for section 136 detainees on an **exceptional basis only**.

Police cells are not suitable places for detaining people with mental

⁶ 'hospital' means: (a) Any health service hospital within the meaning of the [National Health Service Act 2006 or the National Health Service (Wales) Act 2006]; and (b) Any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary of State under that Act; and (c) Any hospital as defined by section 206 of the National Health Service (Wales) Act 2006 which is vested in a Local Health Board.

health problems, and a person's condition can sometimes be exacerbated by being held in such conditions. Forces must develop and agree protocols with mental healthcare trusts and hospital trusts identifying a **first choice** place of safety, and **the criteria** for their use.

A template protocol is available, see **NPIA (2011) *Template Protocol for The Management of Detainees That Require Hospital Treatment***, forces may adapt and use this to agree terms with their local hospital trusts.

Issues to be considered include:

- Arranging appropriate places of safety for individuals detained under sections 135 or 136;
- Arranging assessments for individuals detained under sections 135 or 136;
- The handover procedures between the police and mental health practitioners for patients who may be violent;
- Police escorting and/or transport of individuals to places of safety and mental health facilities;
- The agreed handover procedures for patients and detainees with mental ill health;
- Whether an AMHP should accompany the police when escorting people with known or suspected mental ill health.

Although the word arrest is not used in section 136 of the MHA 1983, detention or removal under this section is a preserved power of arrest under Schedule 2 of PACE and reasonable force may be used.

The person is to be taken to a place of safety to be medically examined by a Section 12 registered doctor and assessed by an AMHP. From the time the person is detained until the time the examination and assessment are completed, the person is deemed to be in lawful custody and can be detained at the place of safety by the police and/or members of healthcare staff.

The person may be transferred from one place of safety to another for the purposes of carrying out the assessment, see **8.4.2 Transfer**. To enable this assessment to take place the person can be detained at the place of safety for up to seventy-two hours (which commences at the time of arrival at the initial place of safety). It is

not necessary under section 136 of the MHA 1983 for a police officer to be present during this period.

The person is entitled to legal advice (under section 58 of PACE and Code C) when detained in a police station as a place of safety. Under section 56 of PACE and Code C, the detainee is entitled to have one person who is known to them, or likely to take an interest in their welfare, informed of their whereabouts. However, officers should ensure that, wherever possible, others are also aware of the situation if the detainee requests this.

8.4.2 TRANSFER

Section 44 of the MHA 2007 amends sections 135 and 136 of the 1983 Act to enable a person detained at a place of safety to be transferred to another one, within the time limit for detention (seventy-two hours). In practice, this means that where a violent or potentially violent individual has been detained under sections 135 or 136 of the MHA 1983 and has (under those exceptional circumstances detailed) been taken to a police station as the initial place of safety, they may then (within the seventy-two hour overall detention limit) be transferred to a suitable hospital as appropriate to the risk assessment, medical assessment and treatment needs of the individual. This assessment will have involved the AMHP, and the hospital (or other second place of safety) must have formally accepted they are willing to receive the patient. In this situation the PER Form should be accompanied as a minimum by the **Detainee Medical Assessment Form (450)**, and the **Detainee Medication Form (450a)** under confidential cover if required.

The police may be asked by an external agency to assist in transporting a violent or potentially violent person to a mental health establishment after they have been detained under the MHA 1983. The needs of the individual and the circumstances of the situation should be assessed to determine the safest method of transportation.

Options include:

1. An ambulance with police personnel present to assist the ambulance staff and any mental health staff;
2. A police vehicle with mental health staff present to monitor and assist in communicating with the detainee (an unmarked police vehicle would be most appropriate where this is available).

At least two staff should be involved in the transportation of such detainees.

Where a person has been sedated or given medication by healthcare professionals before being transported, this may affect the decision-making process above.

Forces should establish procedures and agreed inter-agency protocols for dealing with requests for the transportation of detainees with mental ill health. Whilst developing these protocols managers should consider: time standards for transportation, which organisation should be notified in the event of a breach of these standards, and governance arrangements.

For further information see: ***ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities***

- **6.4.7.1 Transport.**

8.5 MENTAL HEALTH PROFESSIONALS

An Approved Mental Health Professional (AMHP) was formerly known as an Approved Social Worker or ASW.

Relevant aspects of the role of an AMHP are:

- Considering whether or not an application for detention in hospital of an individual should be made;
- Making arrangements for the admission and conveyance of patients to hospital;
- Information gathering and initial risk assessment in pre-planned assessments under the MHA 1983, including undertaking a risk assessment to consider if a request for police assistance is required (and sharing appropriate information with the police to help with the police risk assessment);
- Decisions about police involvement in pre-planned assessments;
- Using their authority to transfer a person detained in a place of safety to another place of safety (or authorising other persons to undertake the transfer).

For further information see The Mental Health Act 1983, the Mental Capacity Act 2005, and ***ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities***

Disabilities, Section 6 Use of Police Powers under the MHA 1983 and the MCA 2005.

If a person is detained for assessment or treatment in hospital, or in the community under supervised community treatment (SCT), the person with overall responsibility for their case is known as the Responsible Clinician (RC). The RC must be an approved clinician, ie, approved by the Secretary of State (in relation to England) or the Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of the MHA 1983.

Forces should ensure that multi-agency protocols include clear arrangements for supporting, where relevant, AMHPs to conduct out-of-hours assessments.

8.6 INTERVIEW AND APPROPRIATE ADULTS

Whenever a custody officer considers or has been told in good faith that a suspect may be 'mentally disordered or otherwise mentally vulnerable, they must request an appropriate adult to be present, see PACE Code C, paragraph 11.15. This duty remains even if a healthcare professional's view is that an individual does not meet the formal definition.

For further information see: ***ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities.***

- **7.5.7 Recognising Mental Ill Health or Learning Disabilities in Suspects.**

Note IG of PACE Code C states that where the custody officer has any doubt about the mental state or capacity of a person detained, the person should be treated as mentally vulnerable and an appropriate adult called. Vulnerability may be caused by the detainee's level of literacy, any auditory impairment, speaking difficulties or an inability to understand English.

An appropriate adult can provide support, advice and assistance to the suspect and be present at any interview conducted by the police. The appropriate adult may be a family member or carer, volunteer or social/health care professional. Increasingly, organised groups of trained volunteers carry out this role. It is good practice to use an independent, trained appropriate adult from the local appropriate

adult service if such a service exists locally. Forces should not use police staff or officers to carry out this role. A person cannot act as an appropriate adult if they are suspected of involvement in the offence, are a victim or witness, are involved in the investigation or have received admissions prior to attending the police station (PACE Code C, section 1). For more information on the role of appropriate adults, see ***Home Office (2011) Guide for Appropriate Adults.***

Under PACE minor variations in the wording of the caution are permitted providing that the 'sense' of the caution is preserved. If it appears that a person does not understand the caution, the person giving it should explain it in their own words (PACE Code C, Notes for Guidance 10D).

For further information relating to cautioning and interviewing mentally disordered or vulnerable people and people with learning disabilities or difficulties, see ***ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities***

- **7.5 Criminal Justice Response:**
 - **7.5.6.1 The Right to Silence;**
 - **7.5.6.2 The Right to Legal Advice;**
 - **7.5.8 Fitness for Detention and Interview;**
 - **7.5.11 Interviewing Suspects.**

Officers and staff should be aware that:

- The presence of an appropriate adult is not an adequate substitute for legal advice;
- A mentally vulnerable detainee may require extra time and help in understanding the legal process;
- A suspect with mental ill health or learning disabilities may be more unlikely to **ask** for a solicitor.

An appropriate adult may request the presence of a legal representative on behalf of the detainee even if the detainee has not asked for this. It should be noted, however, that the detainee cannot then be forced to see the legal representative.

There should be no undue delay in charging decisions. If the suspect is mentally disordered or otherwise mentally vulnerable, PACE Code C (Annex E, paragraph 11) specifies that where the decision has been taken to proceed with a prosecution, the resulting action – primarily the charging – should be undertaken in the presence of an

appropriate adult. The appropriate adult's presence is required, however, only if that person is already at the police station. There is no power under PACE to detain a person and delay action solely to await the arrival of the appropriate adult (PACE paragraphs 16.1 and 16C).

8.7 CUSTODY EXIT AND AFTERCARE STRATEGIES

Forces should agree with partner agencies an exit and aftercare strategy for mentally vulnerable people on release from custody which includes, as appropriate, an assessment of a particular individual's vulnerability and potential mental health or social care needs and referral to appropriate services.

Examples of the types of community-based treatment, care and support that may be available include:

- Accident and Emergency Services;
- Acute Mental Health Services;
- Assertive Outreach Services;
- Child and Adolescent Mental Health Services (CAMHS);
- Community Development Workers (CDWs);
- Community Forensic Teams;
- Community Learning Disability Teams;
- Community Mental Health Teams;
- Crisis Resolution and Home Treatment Services;
- Early Intervention Services;
- Out-of-Hours Services;
- Primary Care Mental Health Services;
- Residential Homes;
- Specialist Services and Support Groups (eg, The Royal British Legion);
- Drop-in, day centre and other support and advice services provided by the local voluntary and community sector and charities (eg. The Royal British Legion and Soldiers, Sailors, Airmen and Family Association (SSAFA) for ex-service personnel).

For further information see ***ACPO and DH (2010) Guidance on Responding to People with Mental Ill Health or Learning Disabilities;***

- **3.5 Pathways to Care.**

Referral can mean that intervention is provided to those who cannot find it for themselves or have potentially not been supported to do so prior to their detention. As well as being positive for the individual concerned, this referral may address the possible offending stimuli for that individual and thus reduce reoffending and future demand on the police.

Note: Service agreements between the police and healthcare providers should take into account the fact that release may not be delayed pending the provision of a relevant service. For example, where someone is arrested for a (minor) criminal offence and the decision is taken while they are in police custody to divert them to the health service, the person should be diverted from the police station as soon as possible and, in any event, within twenty-four hours of their arrest. Where possible, forces should establish procedures and agreed inter-agency protocols for dealing with requests for referral of detainees. While developing these protocols, managers should consider time standards for transfer from custody and which organisation should be notified in the event of a breach of these standards, and governance arrangements.

8.7.1 HOME OFFICE CIRCULAR 66/1990 PROVISION FOR MENTALLY DISORDERED OFFENDERS

Home Office Circular 66/90 Provision for Mentally Disordered Offenders requires that diversion for mentally disordered offenders be considered before a decision on charging is made, and that mentally disordered offenders should, wherever possible, receive health and social care as an alternative to being punished by the criminal justice system.

Diversion of this type will require collaboration between the police and health and social care agencies, and may involve:

- Removing the suspect to a place of safety under section 136 MHA 1983;
- Arranging for psychiatric assessment to be carried out;
- Referring the suspect to community health services;
- Facilitating the person's voluntary admission to hospital.

9

CHILDREN AND YOUNG PEOPLE

Contents

- 9.1 Risk Assessment**
- 9.2 Detention Rooms and Cells**
- 9.3 Sharing Information and Duty of Care**
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- 9.6 Appropriate Adults**
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- 9.8 Police and Criminal Evidence Act 1984
Transfers**

9.1 RISK ASSESSMENT

When carrying out the risk assessment, consideration should be given to specific vulnerabilities associated with the detention of a child or young person.

The term 'juvenile' is used to describe a person under the age of 17 years (based on section 37(15) PACE). References to 'children' and 'young persons/people' extend to people who are under 18 years old, and will apply to risk assessment and care and welfare.

Vulnerability is defined by section 23(5A) of the Children and Young Persons Act 1969 (as amended) and relates specifically to a young person's physical or emotional immaturity or propensity to harm themselves. When carrying out the risk assessment of a young person in police custody precise language is needed to describe the young person's behavior and characteristics and how these may affect decision making on the level of supervision, and the appropriate method of disposal or diversion.

Young people who have been detained are, when compared with the normal population, statistically more likely to:

- Suffer from mental health problems;
- Have substance misuse problems;
- Have literacy and numeracy levels below that expected nationally for their age;
- Have specific difficulties with speech, language and communication;
- Have greater difficulty expressing their views and participating in decision making;
- Have low self-esteem and confidence;
- Have been found to be in 'high levels of housing need', that is, they may have been living in inadequate housing or placed in temporary accommodation, bed and breakfast or a hostel.

Indicators of increased vulnerability or risk in children and young people

The following list is taken from the **Youth Justice Board YJB 001-Placement Confirmation** form. It provides indicators of risk on

entry to prison or secure accommodation, but it may be used to show potential increased vulnerability in police custody.

Welfare

The child or young person:

- Is currently accommodated by voluntary agreement with parents or is an unaccompanied asylum seeker;
- Was previously accommodated by voluntary agreement with parents or was an unaccompanied asylum seeker;
- Is under, or was previously under child protection categories of emotional abuse, neglect, physical abuse, sexual abuse, other;
- Is in care or eligible for leaving care services;
- Is emotionally immature;
- Has a history of abuse or trauma;
- Has learning difficulties;
- Is physically immature;
- Is currently remanded to local authority accommodation;
- Was previously remanded to local authority accommodation;
- Is currently subject to a care order;
- Was previously subject to a care order;
- May be a victim of bullying.

Health

The child or young person:

- Has ADHD (attention deficit hyperactivity disorder);
- Requires detox;
- Is expressing or displaying depression;
- Has mental health concerns;
- Is on medication;
- Is a parent;
- Is pregnant;
- Has substance misuse problems.

Risks to others

The child or young person:

- Is currently displaying aggressive behaviour;
- Has previously displayed aggressive behaviour (PNC Warning Marker or intelligence);
- Has gang related issues;
- Has a history of bullying;
- Is on the sex offender register;
- Is currently using sexually inappropriate behaviour;
- Has previously used sexually inappropriate behaviour.

9.2 DETENTION ROOMS AND CELLS

Newly built facilities usually have Lambeth cells which are unisex and suitable for young persons whereas older suites tend to use detention rooms for this purpose. Custody management plans should clearly identify the rooms to be used to detain young persons.

For further information see **Home Office (2010) *Police Buildings Design Guide*** (HOPBDG) and **11 Buildings and Facilities**.

9.3 SHARING INFORMATION AND DUTY OF CARE

The Children Act 2004 requires police authorities and chief officers to cooperate with arrangements to improve the well-being of children with regards to:

- Their physical and mental health;
- Protection from harm and neglect.

Local Safeguarding Children Boards (LSCBs) require effective information sharing systems. The Children Act 2004 encourages agencies to share early concerns about the safety and welfare of children, and to take preventive action.

The Youth Offending Team (YOT) is required to be notified of young persons, under the age of 18 years, who are issued with a reprimand or final warning.

The custody officer must ensure that concerns arising from the detention of a child or young person are communicated to the appropriate agency. Information sharing is required when a child is to be released from police custody if:

- There are concerns about their welfare arising from risk assessments or other available information;
- There is a risk of significant harm to the child;
- This information may be relevant and allow agencies to protect the welfare of a child.

Referrals should be made in accordance with **ACPO (2009) *Guidance on Investigating Child Abuse and Safeguarding Children, Second Edition***.

For more information see **Youth Justice Board/ACPO (2005)**

Sharing Personal and Sensitive Personal Information in Respect of Children and Young People at Risk of Offending, A Practical Guide and **6.12 Diversion and Referral.**

9.4 GIRLS UNDER THE AGE OF 17 YEARS

Girls under the age of 17 years must be under the care of a woman while being detained, conveyed or waiting to be so. This is a requirement under section 31 Children and Young Persons Act 1933.

'Under the care of a woman' in this context means a female police officer or female member of police staff (preferably designated as a detention officer). Subject to the risk assessment, the 'carer' need not be physically present and with the detainee at all times, but must be readily available and assigned to the detainee throughout the period of detention. Each case must be treated individually and consideration should always be given to whether a carer should be physically present or not. The assigned responsibility can be shared by more than one female carer and may be transferred at shift handover.

Once assigned, the carer should arrange with the custody officer to visit the detainee and check on her welfare needs.

The detainee should be told that she can ask to see the carer at any time.

Forces must implement policies and procedures to ensure that all girls under the age of 17 years who are detained and in custody are under the care of a woman.

9.5 TRANSPORTATION OF YOUNG PERSONS

Children or young persons in custody will not be allowed to associate with adult detainees. An exception to this is permitted in accordance with section 31 Children and Young Persons Act 1933, where the young person is jointly charged with an adult or relatives.

Arrangements to prevent association should be made when the child or young person is:

- Detained in a police station;
- Being conveyed to or from any criminal court;

- Attending court.

Young persons should not be carried in a vehicle with adult detainees unless the vehicle being used has been designed and built to carry them simultaneously. Vehicles that are available for this specific purpose have been authorised under the new (2011) PECs contract arrangements.

9.6 APPROPRIATE ADULTS

Forces should establish policies and protocols for providing access to appropriate adults for young persons in police custody. Local Youth Offending Teams (YOTs) have a statutory responsibility to ensure the provision of an effective appropriate adult (AA) service for juveniles, whether they provide the service themselves or contract a voluntary or private sector agency to deliver on their behalf. It is the responsibility of the AA provider to work with the local force to develop policies and protocols to ensure the effective provision of AA services in line with **Youth Justice Board, (2010) Case Management Guidance B421**. This guidance makes it clear that the AA service should operate out of hours as well as within standard working hours.

All AAs, custody managers, custody officers and staff must be aware of their role as defined by PACE and also of any agreed local policies, protocols or service level agreements for the provision of AAs. For further information see PACE and section 38 Crime and Disorder Act 1998.

PACE Code C 1.7(a) defines an appropriate adult (for a juvenile) as:

1. the parent, guardian or, if the juvenile is in local authority or voluntary organisation care, or is otherwise being looked after under the Children Act 1989, a person representing that authority or organisation;
2. A social worker of a local authority;
3. Failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police.

Appropriate adults must be able to provide effective support. A parent should be considered in the first instance. Parents may need reassurance or practical assistance to attend the police station, and to understand the nature of the role of appropriate adult. For

information that may be provided on the role of an AA see ***Home Office (2011) Guide for Appropriate Adults.***

Alternative arrangements should be made when:

- Reasonable efforts have been made to contact the parents without success;
- Parents have refused or are unable to attend;
- Parents are disqualified because they are involved or a victim of the alleged offence;
- Parents have received admissions prior to acting as an appropriate adult; or
- The young person is estranged from the parent, and they expressly and specifically object to their presence.

For further information see PACE Code C, Notes for Guidance, 1B.

Detention can be very stressful for young people. It is important that an appropriate adult attends as soon as is practicable in order to minimise the necessary period of detention. The National Standards for Youth Justice (2010) require attendance within two hours of the initial request being placed. In order to use time and resources to best effect, YOTs should consider the location and travelling time of the AA requested, as well as the availability and arrival time of the solicitor and arrangements for those jointly arrested.

It is useful for the AA to have knowledge of the young person's circumstances and background. In order to facilitate this, YOTs need to identify whether or not the young person is known to the YOT or Social Services Department and in what capacity. Where there is a supervising officer or allocated social worker, they should be contacted to ascertain what information is available about the young person.

Careful consideration, especially when relating to volunteers, should be given when requests to attend relate to violent or sexual offences. A trained social worker is more likely to have the knowledge and experience to deal with this.

Particular consideration should also be given to ensuring that young people who are identified as having mental ill health or learning disabilities/difficulties are appropriately supported. PACE Code C, Notes for Guidance 1D, state that in these circumstances a trained and experienced professional may be 'more satisfactory' than a

relative. The detainee's own wishes should be respected and their choice between a relative or professional AA should be accommodated where possible.

9.7 YOUTH OFFENDING TEAMS

Youth Offending Teams (YOTs) are made up of representatives from the police service, the probation service, social services, health, education, drugs and alcohol referral teams, and housing officers. Each YOT has a manager who is responsible for coordinating the work of the youth justice services.

YOTs aim to identify the specific causes of a young person's offending as well as measure the risk they pose to others. This enables YOT to establish a suitable programme to address the needs of the young person.

9.8 POLICE AND CRIMINAL EVIDENCE ACT 1984 TRANSFERS

If juveniles under the age of 17 are denied police bail, they will usually be transferred to local authority accommodation under section 38 (6) of PACE, (there are exceptions to this).

PACE transfers take place in order to limit the amount of time juveniles are required to spend in police custody. The responsibility for the child or young person passes from the police to the local authority. This transfer of responsibility includes transfer of the power to detain them, and responsibility for ensuring that they appear at court (in accordance with Section 46 of PACE).

For more information on non-eligibility for PACE transfers, the arranging of transfers, and relevant age limits and requirements, see Section 38 (6) of PACE and ***Home Office Circular No 78/1992 Criminal Justice Act 1991: Detention Etc Of Juveniles.***

It should be noted that when referring to Home Office Circular 78/92 above, Parts 1 & 2 of Schedule 15 to the Criminal Justice Act 2003 now list the violent and sexual offences for the purposes of s.38(6A) PACE, see

<http://www.legislation.gov.uk/ukpga/2003/44/schedule/15>

10

DEATHS IN CUSTODY AND SUCCESSFUL INTERVENTIONS

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10.1 DEFINITIONS

Successful Interventions

For the purposes of this guidance the terms '**successful intervention**' and/or '**adverse incident**' mean:

Any incident which, if allowed to continue to its ultimate conclusion, would have resulted in the death, serious injury or harm to any person.

Death in Custody

There are four categories which define death in custody or following contact with the police.

- Category 1 Fatal road traffic accidents involving the police
- Category 2 Fatal shooting incidents involving the police
- Category 3 Deaths in or following police custody
- Category 4 Deaths during or following other types of contact with the police

For further information on definitions and referral of complaints and conduct matters to the IPCC see ***IPCC (2010) Statutory Guidance Statutory Guidance to the police service and police authorities on the handling of complaints.***

10.1.1 FIRST ACTIONS FOLLOWING A SUCCESSFUL INTERVENTION

Responsibility for managing the first actions following a successful intervention lies with the custody officer.

Checklist 14 Actions to Be Taken When a Successful Intervention Occurs in Custody

- Check for vital signs and consider first aid.
- Call for medical support if available within the custody suite.
- Consider the need for an ambulance and call one if appropriate.
- Allow the detainee to be taken to hospital if required.
- Brief ambulance staff or hospital staff on medical history while in custody.
- Should the detainee be accompanied by a police officer?
- Authorise a police officer(s) not involved in the incident or directly responsible for the detention of the person to accompany the detainee to hospital.
- Do not delay the detainee's departure to hospital if it is not immediately possible to find a suitable officer(s) to accompany them to hospital.

Immediate Next Steps

- Inform the duty inspector.

Consider doing the following in conjunction with the inspector. These actions will be based on the seriousness of the actual harm and the intended or likely consequences of their actions:

- Identify all potential scenes and secure as appropriate.
- Photograph the whiteboard.
- Ensure that the incident and any subsequent actions are noted on the custody record. This should include providing the time of those actions and the time the record is made.
- Ensure an incident log/serial/report is created and commence a scene log.
- Consider relief of custody staff for remaining shift and their next shift.

Next Steps

- Inform the Professional Standards Department (PSD) – they will consider compliance with the statutory reporting to the Independent Police Complaints Commission (IPCC) (where death or serious injury has not occurred there is no mandatory referral requirement however voluntary referral may be appropriate).
- Inform the relevant Police Federation representative. They can advise the officers involved and secure legal representation if required.

- Complete a self-harm report.
- Arrange debrief. This should be carried out only after the officers involved have provided an account and the needs of the investigation have been met. It may be that such a debrief only takes place following conclusion of the investigation. These considerations do not, however, preclude speaking to relevant staff on issues of welfare and the next stages of any PSD and IPCC actions.

Checklist 15 Actions to Be Taken Following a Successful Intervention When It Occurs in a Place that Is Not a Police Station (Incident Following Police Contact)

- Check for vital signs and apply first aid as necessary.
- Consider the need for medical support.
- Consider whether the detainee should be transported to hospital or call an ambulance if appropriate.
- Consider the need for the detainee to be accompanied by a police officer if taken to hospital.

Immediate Next Steps

- Inform the duty inspector.
- Identify all potential scenes and secure as appropriate.

Next Steps

- Inform the PSD.
- Inform the relevant Police Federation representative. They can advise the officers involved and secure legal representation if required.
- Arrange debrief. This should be carried out only after the officers involved have provided their initial account and the needs of the investigation have been met. It may be that such a debrief only takes place following conclusion of the investigation. These considerations do not, however, preclude speaking to relevant staff on issues of welfare and the next stages of any PSD and IPCC actions.

Checklist 16 Actions to be Taken When a Death Occurs in Custody

- Check for vital signs and consider first aid.
- Call for medical assistance.

If death is confirmed:

- Identify all potential scenes and secure as appropriate;
- Close the custody record for that detainee and ensure that all future actions are recorded in the scene log;
- On paper custody records underline the last entry in red (timed and signed) or secure the IT record and make a suitable entry on it;
- Ensure an incident log/report/serial is created and commence a scene log;
- Call an inspector to the scene;
- Inform the duty inspector/custody inspector, who will inform custody command or similar as per force structure;
- Inform the Criminal Investigation Department (CID) as applicable;
- Inform the PSD as applicable;
- Identify witnesses, the last person to see the detainee alive and the person who first saw the deceased detainee – they need to be available as required;
- Inform the relevant Police Federation representative, who can advise the officers involved and secure legal representation if required;
- Consider moving those detainees who may be witnesses;
- Consider closing the custody suite and transferring all the detainees;
- Arrange a critical incident debrief for staff involved. This should be carried out only after the officers involved have provided their initial account and the needs of the investigation have been met. It may be that such a debrief only takes place following conclusion of the investigation. These considerations do not, however, preclude speaking to relevant staff on issues of welfare and the next stages of any PSD and IPCC actions.

Checklist 17 Actions to be Taken When a Death Occurs in a Place that Is Not a Police Station (Incident Following Police Contact)

- Check for vital signs and consider first aid.
- Call for medical assistance.

If death is confirmed:

- Identify all potential scenes and secure as appropriate;
- Inform the duty inspector who will either attend the scene or nominate an officer of inspector rank or above to attend the scene;
- Inform the CID as applicable;
- Inform the PSD as applicable;
- Inform the relevant Police Federation representative, who can advise the officers involved and secure legal representation if required;
- Identify witnesses;
- Arrange a critical incident debrief for staff involved. This should be carried out only after the officers involved have provided their initial account and the needs of the investigation have been met. It may be that such a debrief only takes place following conclusion of the investigation. These considerations do not, however, preclude speaking to relevant staff on issues of welfare and the next stages of any PSD and IPCC actions.

The welfare of staff, other detainees and the relatives of the deceased must be considered in addition to the needs of the ongoing investigation.

Forces must ensure that there are local procedures in place to deal with incidents of death and successful interventions in custody.

10.1.2 REFERRAL TO THE IPCC

The police must refer specific complaints or incidents that could damage public confidence in policing to the IPCC. Mandatory referrals, along with other cases that the police may decide to refer to the IPCC, assist the police in demonstrating openness.

10.1.3 INCIDENTS OF DEATH OR SERIOUS INJURY

There is a statutory duty to refer incidents to the IPCC where:

- Persons have died or been seriously injured following some form of direct or indirect contact with the police; and
- There is reason to believe that the contact may have (directly or indirectly) caused or contributed to the death or serious injury.

These will be cases that do not involve a complaint or conduct matter when first identified and categorised.

All deaths and all successful interventions (untoward incidents) that are referred to the IPCC will be investigated. The IPCC will assess the seriousness of the case and the public interest and determine the appropriate form of investigation. These are as follows.

Independent investigation – conducted by IPCC staff into incidents that cause the greatest level of public concern, have the greatest potential to impact on communities or have serious implications for the reputation of the Police Service. In independent investigations, IPCC investigators have the powers of a police constable.

Managed investigation – conducted by the police, under the direction and control of the IPCC, when an incident or complaint or allegation of misconduct is of such significance and probable public concern that the investigation needs to be under the direction and control of the IPCC but does not need an independent investigation.

Supervised investigation – conducted by the police when the IPCC decides that an incident a complaint or allegation of misconduct is of less significance and probable public concern than for an independent or managed investigation but oversight by the Commission is appropriate.

Local investigation – appropriate where the IPCC concludes that none of the factors identified in terms of the seriousness of the case or public interest apply.

The principles that underpin investigations into serious incidents, and which are often initiated where there is no public complaint or

recorded conduct matter, are as follows:

- Investigations should be a search for the truth.
- The starting point is to investigate the incident, not the assumption that a person is to blame. It may be that as the investigation progresses, it needs to focus on the performance or conduct of individuals and that they should be held to account.
- The investigation process must be independent, competent, proportionate and timely.
- Police officers and police staff are entitled to a consistent investigation process wherever they work.
- The investigation process must be open and must improve communication with those who have complained, and members of the police service.
- Where possible, the focus should be on learning lessons, not apportioning blame.

Further information on investigating complaints and potential misconduct can be found in ***IPCC (2010) Statutory Guidance to the Police Service and Police Authorities on the Handling of Complaints***.

10.2 THE CORPORATE MANSLAUGHTER AND CORPORATE HOMICIDE ACT 2007

Definition and Elements required

A police force is guilty of an offence **if** the way in which its activities are managed or organised:

- (a) causes a person's death;
- and
- (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

The force will be guilty of an offence under this section only if the way in which its activities are managed or organised by the senior management is a substantial element in the breach.

An individual cannot themselves be guilty of aiding, abetting, counselling or procuring the commission of the offence of corporate

manslaughter.

Where suicide has occurred and the judge has found that there was a relevant duty of care held by the police force for the detainee, a jury must decide whether the police force is guilty of corporate manslaughter under the Act. For more information see section 2(6) of the Corporate Manslaughter and Corporate Homicide Act 2007.

10.2.1 DUTY OF CARE

A relevant duty of care includes a duty owed to a person who, by reason of being a person within subsection (2), is someone for whose safety the organisation is responsible.

Custody Duty of Care Subsection 2 (1)(d)

Subsection 2 provides:

A person is within this subsection if he or she is:

- (a) Detained at a custodial institution or in a custody area at a court (a police station or customs premises or service custody premises);
- (b) Detained at a removal centre or short term holding facility;
- (c) Being transported in a vehicle or being held in any premises in pursuance of prison escort arrangements or immigration escort arrangements;
- (d) Living in secure accommodation in which he/she has been placed;
- (e) A detained patient;

10.3 POST INCIDENT MANAGEMENT

Where an individual has died in police custody, it is in the interests of the public, the police service and everyone involved in the incident, that subsequent procedures should be open and transparent, and that the integrity of all action can be demonstrated. ECHR Article 2 places a positive duty on the State to investigate any death (or serious injury) at the hands of the State. In order to satisfy Article 2, the investigation must be effective. The European Court of Human Rights has held that this investigation must:

- Be on the state's own initiative (e.g. not civil proceedings);
- Be independent, both institutionally and in practice;

- Be capable of leading to a determination of responsibility and the punishment of those responsible;
- Be prompt;
- Allow for sufficient public scrutiny to ensure accountability;
- Allow the next of kin to participate (2003) 37 ECRR 2;
- if agents of the state were responsible, be capable of determining whether the killing was justified under Article 2.

These principles were approved by the House of Lords in the case of *R (ex parte Amin) v Secretary of State for the Home Department* [2003] UKHL 51 (the Zahid Mubarek case).

The requirements under Article 2 ECHR are, therefore, relevant and can extend to any situation in which death or serious injury of a detainee occurs.

The essential purpose of an Article 2 investigation is:

- To secure the effective implementation of laws safeguarding the right to life; and
- In those cases involving agents of the State, to ensure their accountability for deaths occurring under their responsibility.

Where a death has occurred following the use of a restraint technique, the investigation must be capable of leading to a determination of whether any force that may have been used was or was not justified in the circumstances.

Where any death of a detainee in police custody has occurred, steps must be taken to secure all relevant evidence, including witness testimony and forensic evidence. The procedures adopted should be designed to demonstrate integrity of purpose in all actions and discussions between the officers involved.

Any deficiency in the investigation which undermines its capability of establishing the circumstances of the case and any responsibility is liable to fall short of the required measure of effectiveness.

Incidents involving death in police custody may well incur public and media interest, and can be highly emotive and stressful for all involved. As a consequence, both the investigative function and the chief officer's duty of care to officers and police support staff involved must be afforded a high priority.

The duty of care to officers and police staff extends to welfare, physical, psychological and medical support. In addition, the police staff associations have arrangements for providing advice and support to officers. In facilitating the provision of these services, investigating officers, post incident managers (See **10.3.3 The Role of the Post Incident Manager**) and staff association representatives have distinct roles. It is, however, essential that all officers, post incident managers and those involved in any debriefing process are able to demonstrate integrity of purpose in all communications between each other and in record making and debrief procedures.

The responsibility for securing evidence and taking appropriate action in an Article 2 investigation remains with the Police Service until such times as the IPCC has taken over the investigation.

It is the responsibility of the police force being investigated to **facilitate** that investigation through, for example:

- Identification and preservation of the scene and exhibits;
- Identification of immediately available witnesses;
- Securing of physical evidence;
- The availability of experienced family or witness liaison officers.

Early notification to the IPCC will enable agreement to be made on procedures to be adopted and initial actions to be taken by the police.

If a death has occurred outside the police custody suite, for example, at the scene of an incident following arrest, the scene must be secured as soon as is practicable. Officers involved in the incident should return to a police station or other suitable location where post-incident procedures will take place. This will assist in securing the integrity of the scene, defuse any tensions at the scene and enable post-incident issues, including those of evidence and welfare, to be attended to.

10.3.1 PROVIDING ACCOUNTS

Where an **initial account** is made by officers they should, subject to any legal advice that they are given, be made as soon as practicable. Accounts should be recorded in writing, timed, dated and signed.

Each officer's initial account should only consist of their individual recollection of events and should, among other things, state what they believed to be the facts. This account should also provide information on any use of restraint or force (eg, CS or Taser Conductive Energy Device) and why it was necessary.

Detailed accounts should not normally be made immediately, but can be left until the officers involved are better able to articulate their experience in a coherent format, normally after at least forty-eight hours.

As a matter of general practice, officers should not confer with others before making their accounts (whether initial or subsequent accounts). The important issue is to individually record what their honestly held belief of the situation was at the death. If, however, in a particular case a need to confer on other issues does arise, then, in order to ensure transparency and maintain public confidence, where some discussion has taken place, officers must document the fact that this has taken place, highlighting:

- The time, date and place where conferring took place;
- The issues discussed;
- With whom;
- The reasons for such discussion.

There is a positive obligation on officers involved to ensure that all activity relating to the recording of accounts is transparent and capable of withstanding scrutiny.

Where an officer has any concerns that the integrity of the process is not being maintained, they must immediately draw this to the attention of the person in charge of the post-incident process and ensure that this is documented.

The custody record will detail events and interactions within a custody suite; however, where an incident has occurred outside the custody unit, recollection of detail will be key to the investigation. Officers or staff who have been involved in a traumatic incident will often experience a range of physiological and psychological responses which may determine their perception of time, distance, auditory and visual stimuli and the chronology of key events. This may affect their ability immediately after the incident to recall what may be important detail. Where, over time, officers and staff recall more information, this should be recorded in a further account.

It is the responsibility of each individual police officer involved in the incident to ensure that any information that may be relevant to the investigation is disclosed, recorded and retained. This information should include an officer's own observations relating to the incident and any accounts received from witnesses (eg, custody staff, other officers, escort staff, court staff, members of the public and other detainees).

10.3.2 DOCUMENTATION AND DISCLOSURE

The originals of all documents, records, forms and statements generated as a result of an incident must be handed over to the force Professional Standards Department or IPCC at the earliest opportunity.

The Code of Practice issued under section 23(1) of the Criminal Procedure and Investigations Act 1996 requires that all material obtained in the course of an investigation that may be relevant to the investigation is retained for disclosure purposes.

10.3.3 THE ROLE OF THE POST INCIDENT MANAGER

Post Incident Managers (PIMs) facilitate, manage and ensure the integrity of the post-incident procedure. Their role is not limited to deaths in custody and may include situations such as police involved shootings and serious injury traffic collisions involving police officers. PIMs often perform their role as part of a PIM team, under the direction of an overall PIM.

A PIM will usually be nominated by the force to which the custody suite belongs or the arresting officer belongs. This will apply to any policing incident or operation, including those which cross force boundaries. Appropriate support should be available from the force in which the incident occurs. Forces should consider the possibility of such occurrences and have appropriate joint operational force and regional protocols to deal with post-incident procedures.

The PIM's role is to facilitate the investigation, ensure integrity of process, and establish the basic facts of what happened. In the first instance the PIM should obtain this information from a source other than the custody officer. If, however, this information is only available from the custody officer, the PIM should remind them of the importance of legal advice before seeking the information. The PIM will also ensure that the basic facts are passed to the investigator.

10.4 LEARNING THE LESSONS

Forces must have established policies and procedures to ensure that deaths and successful interventions are reported, recorded, investigated and analysed, and that the lessons learned are collated, disseminated and implemented. The lessons should be followed even when the incident is not being investigated as a conduct matter or complaint.

A useful source of information about IPCC investigations and can be found at: <http://www.learningthelessons.org.uk/Pages/default.aspx>

10.4.1 LEARNING FROM INVESTIGATIONS

The PSD, external force or IPCC independent investigations into deaths and successful interventions will produce recommendations for individual forces, and forces will be required to respond to these recommendations. There must be a system to ensure these lessons are implemented within operational policing. This requires strong links between the PSD, operational policing/custody and police training.

There will be recommendations for learning which apply to all forces. The IPCC is working with the Home Office and ACPO, and liaising with national and regional custody forums, to ensure that there are effective collation and dissemination processes.

In the case of external police or independent IPCC investigations, the inquiry's terms of reference will establish effective liaison arrangements between the force and investigators. This is to ensure that the emerging facts and early lessons are communicated as soon as possible, without compromising the investigation outcomes.

10.4.2 OTHER AGENCIES

The cross-sharing of lessons with other stakeholder and practitioner groups may help raise understanding, minimise deaths in custody, and reduce the occurrence of successful interventions. Liaison with local stakeholder groups should be considered through the regional custody network and notified to the National Custody Forum. Lessons learned are shown on the Home Office webpage at **<http://police.homeoffice.gov.uk/operational-policing/powers-pace-codes/saferdetention>**

11

BUILDINGS AND FACILITIES

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11.1 HEALTH AND SAFETY

Owing to the specialist and safety critical nature of police custody facilities, products, materials and specifications used should be tried and tested within the police custody market. Appropriate effective design and planning, building and maintenance of police custody suites, minimises risk.

All new custody suites should be built in accordance with the **Home Office (2010) Police Buildings Design Guide (HOPBDG) Custody Chapter 10**, which provides essential guidance. Additional information is contained the **National Police Estate Group (NPEG) (forthcoming) Custody Best Practice document**.

Where alterations or maintenance works are carried out, contractors should be told of the specifications required. The completed work should be inspected by a person who is competent to ensure that it conforms to those specifications. To avoid operational disruption, access to mains services such as gas, water and electricity, and meter switchgear should, wherever possible, not be sited within the operational areas of a custody suite.

Custody suites at non-designated stations must meet the same health and safety standards and be fit for purpose. Where existing buildings cannot reasonably be modified to fully meet new built standards, improvement to existing facilities should be carried out within available resources. Risk assessment should be carried out and appropriate control measures engaged. Where appropriate, Standard Operating Procedures should be put into place.

11.1.1 DEFINITION

The Health and Safety Executive (HSE) defines a hazard as 'anything that may cause harm', and a risk as 'the chance, high or low, of somebody being harmed by the hazard, and how serious the harm could be'. All employees have a responsibility under Health and Safety legislation to identify hazards and risks.

Risk management, as set out in Health and Safety legislation, must be used when assessing possible hazards. Further information is available from the HSE website: <http://www.hse.gov.uk>

11.1.2 LIGATURE POINTS

The most innocuous fixture, fitting or space can provide a ligature point for a person intending to self-harm or take their own life. Previous deaths in custody and near misses have involved ligature points in, on or surrounding the following places within cells or detention rooms:

- Old wooden benches;
- Ventilation or heating grilles where they are poorly positioned or the grille apertures are too large;
- Toilets with filler or sealant missing between the junctions with walls and floors;
- Washbasin tap fittings or plug holes;
- Welding around doors that creates points, blade edges or provides gaps between steel sections;
- Poorly fitting doors providing means of wedging a ligature;
- Cell hatches which are defective or do not shut properly and can be opened by the detainee from inside the cell, thereby providing a gap into which a ligature can be lodged;
- Unsuitable door handles, for example, 'T' handles;
- Light fittings that provide any means of attaching a ligature, accessing the fitment internally or shattering the lens;
- Walls or tiles with render or grout missing;
- Smoke detectors which provide a potential means of ligature attachment;
- Cell call buzzers or toilet flush mechanisms that have not been fitted or bedded flat to walls or have in any way come loose;
- Cell door spy glass (loose, cracked or otherwise defective glass lenses or casings);
- Cell window fixing points;
- Cracks or gaps between cell fittings and walls, floors or ceilings;
- Crack or gaps that have been improperly filled with a soft mastic;
- Floor drainage grilles;
- Half height privacy walls which provide access to high level fittings or themselves provide a climbing self-harm aid;
- Hand wash unit drain points and hand wash units that allow a shoe or similar item to be lodged within them.

People who are determined to self-harm may go to extreme lengths to do so. Detainees can and will be ingenious in the methods they use. Items such as the mattress, blanket and pillow (if provided)

should be checked for damage to ensure they do not provide potential ligature material.

To take their own life using a ligature, a person requires both the means of forming the ligature and the means of attachment, normally to a structure. Removing one or, preferably, both opportunities minimises the risk.

Staff who inspect cells must be aware that ligature points can be found at high and low levels. They can take any form, eg, cracks, gaps in benches, any pipe, tube, bar or similar fittings. Inspections should be conducted methodically, working from the ceiling to ground level. This is not just a problem in older custody suites, but can equally occur in new buildings.

Poor repair work can create ligature points. Repairs must be undertaken professionally, with material appropriate to the specific situation. The higher initial cost of safer materials will be offset by their longevity and safety.

If a potential ligature point is identified, the detainee should either be removed from the cell or the risk effectively managed. Where the ligature point has been caused by damage or wear, remedial work should be carried out as soon as is practicable. The custody officer will be required to constantly manage the risks associated with that cell when it is in use until it has been fixed/improved, inspected, and declared safe for normal operational use, see **11.2 Maintenance of a Custody Suite**.

11.1.3 FIRST-AID EQUIPMENT

All first-aid equipment should be suitably stored and properly identified. First-aid containers should be placed conveniently and, where possible, close to hand-washing facilities. The minimum contents are set out by the ACPO Working Group in First Aid Skills in the **ACPO Police First Aid Learning Programme**, see **ACPO First Aid Skills for Custody (FASC) Module 3**.

Sufficient quantities of each item should be available in every first aid container. For further information, see **ACPO Recommendations for Contents of First Aid Kits**.

The contents of first-aid containers should be examined frequently and be restocked as soon as possible after use. Care should be taken

to discard items safely after the use-by date has passed.

11.1.4 SUICIDE INTERVENTION KIT

All custody suites should be equipped with a suicide intervention pack.

Forces should consider issuing all custody staff with ligature knives or emergency cut-down tools, which should be carried at all times when in the custody suite.

11.1.5 CELL CALL SYSTEMS

All cells should be fitted with a working cell call system. Where the cell call system is found to be defective, the cell should be put out of service until the system is repaired. If this causes significant issues for management of the custody suite, control measures should be put into place for the managed use of that cell, against risk assessment, until the cell call system is repaired. The cell call controls within the cells must be safe for police custody use.

11.1.6 ENTRY TO THE CUSTODY SUITE

Wherever possible, detainees under escort should enter through a custody vehicle dock to provide security and privacy. Other visitors such as family members, appropriate adults, solicitors and those returning on bail should come through a public entrance. When detainees, who have been exposed to CS spray, or another incapacitant spray enter the custody suite, contamination issues must be addressed.

11.1.7 HOLDING AREAS

On arrival at the police station all detainees must appear before the custody officer as soon as practicable. It may sometimes be necessary for staff to wait with a detainee until they can be seen by custody staff. Custody suites should be designed with areas for staff to wait with their detainees. Such holding areas should be located between the vehicle dock and the main charge area. The detainee should be provided with a reasonable degree of privacy while being held, allowing space for the arresting officers to remain with the detainee to ensure their safety.

A detainee becomes the responsibility of his/her designated custody officer as soon as they arrive at the police station and are booked into custody. See **2.4 Arrival at the Station.**

11.1.8 CELL CORRIDORS

Cell corridors should be CCTV recorded and capable of being monitored through CCTV. Cell corridor areas should be fitted with an effective affray alarm system.

11.1.9 ALARM SYSTEMS

Attack alarm systems, which allow immediate assistance to be summoned, must be installed throughout the custody suite. Care should be taken not to place additional furniture or technical equipment in locations that might hinder access to alarms. When in a room with a detainee, staff should be seated closest to the door, with the attack alarm call point readily accessible to them.

Consideration should be given to linking custody alarms to force control rooms so that other staff can assist if they are activated. Forces should avoid systems that only allow access to the custody suite by someone inside opening the door. There must be a method of opening the entrance from the outside in an emergency.

11.2 MAINTENANCE OF A CUSTODY SUITE

It is recommended that all new cells meet the standard Home Office police cell design and specification. When older cell stock is refurbished it is recommended that cell fittings meeting current Home Office police standards are installed.

Custody managers should ensure that routine checks by custody staff are supplemented by a regular regime of cell inspections and inspections of equipment. See **Appendix 2 Custody Suite Inspection and Maintenance Regime.**

A competent person, who is aware of the specific risks associated with detention, should be identified. They must have the authority to declare cells fit for occupation or to close them should they not meet health and safety requirements. This task should be carried out in consultation with the custody officer (if that the custody officer is not

the nominated person) as they will ultimately be responsible for the placement of a detainee in the cell.

Cells which have been taken out of use for safety reasons must be inspected after remedial work has been completed and before they can be reused. This includes cells which have been taken out of service after ligature points have been found.

Custody managers should establish stock control systems, taking into account projected demand and realistic lead times.

A risk assessment must be completed before any moveable furniture is placed in areas such as medical and interview rooms. The materials used must be capable of withstanding heavy impact and in medical rooms of meeting requirements for infection control and forensic cleaning. (These requirements may be specified by the healthcare professional themselves, or within the contract for healthcare services to custody).

For information relating to the equipment and supplies required in the medical room see the approved ***Faculty of Forensic and Legal Medicine (2007) Operational Procedures and Equipment for medical rooms in police stations and victim examination suites***

11.2.1 CELLS

All cells should have adequate natural and artificial light. Cell fittings and furnishings should meet the appropriate current fire rating and must be highly robust to withstand extreme and continual abuse. They should be constructed and maintained to prevent ligature attachment or other forms of self-harm. Furnishings in areas of a custody suite accessible to detainees should be secured to the floor where operationally practicable; they should also be well maintained and not have any sharp edges. Furniture should not be allowed to come loose in a way that would enable a detainee to wedge part of their body in or behind it, or to create a ligature.

11.2.2 HATCHES

All cell hatches present risks. Older police cells which may not have been designed to current specifications present greater risks. Consideration may be given to replacing old hatches of the types

associated with past self-harm incidents with safer current Home Office approved types. Hatches must always be left fully closed after use. Signs may be placed on cell doors to remind staff of this.

11.2.3 DOORS

All cell doors should open outwards and be fitted with the Home Office anti-ligature handle and an adjustable and removable door keep. Doors should be well maintained and fitted tightly. A maximum gap of 2mm is advised between the cell door and rebate when the door is closed.

All doors to rooms that a detainee may have access to within the custody suite should have vision panels. The only exception is the medical examination room where a balance must be struck between safety of the staff and the detainee, and confidentiality.

11.2.4 BOOKING-IN AREA

The layout of the reception or booking-in area should allow the custody officer to have unimpeded vision of the detainee and allow good verbal communication during the booking-in process. The layout should also allow the detainee a reasonable degree of visual and auditory privacy during the booking-in and charging process. The use of privacy screens or a separate, discreet charging area may help in this regard.

11.2.5 THE EXERCISE YARD

An external exercise yard should be provided in all new custody suites. The yard should be free from ligature points and any other features that might permit self-harm.

Before a detainee is allowed to use the exercise yard, the custody officer must carry out a risk assessment to determine whether the detainee may safely be left in the yard unsupervised for a designated period of time, and/or, to determine an appropriate level of supervision and monitoring. For further information see **3 Risk Assessment**.

11.2.6 CLEANING

Risks can be greatly reduced by adopting a comprehensive cleaning

regime of all custody areas. Procedures for specialist cleaning services to remove body fluids must be considered. Adequate drainage should be provided in custody areas and exercise yards. If drainage becomes contaminated by body fluids, this must also be professionally cleaned.

Rooms used for medical examinations must be thoroughly cleaned and those used for forensic examination must be forensically cleaned.

All cleaning fluids should be stored securely.

11.3 FIRE SAFETY

As a secure facility in which building occupants are not all free to leave in the event of a fire, special attention must be paid to ensuring safety should one occur.

See **HOPBDG Chapter 10 Custody** for Home Office Fire Adviser advice. It should be considered that some of this advice is statutory in nature and applies equally to both old and new police custody suites.

Where a custody suite is built and maintained according to the HOPBDG, some fire safety requirements that are usually applicable will not apply to the custody suite. For example, the requirement will be removed for panic release bars on external doors to secure areas, break glass fire alarm points and the provision of fire extinguishers in corridors.

Fires within police custody suites are relatively infrequent but potentially very serious events. Due to low fire loading, in most instances smoke and smoke control will be the principal issues for detainees and staff rather than fire itself.

Police forces are advised to ensure that:

- 1) A competent person responsible for fire safety issues within each force is made responsible for reading, understanding and ensuring compliance with **HOPBDG Chapter 10 Custody PD5 Fire Safety** in all operational custody suites.
- 2) The ability of smoke detection equipment to automatically detect smoke within a cell is regularly tested and recorded.

3) Cold smoke tests are carried out to inform staff what may happen to smoke within cells when the cell door is opened so that they can safeguard their own and detainees' safety in the event of fire.

4) An appropriate plan is in place that will allow staff to safely evacuate the cell in which the fire has occurred without placing the life of that detainee, other detainees, or their own lives, at serious risk.

5) Appropriate fire evacuation plans ranging from phased partial evacuation up to and including total evacuation are agreed, recorded and kept in a readily accessible place. All custody staff must be aware of that these plans and they should be practised regularly.

Tests indicate that a cell in which a custody mattress and blanket have been ignited may not be a tenable or survivable environment after a very few minutes, the principal risk being the smoke generated. **Waiting for emergency service response may not be an appropriate or adequate response.** Inappropriate ventilation systems in older suites that do not achieve negative air pressure within the cell may place staff and other detainees at risk when the cell door is opened. This is due to smoke release into the cell corridor. Forces are advised either to ensure that the suite ventilation system is reconfigured to safe allow evacuation in these circumstances, or to put in place alternative and adequate safeguarding measures.

For more detailed information or advice on fire safety contact the Home Office Technical Standard Unit.

11.4 CCTV

CCTV can be used for both **monitoring the welfare of detainees** and for the **prevention and detection of crime**.

Forces should establish a policy stating the purpose of the CCTV system and this must be declared in force notifications to the Information Commissioner, see Data Protection Act 1998, Sections 17 and 18. In addition, the policy should specify whether CCTV is intended to be used for general monitoring of staff performance.

To comply with the Information Commissioner's Code of Practice, CCTV images must not be retained longer than is necessary for the intended purpose.

Where CCTV is in use, forces must establish policies and protocols to protect the detainees' privacy and prevent abuse of the system.

The active use of CCTV fitted in a cell should be considered on an individual basis, subject to the risk assessment. Any request by detainees to have the CCTV turned off shall be refused, see PACE Code C, paragraph 3.11.

CCTV images must not be used to circumvent identification procedures. Identification procedures must be carried out in accordance with PACE Code D.

11.4.1 PLANNING

Forces must decide on the areas that CCTV should cover. When establishing force policy for CCTV in custody suites, consideration should be given to having all cells fitted with CCTV. CCTV coverage should be as advised in the HOPBDG. The following areas should also be considered in CCTV requirement planning:

- The vehicle docking area;
- Entrance to the custody suite;
- Access corridors to and from the rest of the police station;
- Holding areas;
- The charge room area;
- The custody officer's desk in the charge room (should provide separate images showing the officer's face/body, detainee face/body and property transfer on desk);
- Detainee property store or entry to this area;
- Cell corridors;
- Entry to the interview rooms;
- The fingerprinting area;
- The evidential breath analysis device room;
- Exercise yard;
- The custody office CCTV equipment cabinet;
- The custody CCTV viewing area;
- Cell interiors (including detention rooms).

CCTV may visually cover the following areas but, because of the need to protect legal privilege, should not have audio recording or audio monitoring facilities:

- Rooms set aside for private legal consultation;
- General interview rooms.

The **IPCC (2011) Deaths in or Following Police Custody: An examination of the cases 1998/9–2008/9**, recommends that police forces should make CCTV available in at least one cell in the custody suite, to be used when a detainee is identified as being at risk, and, where available, that it is fully operational.

Access to images recorded on custody CCTV must be controlled to protect the rights and dignity of individuals and to maintain the continuity of evidence.

Policy should ensure:

- Screens for monitoring live images from cells are placed out of the sight of anyone who is not directly involved in monitoring the detainee's welfare;
- Opportunities for accidental or casual viewing by detainees are minimised;
- Facilities for playing back recorded images are housed in a separate area and operated only by trained staff. All viewings must be documented.
- The CCTV monitoring area should itself be covered by CCTV and staff should be made aware that they are being recorded while performing this function.

Monitors for communal areas can be displayed anywhere in the custody suite and can be a useful way of reminding and reassuring detainees and staff that CCTV is in use.

For reasons of privacy, the following areas must not be covered by the CCTV system:

- The examination area of the healthcare professional's consulting room, (other areas of the consulting room can have CCTV for the safety of staff and detainees);
- The shower area/wash areas;
- All WC areas.

The cell WC area should be pixelated on monitors for privacy reasons. The full image should be recorded without pixelation.

Monitoring staff should have the ability to remove pixilation (this act being auditable on the system) when needed for short periods to check detainee safety.

Retrieving Images and Footage

Non-digital systems should be fitted with an audible warning device that indicates when tapes are approaching the end. This is to ensure that recording is continuous and that errors do not arise in the storage of video footage.

Where material is required to be backed up, copied or extracted from technical equipment, specialists trained and authorised in such procedures should be used. This includes making master and working copies of material. The use of specialists will prevent the potential loss of images and safeguard the integrity of evidential material. Details of trained personnel should be available to custody staff.

Where images have been transferred to disc, cassette or any other medium, auditable storage systems must be used.

For further guidance on procedures on downloading and storing digital images, see **ACPO (2007) Practice Advice on Police Use of Digital Images**.

11.4.2 RESPONSIBILITY FOR THE CCTV SYSTEM

Forces should ensure that clear lines of responsibility for the ownership and administration of the system are established, including responsibility for day-to-day operation, the integrity of the system and any recorded footage. A fault-reporting procedure and maintenance programme should be included to ensure that the operational availability is maximised.

Custody managers should establish an inspection regime for the CCTV system, including both the hardware and software, to ensure the suitability of images. Recording quality should also be checked.

11.4.3 CCTV SIGNS

PACE Code C, paragraph 3.11 requires that notices are prominently displayed where CCTV cameras are present in the custody suite. While there is no legal requirement for signs to be used in individual

CCTV-equipped cells, it is good practice to have the ceiling and door surfaces of each monitored cell clearly labelled with a stencilled sign indicating that CCTV is in operation.

Section 9 of the **Information Commissioner's Office (2008) CCTV Code of Practice** requires that signs are suitably placed so that the **public and staff** are aware that they are entering an area covered by CCTV. The size and position of such signs is not prescribed, but they should be clearly visible and legible. Signs should identify the purpose of the system, who is responsible for its operation and contact details for enquiries. Although not specified in the code, provision should be made for those who cannot read English or those who are vision impaired. Pictorial or multi-lingual signs or verbal communication of the required information can be used in such instances.

11.4.4 USE AND MONITORING OF CCTV

Where a decision has been taken to monitor the welfare of the detainee using continual CCTV cell observation, the purpose of this control should be recorded on the custody record along with the name of the person(s) responsible for the monitoring.

The decision to use continual CCTV cell monitoring should be based on the risk assessment rather than resourcing levels. The officer or member of staff who is appointed to monitor detainees continuously via CCTV should not be expected to view more than four cells simultaneously on a split screen display, or to carry out additional duties that will distract them from continuously viewing the CCTV.

CCTV must not replace visits to detainees, other physical checks for well being, or the need for close proximity observations for detainees assessed as high risk.

Cells equipped with CCTV should not generally be used to conduct strip searches or consultations between detainees and their legal representatives. There may be occasions when recording a strip search via CCTV is desirable for the protection of staff, however, consideration must be given to PACE Code C, Annex A, paragraph 11(b). The recording of the search must be shown to be necessary and proportionate in the circumstances.

For information on the levels of monitoring, see **6.1.2 Monitoring, Observation and Engagement.**

11.4.5 ACCESS TO IMAGES

Detainees, legal representatives and appropriate adults have rights of access to custody records. As audio and video recordings do not form part of the custody record, **routine inspection** of such recordings by detainees, legal representatives and appropriate adults is **not permitted**, see PACE Code C, paragraph 2.1. However, people whose images are recorded on custody CCTV systems are entitled, under The Data Protection Act 1998, to **request access** to the CCTV recordings. Requests for access to CCTV footage should be referred to the force Data Protection Officer. Except in very limited circumstances, police forces are obliged to comply with such requests.

It will be necessary to edit the footage to conceal faces and/or remove sound which could identify other detainees whose right to privacy must also be respected. Disclosure of personal information without the consent of those other detainees would constitute an offence under the Data Protection Act 1998.

Disclosure

Requests for disclosure of CCTV material in relation to an investigation must be processed in accordance with the requirements of the Criminal Procedure and Investigations Act 1996 (CPIA) and its related Codes of Practice. Retention periods for images seized under these circumstances will be the same as for all unused material.

Independent Custody Visitors

The introduction of CCTV into custody suites has raised the question of whether independent custody visitors should have access to footage. This is ultimately a matter for local discretion, but the Home Office view is that visitors should carry out their functions in person and not by viewing either live CCTV pictures or recorded footage. Their role is fundamentally interactive with both detainees and police staff and cannot be discharged remotely. There may also be issues about infringing the privacy of detainees who have not consented to visitors observing them using CCTV. However, where specific incidents or circumstances arise as issues and have been captured on CCTV, visitors might reasonably be allowed access where both the police and the detainee(s) concerned consent.

In a report published by the IPCC (**Hannan, M., Grace, K. and Bucke, T. (2010) *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09***) it is recommended that independent custody visitors should check that CCTV is operational when carrying out their custody visits. Visitors should be able to ask the custody officer whether the CCTV is working and be given a demonstration if necessary.

See **ICVA National Standards on Independent Custody Visiting**, <http://www.icva.org.uk/about/nationalstandards/>

11.5 AUDIO RECORDING

Refurbished or newly built custody suites may have a cell intercom system that allows custody staff to talk to detainees without having to go into the cell.

Where justified, the listening system can be left on to provide additional, limited monitoring of detainees. Where the listening system is to be used in this way, the detainee should be made aware of this. It may be appropriate to display a sign that will alert all detainees to the presence of the system and its use.

The listening system should be switched off if the cell is being used for confidential purposes, such as the provision of legal advice by the detainee's solicitor. If the cell is used for such a purpose, it is appropriate to advise the relevant person (solicitor or other) that the system exists, but will not be used.

12

HUMAN RESOURCES AND TRAINING

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- 12.1 Police Resources**
- 12.2 Contract Staff**
- 12.3 Training and Learning Provision**
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 - 12.4.5 Health and Safety**
 - 12.4.6 Hygiene**
 - 12.4.7 Food Hygiene**

12.1 POLICE RESOURCES

There can be no 'one size fits all' model for staffing levels or resource composition. Forces should establish a staffing model which gives considers the following:

- The number of people detained each year;
- The number of detainees anticipated in future years;
- The efficiency of the custody process;
- Demand levels, ie, peak times of day, month and year including seasonal variations;
- Geographical area;
- Resourcing of special events;
- The physical structure and design of the custody suite;
- Staff training;
- Succession planning;
- Operational resilience;
- All custody staff, including custody officers are entitled to proper breaks away from the custody environment.

The following resources must be available when required:

- Custody officers;
- Detention staff (police officers/staff/private);
- Healthcare professionals;
- Legal advice;
- Referral scheme workers;
- Interpreters via telephone/videophone or in person;
- Appropriate adults for juveniles, detainees with mental ill health or learning disabilities or otherwise vulnerable adults.

The use of private contracts for some roles within custody may help to maximise the efficient use of designated staff.

Police forces should ensure that custody officers and staff are clear about their individual roles and responsibilities in the custody suite.

The duty or custody inspector should have effective oversight and supervision of custody. Lines of management need to be clear and unequivocal, and should be graphically conveyed to all staff performing custody duties. It is essential that all staff are trained and competent to perform their role in custody and are aware of:

- Their responsibilities;
- Their obligations under PACE; and
- The expectations of their colleagues and the force.

Under the Health and Safety at Work etc Act 1974 an organisation (a police force is included within the definition of an organisation) has a duty under the Act and liability as an employer that extends to both employees (police officers and staff) and those who are not strictly employees but who provide a service to it, ie, agency or contract staff. An employer's duty is generally accepted to include:

- (a) A duty to provide and maintain a safe place of work and equipment;
- (b) To provide competent employees;
- (c) To establish and enforce a safe system of work.

All duties are personal and can not be delegated.

Each force should have a role profile for the role of:

- Custody officer;
- Detention officer;
- Detention assistant;
- Escort officer.

Clear lines of designated responsibility, thorough risk assessment, and handover briefings are essential to protect the safety of detainees and custody personnel. Information recorded on the custody record must be clear accurate and completed in a timely manner.

12.2 CONTRACT STAFF

The responsibilities and duties of privately contracted detention staff will vary according to the contractual arrangements made by each force and whether or not staff are designated as detention and/or escort officers.

Contract staff working within the custody environment and as designated detention and escort officers must be fully aware of their role and how it integrates with the police officers and staff they work with. Contract staff must be trained to fully understand and appreciate their designated legal responsibilities.

It is advised that custody managers and custody officers take time to fully read the employment contracts and wider contractual arrangements made between forces and private companies for custody staff. These contracts govern the working relationship that custody officers have with the contracted staff that they supervise.

Contracts and role specifications may include details of certain duties and responsibilities that differ from initial expectations and assumptions made. It will also benefit police custody managers, officers and staff to have an awareness of the content of relevant healthcare professional contracts and cleaning contracts, so that forces are able to monitor standards effectively and hold staff to account according to the requirements of their contract.

Custody officers should make themselves aware of the procedure for raising issues or concerns about learning needs or professional competence for a contracted employee. A single member of staff who does not demonstrate an adequate level of knowledge, understanding or operational competence has the potential to cause a detainee neglect and suffering and in the worst case scenario, death.

Schedule 4, Part 3 of the Police Reform Act 2002 deals with the powers and duties of designated detention officers (see paragraphs 25 to 33C). It should be noted that the powers that detention officers have been designated with may vary between forces (according to the operational requirements of the force).

12.3 TRAINING AND LEARNING PROVISION

Forces must ensure that all staff working in the custody suite are trained and competent before being appointed or allocated tasks within the custody suite. All custody staff have a high degree of responsibility for detainees within custody.

Where possible, forces should use qualified trainers who are also qualified assessors and who have recent prior custody experience. Trainers should be operationally competent and should maintain that competency. The practice of shadowing experienced members of staff is recommended as an effective means of improving staff competence.

There must be continuing access to refresher training and learning opportunities while in post. The period required for refresher training should be determined by its content and the method of delivery. Training needs analysis of existing custody staff should be conducted to identify whether further training is required.

Police custody officers, designated detention officers, designated

escort officers, and non-designated custody assistants and constable gaolers must receive training and refresher training in first aid, staff safety, and control and restraint. In addition to formal training, staff retain individual responsibility for their own professional and personal development.

All contracted staff must be suitable, trained and able to undertake their contracted role within police custody. Privately contracted designated detention officers who undertake booking-in work must be adequately trained in risk assessment.

Mutual benefits can be achieved through joint agency training, for example, staff from mental health teams could deliver training to custody staff on dealing safely with detainees with mental ill health.

Checklist 18 Custody Training

- All police officers and staff working in a custody suite must receive National Custody Officer Learning Programme (COLP) training before they commence their role, and refresher training while in post.
- Custody managers should identify the training requirements for existing staff by conducting a training needs analysis.
- All designated and contracted staff must be adequately trained and able to undertake their role within custody.
- All custody officers and staff should receive personal safety training in accordance with **ACPO (2007) Personal Safety Manual of Guidance** and the **ACPO (2009) Guidance on Personal Safety Training**;
- All police custody officers and staff must be appropriately trained in first aid having completed the **ACPO Police First Aid Learning Programme Modules 2 and 3**.
- All custody officers and staff must be trained to use the PNC and local IT systems (and the PND where available);
- All custody officers and staff must be trained in how to respond to deaths or near misses in custody and how their role will be affected by post-incident investigation;
- All custody officers and staff must be trained to meet their obligations under the Corporate Manslaughter and Corporate Homicide Act 2007 and relevant Health and Safety legislation;
- All staff required to prepare food for others must be suitably qualified in food hygiene.

12.4 NATIONAL CUSTODY OFFICER LEARNING PROGRAMME

The National Custody Officer Learning Programme (COLP) provides the framework for custody officer training and is consistent with this guidance. All forces should use the national training programme as a minimum standard.

12.4.1 RISK ASSESSMENT

All staff who work in custody must be trained in risk assessment as it is fundamental to the welfare of detainees and all those present within the custody environment. This requirement includes all officers, police staff and private contract staff.

For further information see **2.2 Pre-Custody Risk Assessment, 2.5 Medical Attention, 3 Risk Assessment, 4.5.1 Risk Assessment after Restraint, 7.3 Additional Risks Associated with Alcohol, 7.4 Additional Risks Associated with Drugs** and **8.3 Risk Assessment (Mental Health)**.

12.4.2 CONTROL AND RESTRAINT

All custody staff must be trained in personal safety in accordance with **ACPO (2007) Personal Safety Manual of Guidance**. Additional provision should be made for joint training for groups of custody staff who regularly work together.

Forces must make full personal safety training and personal safety refresher training available to custody officers and staff as appropriate to their role. For further information see **4 Control, Restraint and Searches**.

12.4.3 PNC, PND AND LOCAL IT SYSTEMS

Custody staff should be trained in the use of the Police National Computer (PNC) system prior to taking up their post, and should have the ability to access the Police National Database (PND) and local force intelligence.

12.4.4 FIRST AID

There are four modules to be covered in accordance with the **ACPO Police First Aid Learning Programme**.

- Module 1 Emergency Life Support (ELS)
- Module 2 First Aid Skills – Police (FASP)
- Module 3 First Aid Skills – Custody (FASC)
- Module 4 First Aid Skills – Enhanced (FASE, paragraph 6.1)

Police custody staff must receive training to at least Modules 2 and 3 prior to taking up posts in custody. Refresher training must be completed at least every twelve months.

Some contracted custody staff may not be trained, or adequately trained, in first aid. Minimum service requirements within all private contracts for custody staff should include a reference to an obligation for contract custody staff to immediately report any identified a need for urgent first aid to the custody officer. The custody officer will then arrange for the necessary first aid to be provided.

It is recommended that custody suites are staffed to ensure the provision of immediate medical care to detainees prior to the arrival of ambulance crews or other medically trained persons, ie, that there is always at least one officer or member of staff who is trained in first aid working within the custody suite at any time.

12.4.5 HEALTH AND SAFETY

All staff should be trained to meet their obligations under Health and Safety legislation. Initial health and safety training must be specific to the role as well as giving an overview of Health and Safety legislation.

Staff safety training and the use of the National Decision Model (NDM) will help to reduce risks to staff and members of the public while minimising the potential risks to detainees. Personal protective equipment should be provided where appropriate.

For more information see **ACPO (2007) Personal Safety Manual of Guidance**.

12.4.6 HYGIENE

Custody suites should be provided with hygiene control measures similar to those found in hospitals for the control of MRSA and other known infections. This includes using hygiene wipes and hand scrubs. Staff must be trained to use them properly. For further information see **11.2.6 Cleaning.**

12.4.7 FOOD HYGIENE

All staff involved in the preparation of food supplied to others should hold a basic food hygiene certificate, unless the preparation is purely reheating sealed or pre-cooked items.

13

CONTINGENCY PLANNING

Contents

- 13.1 Contingency Planning**
- 13.2 Evacuation**

13.1 CONTINGENCY PLANNING

Forces should establish protocols with other emergency services and develop local procedures that cover responsibilities for emergency situations in custody.

Contingency plans should be established for the following scenarios:

- Major incidents resulting in a high volume of arrests;
- Activation of Operation Safeguard (use of police cells to hold Home Office prisoners), or a dramatic increase in prison 'lock-outs';
- Death in custody;
- Bomb threat;
- Terrorist detainees;
- High-profile detainees likely to attract media and public attention;
- Other sensitive detainees;
- Fire;
- Chemical, Biological, Radiological or Nuclear (CBRN) incident.

13.2 EVACUATION

Contingency plans for evacuation of a custody suite should make provision for alternative accommodation for detainees if an immediate return to evacuated premises is not possible. All staff engaged in custody duties should be briefed on the evacuation plans. A copy of the plans should be available at an agreed location outside the facility for use by other emergency services.

Forces must establish evacuation plans for all of their custody facilities, and ensure that all custody staff are trained in the procedures to be followed in the event of a fire or other emergency requiring the evacuation of the custody suite.

It is recommended that evacuation plans are tested on a regular basis and that, where possible, this testing is run in joint exercise with local Fire and Rescue Services.

1

Appendix

Management of an 'At-Risk Detainee' from a Prison or Young Offender Institution (YOI)

What to Do When You Receive an At Risk Detainee from a Prison or Young Offender Institution (YOI)

There are occasions when the police take people into custody who may already be in prison and who could be on a care or support plan, having been identified as a suicide or self-harm risk. Some examples are:

- When a prisoner is lodged overnight in police cells because of the distance of the court from any prison, and they are due back in that court the following morning.
- When a prisoner is released to police custody (sometimes referred to as a police presentation) because of outstanding elements of an investigation or new charges.
- When a prisoner is arrested on release from prison (known as a re-arrest or gate arrest). It is, therefore, possible that police custody staff will temporarily have in their custody an at-risk prisoner but may have no information about how to maintain the care/support plan that is already in place for them. To assist police custody staff, the current systems in use in prisons and YOIs and what police custody staff need to look for if an at-risk prisoner comes into their custody suite are explained here.

When taking over responsibility for prisoners, always make an immediate check for at-risk status.

All public and private prisons use the ACCT system to identify and care for prisoners thought to be at risk of suicide or self-harm. ACCT stands for Assessment, Care in Custody and Teamwork, and is easily identifiable as an A4 orange form. It is an assessment and care planning tool.

There are two reasons to provide the police with the ACCT Plan.

1. To provide details to custody staff of the risk and what can be done to support the detainee and keep them safe.
2. To provide information for staff at the prison/YOI that the detainee is returned to, about any important events while out of the prison/YOI, thereby aiding them to continue care for the detainee.

If the ACCT Plan is not returned to the prison/YOI the second point is lost.

What to do if the detainee is on an open ACCT Plan

Check the information on both the front and inside front cover of the ACCT Plan. In particular, look at the:

- 'Required frequency of conversations and observations' box on the front cover;
- 'Triggers/warning signs' box on the inside front cover as this may contain particular behaviours or events to be aware of.
- Look at the 'Concern and Keep Safe Form' (page 3) to learn why the ACCT Plan was opened.

Look at the current 'CAREMAP' (pages 13 and 14) to see what action is required to keep the detainee safe.

Occasionally, where the ACCT Plan has only just been opened, there may not be anything written on the CAREMAP. In this case look at the 'Immediate Action Plan' (page 4) to see what action to take.

Look at the 'On-Going Record' (pages 21 and 22) to see what has recently happened.

Check the Person Escort Record (PER) for any further information.

If anything is unclear, ask the staff handing over the detainee for more information.

While the detainee is in your care:

- Maintain the ACCT Plan (this can provide important information for staff at the prison/YOI that the detainee is returned to). Document relevant conversations, observations, significant events, changes in mood, behaviour or circumstances on the PER and on the On-Going Record (pages 21 and 22). The minimum frequency suggested by the prison/YOI for making such records is indicated in the 'Required Frequency of Conversations and Observations' box on the front cover.
- Continue to follow your policies for receiving and caring for an at-risk detainee.

Remember to:

- **Talk to the detainee;**
- **Send the ACCT plan with the escort staff to the prison/YOI the detainee is to return to, and note this on the PER;**
- **Keep a copy with the custody record.**

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Appendix

Custody Suite Inspection and Maintenance Regime

A suggested inspection and maintenance regime for custody suites incorporating advice is contained within **Home Office (2010) Police Buildings Design Guide** (HOPBDG). It is a matter for local policy how it operates.

Daily

The following could be the responsibility of all custody staff and are in addition to the areas identified in **4.6.5 Cell Searches** and **11.1.2. Ligature Points:**

- Test cell call system (should be checked when detainee is placed in a cell);
- Inspect for damage in custody suite (risk assess for continued use);
- Inspect cells each time they are vacated;
- Clean suites daily, although some areas may need to be cleaned more frequently;
- Check contents of first aid kits and any suicide intervention kits, replacing any used or missing articles;
- Ensure recording equipment is tested before use if it does not have auto-test facility.

As Required

- Check and re-set calibration of specialist equipment (for example, livescan, evidential breath test machine);
- Clean forensic search rooms after use to ensure that they are suitably sterile for the next time they are required.

Weekly

The following could be the responsibility of the Custody Manager or equivalent:

- Test the fire alarm;
- Test the emergency call alarm system;
- Check the cleaning of all surfaces;
- Inspect exercise yard/vehicle dock for damage/potential problems.

Monthly

The following could be the responsibility of the Custody Manager, Duty/Custody Inspector or equivalent, to:

- Assess the need for any specialist cleaning regime.
- Check the cleaning and topping up of floor gullies, including exercise yard. Note: Some internal gullies may require more regular topping-up due to evaporation.
- Ensure a testing regime for power failure is completed to maintain uninterrupted power supply (UPS) and generator working capability.

Quarterly

The following could be the responsibility of a building surveyor with the Custody Officer/Custody Manager and the Health and Safety representative with the custody portfolio:

- Quarterly inspection of all areas with the building surveyor with the Custody Officer or Custody Manager;
- Checks of operating efficiency of heating, cooling and ventilation plan including filter replacement;
- Health and Safety Risk Assessment 'walk through' – this must be carried out after, for example, each change in layout and change in equipment use.

Annually

The following could be the responsibility of the building surveyor with the Custody Officer/Custody Manager and the Health and Safety representative with the custody portfolio:

- Annual checks undertaken by specialist suppliers/manufacturers;
- Decoration check (biannually and redecorate as required);
- Annual search of the custody suite (this could be an opportunity for the search team to carry out training);
- Calibration check of building management control systems;
- Undertake the testing regime for a power failure to ensure UPS and generator working capability;
- Water testing, disinfecting and certification;
- Deep cleaning of suite by professional cleaning company;
- Practise evacuation drills.

3

Appendix

Abbreviations and Acronyms

AA	Appropriate Adult
ABC	Airway, Breathing and Circulation
ABE	Achieving Best Evidence
ACPO	Association of Chief Police Officers
ACCT	Assessment, Care in Custody, and Teamwork (Plan)
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
AMPH	Approved Mental Health Professional
APP	Authorised Professional Practice
ASW	Approved Social Worker
A&E	Accident and Emergency
CAMHS	Child and Adolescent Mental Health Services
CBRN	Chemical, Biological, Radiological or Nuclear
CCTV	Closed Circuit Television
CDW	Community Development Worker
CID	Criminal Investigation Department
CJS	Criminal Justice System
COLP	National Custody Officer Learning Programme (NCALT)
CPD	Continuing Professional Development
CPIA	Criminal Procedure and Investigations Act 1996
CPO	Community Protection Order
CPS	Crown Prosecution Service
CSO	Community Safety Order
CT	Computerised Tomography (Scan)
DAAT	Drug and Alcohol Action Team
DH	Department of Health
DNA	Deoxyribonucleic Acid
DPA	Data Protection Act

DPMF	Detained Person Medical Form
DPP	Director of Public Prosecutions
DSPD	Dangerous and Severe Personality Disorder
DSS	Department of Social Security
DTs	Delirium Tremens
DTTO	Drug Treatment and Testing Order
ECHR	European Convention on Human Rights
EHRR	European Human Rights Reports
ELS	Emergency Life Support (First Aid Learning Programme Module 1)
EPO	Emergency Protection Order
EU	European Union
FASC	First Aid Skills for Custody (First Aid Learning Programme Module 3)
FASE	First Aid Skills Enhanced (First Aid Learning Programme Module 4)
FASP	First Aid Skills Police (First Aid Learning Programme Module 2)
FFLM	Faculty of Forensic and Legal Medicine
FIB	Force Intelligence Bureau
FME	Forensic Medical Examiner
FOIA	Freedom of Information Act 2000
GP	General Practitioner
HCP	Health Care Professional
HIV	
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Probation
HMI Prisons	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service

HRA	Human Rights Act 1998
HO	Home Office
HOPBDG	Home Office Police Building Design Guide
HRA	Human Rights Act 1998
HSE	Health and Safety Executive
ICV	Independent Custody Visitors
IIMARCH	Intelligence, Intention, Methodology, Administration, Risk Assessment, Communication and Human Rights model
IO	Investigating Officer
IPCC	Independent Police Complaints Commission
IPLDP	Initial Police Learning Development Programme (Probationer Training)
INI	Impact Nominal Index
IT	Information Technology
LCJB	Local Criminal Justice Board
LSCB	Local Safeguarding Children Board
MAPPA	Multi Agency Public Protection Arrangements
MG 3	Report to Crown Prosecutor for Initial Charging Decision
MHA	Mental Health Act (MHA) 1983
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAAN	National Appropriate Adult Network
NCALT	National Centre for Applied Learning Technologies
NCRS	National Crime Recording Standards
NDM	National Decision Model
Norovirus	Norwalk virus
NPIA	National Policing Improvement Agency
NCRS	National Crime Recording Standards

NHS	National Health Service
NIM	National Intelligence Model
NO	Notification Order
NOMS	National Offender Management Service
NPEG	National Police Estate Group
NTAC	National Technical Assistance Centre
PACE	Police and Criminal Evidence Act 1984
PDP	Potentially Dangerous Person
PDR	Personal Development Review
PER	Person Escort Record
PECS	Prisoner Escort and Custody Services
PI	Public Interest
PIM	Post Incident Manager
PIP	Professionalising Investigation Programme
PNC	Police National Computer
PND	Police National Database
PNLD	Police National Legal Database
POCA	Proceeds of Crime Act 2002
PoLSA	Police Search Adviser
PPO	Prolific and Priority Offenders
PSD	Professional Standards Department
PSO	Prison Service Order
PSU	Policing Standards Unit
RC	Responsible Clinician
RSHO	Risk of Sexual Harm Order
RSO	Registered Sex Offender
SARC	Sexual Assault Referral Centre
SCT	Supervised Community Treatment
SOA	Sex Offender Act

SOCA	Serious Organised Crime Agency
SPOC	Single Point of Contact
SSAFA	Soldiers, Sailors, Airmen and Family Association
SSOU	Serious Sex Offenders Unit
TB	Tuberculosis
TSO	The Stationery Office
TT&CG	Tactical Tasking and Co-ordination Group
UKBA	United Kingdom Borders Agency
UKHL	United Kingdom House of Lords (England)
UPS	Uninterrupted Power Supply
ViSOR	Violent Offender and Sex Offender Register
VS	ViSOR registered offender PNC warning marker
WCU	Witness Care Unit
YJB	Youth Justice Board
YOI	Young Offender Institution
YOT	Youth Offending Team

4

Appendix

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