LEARNING THE LESSONS

ASK YOURSELF: Could it happen here?

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Bulletin 23 – Custody

Learning the Lessons bulletins summarise investigations conducted by the Independent Police Complaints Commission (IPCC) or police forces where learning opportunities are identified. Police forces facing similar situations to those described can use the experience of other forces to improve their policies and practices. The bulletin challenges forces to ask "Could it happen here?"

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Foreword

Carl Gumsley and Tom Milsom

This bulletin provides learning from cases covering the point of arrest through to release from police custody. The themes it contains will be familiar to people who work in the custody environment yet, despite repeated attempts to highlight these issues, they still happen. Not all of the cases in this bulletin have resulted in a death but many have. It is important that lessons are learnt and processes are followed in order to prevent future deaths.

The number of deaths in or following police custody in England and Wales have continued to decline over the last ten years and in 2013/14. The IPCC's annual report into deaths during or following police contact in 2013/14 shows that there were 11 deaths recorded, down from 15 the previous year and less than a third of the 36 recorded in 2004/05 when the IPCC was first set up. However, the number of those recorded as having apparently committed suicide within 48 hours of release from police custody is the highest it has been over the last ten years, at 68 in 2013/14. There is clearly no room for complacency.

One of the most important functions of the Independent Police Complaints Commission (IPCC) is the investigation of deaths following contact with the police, to make sure that lessons are identified and that deaths are prevented. The IPCC has been a key part of the drive to reduce the number of deaths in or following police contact by reporting our findings from investigations and thereby contributing to better guidance and standards.

Although the numbers of deaths in custody has reduced, some of the deaths in this bulletin could have been prevented. It is essential that:

- Arresting officers make sure there is a proper assessment of vulnerability, to inform the initial response and all later actions of the police. This is important to decide whether a person needs to be taken to custody, a healthcare setting or a place of safety.
- Those who come into custody must be fully risk assessed. If a person cannot interact in that process, it is likely to mean that they should not be in custody.
- Any checks or rousing that are put in place are carried out at the frequency and standard expected.
- Any change in a person's condition is properly noted and clinical treatment arranged if appropriate.
- When risks are identified for a person, this information is provided to ongoing custodial providers.

To make sure lessons are learnt, the IPCC has fed the recommendations from our investigations into the revision of the Authorised Professional Practice (APP) on Detention and Custody. The new APP will be published in Summer 2015. We welcome the update of the guidance and all staff working in the custody environment need to understand and be trained on its content to make sure those in custody are kept safe and deaths are prevented.

Carl Gumsley

Tom Milsom

Case summaries

Pre-arrest

1 Risk assessment prior to arrest

Two police officers went to a marina to arrest a man who was wanted on a warrant for non-payment of council tax.

While they were escorting the man from a boat to the shore, he fell off the jetty onto an embankment which was three to four feet below. The officers believed he had suffered an epileptic fit.

The man had come into contact with the police before, and custody records showed that he suffered from epilepsy. However, this information was not available to the officers when they undertook their pre-arrest planning and risk assessment.

The officers called an ambulance, but while they were waiting for it to arrive the man stopped breathing so they started CPR.

The man was taken to hospital by ambulance but died sometime later.

Key questions for policy makers/managers:

- Does your force make sure that relevant information about a person's medical history is routinely transferred on to the Police National Computer (PNC) and force intelligence records? How do you make sure that these help inform any future risk assessments or decision making by officers?
- Which systems or sources of intelligence do you ask officers to routinely check when carrying out a risk assessment before arresting someone?

Key questions for police officers/staff:

- Do you carry out a risk assessment before you arrest someone on a warrant?
- What records/information do you consider to inform your pre-arrest planning and risk assessment?
- What contingencies would you consider as part of the arrest process?

Action taken by this police force:

- The force took steps to make sure medical information is transferred to a person's PNC record.

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Medical care

2 Dealing with a man detained under section 136 of the Mental Health Act

A friend of a man called police after he threatened to harm himself by jumping in front of a train following a break up with his girlfriend.

Three officers went to the scene and detained the man under section 136 of the Mental Health Act. An ambulance was called to transport him to hospital.

A paramedic arrived in a rapid response vehicle. He took the man to hospital and two officers followed behind in a police car.

When they arrived at hospital the paramedic took the man to the accident and emergency department (A&E) rather than a designated place of safety and he was placed in a side room. Police officers left the man at the hospital with A&E staff.

Shortly after they left, the man left the hospital too. The hospital told the police of the man's departure.

Police were then called to an incident where a man had been hit by a train. This was the same man who had been detained but later left the hospital. He later died of his injuries.

Key questions for policy makers/managers:

- How do you make sure officers are aware of the places of safety in your force area where they can take someone detained under section 136 of the Mental Health Act?
- What advice do you give to officers on their responsibilities in relation to people who are detained under section 136 of the Mental Health Act?

Key questions for police officers/staff:

- Are you aware of the places of safety in your force area where you can take someone you detain under section 136 of the Mental Health Act?
- Do you know what your responsibilities are (for example, in relation to handover) when healthcare professionals are involved with a person who is detained under section 136 of the Mental Health Act?
- Are you aware of how your responsibilities differ if an individual who has been detained under section 136 of the Mental Health Act is taken to A&E rather than a NHS place of safety?

Action taken by this police force:

- All local policies were made available on the force intranet site to make them readily available for frontline staff.
- A mental health learning site was developed providing short reference guides on mental health policy and procedure.
- An iCard was developed on the ambulance transportation policy. A mobile version was also developed to be available at incidents.
- A mental health awareness week was held in the force.
- Mental health awareness training events were held across agencies.
- Police officers and staff received one day training. The training covered handovers to mental health teams.
- A monitoring form is being introduced for all section 136 detentions.

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3 Moving a man from hospital to custody

Two intoxicated men had an agitated exchange which led to one man hitting his head on the pavement and becoming unconscious.

The police and ambulance service attended and the man was taken to hospital.

Hospital staff called police when the man became, and continued to be, aggressive and refuse treatment.

Police attended and decided to remove the man to custody.

When the man arrived in custody, the custody sergeant asked him about an injury to his head but did not call a healthcare professional, because the man had just come from a hospital.

Due to the man's level of intoxication he was placed on constant observations throughout the night. During the check at 7.30am the man was lying on the floor. There was no response from the man when he was spoken to or when his ear lobe was squeezed. He was also twitching. He was placed on a mattress and a blanket placed over him. An ambulance was called and paramedics took the man to hospital.

Following the incident, the man was in hospital for about two and a half months and was in a coma for most of this time. Since he has come out of hospital he needs care provided 36 hours per week, at the assisted living care home where he now lives.

Key questions for policy makers/managers:

- Does your force have agreements with local health authorities about how you will respond to calls about people in a healthcare setting who are intoxicated or aggressive?
- What information do you ask hospitals to provide about patients before officers are sent to deal with people in hospital? How do you make sure you are getting the right information?
- What training or guidance have you given to officers to help them spot and deal with people who have head injuries?

Key questions for police officers/staff:

- What information would you consider important to the custody sergeant so that risk can be assessed when bringing a detainee in to custody?
- Do you think you would recognise the effects of a head injury?
- Do you know how to obtain enough detail to inform a thorough risk assessment?

Action taken by this police force:

- The force has shared the learning from this case with their learning and development department who deliver custody training and first aid training.
- The force is working with the NHS hospitals in their force area to make sure accurate and appropriate information is exchanged in similar cases.

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Recognising head injuries

4 Man with head injury who was also intoxicated

Late one evening police took a man into custody after a taxi driver asked for help following a dispute over the fare.

The man was reported to have kicked out at an officer and he was subsequently taken to the ground, handcuffed, and a Violent Person Restraint (VIPER) was used to restrain him before he was carried to the police van. Several police officers reported later that they heard a noise that may have been the man hitting his head on the pavement.

On arrival at the police station five officers carried him into the custody suite and straight into a cell.

The mattress from the bench was placed in the middle of the cell floor and the man was placed upon it.

An officer used CAPTOR spray before restraints were removed from the man.

There was confusion throughout the night and morning as to which custody officer had responsibility for looking after the man. There were also failures in relation to how the man was monitored via cell checks throughout the night and morning by both privately contracted custody staff and custody officers.

Initially the man was active and moved around the cell. On one occasion he tried to lay on the bench but slid to the floor. At around 5am he tried to get up, but was unable to do so and stayed lying on the floor. He remained in this position for some time, before he eventually stopped moving.

He was placed on half hour visits but was not placed on rousing checks. Staff said they believed him to be asleep as several reported hearing loud snoring.

At around 11am officers entered the cell and found the man unconscious, so placed him in the recovery position before calling for an ambulance.

An ambulance arrived and he was transferred to hospital where he was found to have a serious head injury.

Key questions for policy makers/managers:

- What guidance or training do you give to officers to help them identify people with head injuries?
- Does your force policy reflect guidance in PACE and authorised professional practice about how people in custody who are drunk and incapable should be treated?
- What steps does your force take to make sure that all detainees are appropriately risk assessed and that this is revisited during their time in custody?
- Does your force policy reflect the need to report potential injuries of the detainee when booked into custody?

Key questions for police officers/staff:

- What information would you give to the custody officer if you were aware that the detainee may have sustained a head injury either before or during arrest?
- What behaviour from the detainee would make you ask the arresting officer more questions about what may have happened during or before the arrest and what action would you take?
- Would you know what to look for to be able to identify the difference between someone who was drunk and incapable and someone who had a head injury?
- How do you interact with those who you feel are drunk?
- When would you decide that someone is in need of medical help?
- What new information would make you revisit your risk assessment?

Action taken nationally:

- PACE and the Authorised Professional Practice (APP) for detention and custody was amended to state those who are drunk and incapable are in need of medical assistance. It also said those who are under the influence should be checked and roused.

Action taken by this police force:

- The custody computer system was updated to ask more specific questions to allow appropriate risk assessments.
- A full training programme was conducted involving both the custody staff and the private contractor.

- First aid training included recognising and responding to head injuries.
- A principal custody policy was introduced to support staff in the decisions that they make.
- A principal custody officer role who takes primary responsibility for detainee care was introduced in all custody facilities.
- Inspections were carried out by the head of custody to review the knowledge of the custody staff on duty and the custody inspectors across the force.

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Authorised Professional Practice on Detention and Custody states:

A **drunk and incapable** person is someone who has consumed alcohol to the point that:

- they cannot walk or stand unaided, or
- they are unaware of their own actions, or
- they are unable to fully understand what is said to them.

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.

Drunk and incapable individuals are in need of medical assistance in hospital and an ambulance should be called.

Under the influence of alcohol

All detainees should be risk assessed on arrival in custody and throughout their detention. Where a risk assessment shows that the person is not drunk and incapable but that they have a degree of impairment from alcohol or drugs to the extent that any of the following apply, they should be considered as being under the influence and treated accordingly:

- close proximity (level 4) monitoring
- constant observation (level 3) monitoring
- the requirements for PACE Code C Annex H rousing checks.

The amount of alcohol and/or drugs that a detainee has taken cannot be readily confirmed and their reaction to them is also unpredictable.

The importance of monitoring the response to Annex H rousing checks is key to ensuring that any underlying medical conditions (such as head injury or undeclared drug consumption) is identified as soon as practicable.

5 Response to those believed to be drunk and incapable

Around midday police officers went to a property after a man and a woman reported that their son was behaving violently.

When the officers arrived it quickly became clear that the man was not a threat to them and that he was having difficulty walking or talking coherently.

A decision was made to arrest the man on the grounds that he was drunk and incapable.

The man was helped into a police van before being transported to custody.

The journey to custody took approximately 10 minutes.

On arrival the man had to be woken before being helped by two officers out of the van and into the custody suite. Once in custody he was immediately placed in a cell covered by CCTV which was monitored from a screen above the custody charge desk.

Neither the custody sergeant nor any of the custody officers present attempted to speak to the man before he was placed in the cell.

A decision was made by a custody sergeant to place the man on level 3 observations which meant he would be constantly monitored via CCTV and physically checked. A decision was also made that he should be roused at least every 30 minutes and that a health care professional should be called because of his intoxicated state.

The arresting officer was told to carry out the constant observations and the physical checks.

Visits were made to the man approximately every 30 minutes with the officer doing the constant observations carrying out all of those visits (apart from one which was done by a custody sergeant and a detention escort officer). On some entries in the custody record it was recorded that the man was roused. During a number of those visits the man was found to be sleeping and officers received no verbal response from him.

In between the visits the police constable viewed the monitor showing CCTV from the cell while performing other tasks, including making and receiving calls and texts on his mobile phone, dealing with other work related issues and using the internet for non-work related purposes.

A nurse arrived approximately two hours after being asked to attend the custody suite. On arrival the nurse decided to visit another detainee before seeing the man.

Approximately 30 minutes after arriving in custody the nurse visited the man in his cell. It became clear that the man was seriously ill. An ambulance was called and CPR was given.

Attempts to resuscitate the man were held back when the custody sergeant could not find a face mask in the first aid kit which was kept in the custody suite.

The man was taken to hospital by ambulance where he was pronounced dead.

Key questions for policy makers/managers:

- What guidance and training does your force give to officers on dealing with those who are drunk and incapable? Does this include advice about when to take to hospital?
- What steps do you take to make sure that officers are able to carry out constant observation of detainees effectively?
- What steps do you take to make sure that the entries officers make in the custody record accurately reflect the visits they have made to detainees?
- What advice or guidance do you provide to custody staff to help them direct healthcare professionals to deal with detainees in need of most immediate assistance?
- What steps do you take to make sure medical equipment (including face masks and vent aids for CPR) is easily available to custody staff and is properly maintained?

Key questions for police officers/staff:

- What action would you take if you identified someone as drunk and incapable?
- Would you know what was required while conducting a constant observation?
- Are you familiar with the content of Annex H of PACE code C which says how to assess the level of rousability of an individual?
- Do you understand the importance of rousing an individual?
- Are you aware how to access face masks or vent aids used in CPR?

Action taken by this police force:

- All custody staff are required to carry a CPR face mask for emergency use.
- AED/defibrillator devices were installed in every custody suite and staff were given training on how to use them.
- Detainee prompt cards were revised and re-launched.
- Briefing sheets were developed for staff who perform level 3 or 4 observations.
- All operational constables and sergeants were required to attend a half day custody awareness course which included material relevant to dealing with those who were drunk and incapable.
- A learning the lessons page was made available on the force intranet.
- Checks are now carried out to make sure that incidents involving people who are drunk and incapable are handled in accordance with force policy.

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Annex H of PACE Code C states that when assessing the level of rousability, consider:

Rousability – can they be woken?

- Go into the cell
- Call their name
- Shake gently

Response to questions – can they give appropriate answers to questions such as:

- What's 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!

Checks and rousing

6 Rousing an intoxicated detainee

A man was taken to custody after being arrested on suspicion of breach of the peace.

The man was un-cooperative on arrival at the police station and refused to get out of the police van so officers were forced to carry him into the custody suite.

The sergeant on duty told the officers to take the man straight to a cell which was monitored by CCTV. The man was then left there in the recovery position.

The sergeant completed a risk assessment, but despite guidance recommending the man be seen by a doctor, and despite the fact that a forensic medical examiner (FME) was on duty in the custody suite, he did not ask the FME to assess the man.

The man was placed on 30 minute checks. A system within the custody suite allowed officers to set reminders for visits, however no reminders were set this time.

The first check took place at around 11.05pm and was carried out by a civilian detention officer (CDO). They can be seen entering the man's cell and lightly shaking him but he does not appear to be roused as there was no apparent response or movement.

Just under half an hour later an officer recorded that he had conducted a visit on the custody record, but no evidence of this can be seen on CCTV.

Twenty minutes later the same officer who conducted the first check can be seen entering the cell and bending over the man. The man tried to move his head slightly in response, but remained in the recovery position.

At around 12.20am, and again nine minutes later, officers looked through the spy-hole in the door of the man's cell but did not enter the cell or try to rouse him.

At around 1.15am the officer who conducted the last check entered the man's cell but did not rouse the man or record his visit in the custody record.

At around 1.40am a further check is recorded as having been made, but no evidence of this can be seen on CCTV.

Ten minutes later the same officer that conducted the last recorded check looked through the spy-hole in the cell door. The man had still not moved from his original position.

At 2.40am the officer re-entered the cell but did not rouse the man. He returned two minutes later with a sergeant and they tried to rouse the man.

The officer recorded on the custody recorded that "DP is snoring loudly try to wake up but no response."

At around 3.20am he re-entered the cell and tried to move the man's arms and his fingers and rolled him over into the recovery position on his other side. He then left the cell.

Over the next five minutes he carried out two more spy-hole checks then, eleven minutes later, he returned to the cell and checked the man's pulse. He tried to move the man's head, however he did not respond.

The officer then left the cell and returned a few minutes later with a sergeant. The sergeant left the cell a few minutes later to call for an ambulance and returned with a defibrillator while the two officers tried to revive the man.

Paramedics arrived at around 3.50am and the man was taken to hospital where he remained in a persistent vegetative state and died a few months later.

Key questions for policy makers/managers:

- What guidance do you provide custody staff with on seeking healthcare professional advice?
- What training or guidance have you given to officers to identify whether someone is drunk and incapable?
- Do your custody suites have the facility to set reminders for cell visits? If so, is this system used routinely?
- Does your force give staff working in custody annual refresher training on first aid?
- What steps has your force taken to make sure that detainees are properly roused and that any checks are properly documented on the custody record?

Key questions for police officers/staff:

- When would you decide that someone who had consumed alcohol should be seen by a healthcare professional?

- Do you understand the difference between someone who is drunk and incapable and someone who is under the influence of alcohol?

Action taken by this police force:

- All custody staff are given first aid training every 12 months in line with national guidelines.
- All custody staff are trained on the safer detention and handling of persons in police custody guidance (now APP) and refresher courses have been scheduled as part of a yearly training program.

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7 Checking a detainee who is sleeping

A 66 year old man was arrested by police after information relating to his whereabouts was received from a member of the public. He was wanted on warrant after failing to appear in court to face allegations under the Sexual Offences Act 1956, the Indecency with Children Act 1960, and the Criminal Attempts Act 1981.

During the booking in process the man said that he had a heart condition and was diabetic, but that he had not taken any medication so far that day.

The custody sergeant kept an Angina spray that the man was carrying when he was brought into custody.

The custody sergeant decided that the man should be seen by a healthcare professional, and he was taken to hospital where doctors prescribed him medication for some of his conditions.

Neither the doctor nor the officers updated the person escort record.

On his return to custody the man was placed on 30 minute rousal visits. After being seen by the healthcare professional again, the custody sergeant and healthcare professional agreed that the man should be placed on 30 minute visits, without the need to obtain a response from the man.

Visits continued throughout the night and were carried out through the spy hole. At one point during the early hours of the morning the man's face became covered by a blanket so he could not be seen during visits, however officers continued to record that they could see him breathing.

When officers and medical staff entered the cell later that morning to re-administer medication, they found the man had died.

Key questions for policy makers/managers:

- What guidance does your force give to officers on the types of medication that detainees are allowed to keep?
- When officers take someone to hospital are they aware of information they should include in the person escort record?
- How does your force make sure that when a detainee has received treatment at hospital and is then returned to the custody suite, officers have all the information they need about any medication prescribed or any aftercare required to help them provide the best standard of care to the detainee?

Key questions for police officers/staff:

- What action would you have taken if you had noticed that the man's face was covered by a blanket while you were carrying out a check?

Action taken by this police force:

Following the incident the force reminded all custody staff about the following issues:

- All visits to detainees must be recorded on the custody record.
- Detainees who present as no risk of self harm and disclose angina or asthma should be allowed to keep their sprays/pumps with them or the custody record should record the reason for refusal.
- There should be continuity of officers checking a detainee's condition.
- When officers are asked to escort a detainee to hospital they should be fully briefed as to the reasons for attending.
- The custody record should be endorsed when a detainee leaves and returns to their cell.
- Person escort record forms should be completed accurately to show the whereabouts of an individual at all times.
- Handovers between shifts must be recorded on CCTV.
- Custody sergeants accepting responsibility for a detainee at the start of a new shift must enter the cell of any detainee who is asleep and wake them to make sure of their welfare.
- Spy hole checks must not be used to check the welfare of a detainee.

- Custody sergeants should record a full rationale and risk assessment when changing observations.
- When a detainee has a blanket or other item covering their face, they should be asked to remove it to make a proper welfare check.
- Custody records should be clear whether a waking or sleeping review was made.
- When a detainee is visited and is sleeping, staff should record how movement is seen.

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8 Monitoring an individual under the influence

At 10.45am a man was arrested by officers on suspicion of burglary. He was taken to a police station and booked into custody.

The custody sergeant on duty carried out a risk assessment but did not ask the man if he had taken any drugs that day. However, on the custody log the sergeant recorded that he had asked this question, and that the man had said no. He also ticked the box to say that the man did not seem to be under the influence of drugs or alcohol.

The custody sergeant decided that the man should be seen by the on-duty healthcare professional (HCP) because the man had said, during the risk assessment, that he was suffering from post traumatic stress disorder and borderline personality disorder and did not have any medication with him.

The HCP examined the man and, despite denying that he had taken any drugs or alcohol that day, the HCP decided he was possibly under the influence of a substance. The HCP discussed his regime of care with the custody sergeant and they decided that he should receive 30 minute rousal visits. The man was placed in a cell monitored by CCTV at 11.34am.

During the man's detention, his condition got worse. He was subject to checks every 30 minutes by the custody staff, but after a shift change at 2pm, these were made via the cell hatch and no detention officers entered his cell. From 2.18pm, the man is seen to be lying on the floor of his cell and makes no visible movements from this point on.

At 3.33pm, a check was conducted on the man and he was found to be un-responsive in his cell. He was taken to hospital where he was diagnosed to be suffering from the effects of a methadone overdose and suspected pneumonia. He later admitted to having taken three 100ml doses of methadone before his arrest.

Key questions for policy makers/managers:

- When a detainee is placed in a cell with CCTV, how do you make sure that the CCTV is monitored effectively?
- Does your training for custody officers include guidance on rousing, and include information on how to deal with detainees who are un-responsive?
- How does your force check that officers rouse detainees in accordance with guidance?
- What steps has your force taken to make sure that officers record all relevant information in custody records where appropriate?
- How does your force make sure that information is handed over effectively between outgoing and incoming shifts, in particular information about why certain levels of observation are required?
- What steps has your force taken to make sure that staff are kept informed of latest guidance issued by the College of Policing?

Key questions for police officers/staff:

- How would you recognise someone who may have taken drugs?
- How do you provide clear instructions and use CCTV to monitor someone effectively?

Action taken by this police force:

- A comprehensive action plan was drawn up by the force about improvements to be made. These included making sure that custody staff are aware of the safer detention guidelines (now APP); that the handover process from one shift to another is carried out in a structured way; and that more proactive responsibility is taken for monitoring cells through the CCTV system.
- Following the incident the force has achieved improvements to the care and professionalism demonstrated by the custody staff. This was reflected in the latest HMIC inspection which specifically praised the force on this issue.

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9 Transfer of a man from police custody

A man was arrested and taken into custody following an argument with his mother.

He was assessed as low risk for self harm. However, the custody sergeant placed him in an anti-rip suit and on 30 minute visits due to the nature of the offence.

An officer was assigned to deal with the case. He visited the parents of the man and felt that the man was in need of help with his alcohol abuse and mood changes. The officer thought that the court was able to order the man to attend an intervention process, to provide him with the support he needed.

While being interviewed, the man became ill and was taken to hospital where he was treated for alcohol withdrawal symptoms. The following day he discharged himself from hospital, refusing any further treatment and he was returned to custody.

Once back in custody the officer interviewed the man, who admitted the offences and expressed regret. The officer discussed the case with the Crown Prosecution Service (CPS). It was agreed to charge him with common assault, to make sure that he appeared before a court, and that consideration could be given to placing him on a suitable intervention programme, to assist him in overcoming his alcohol and anger problems.

Prior to the man being transported to court by a private contractor, a custody sergeant completed a Prisoner Escort Record (PER) form. He ticked the self harm box on the form and provided extra details on a separately typed sheet, which he stapled to the front cover of the form. The further information stated that the man was suffering from alcohol dependency, depression which was not being treated with medication, and set out the nature of the offence.

The officer felt that, taken together, the information given may provide factors which should be considered in carrying out a risk assessment for self harm.

While the man was at court, the CPS lawyer re-determined the charges and included a charge of making threats to kill, a much more serious charge. The magistrates agreed and remanded the man into custody, awaiting an appearance at Crown Court.

The man was transported to prison, where he took his own life the following day.

Key questions for policy makers/managers:

- How do you advise officers to record additional information about a detainee's vulnerabilities on the PER if more space is required?
- How does an escort private contractor transporting those to court consider the information on the PER form to manage risk?
- What steps does your force take to make sure that PER forms are completed correctly?
- How do you make sure that staff working in custody are kept informed of any changes to guidance and complete any appropriate training?

Key questions for police officers/staff:

- If you had extra information that you could not fit on the PER form, how would you pass this to other agencies?

Action taken nationally:

- The national offender management service which owns the PER form, is looking at the use and design throughout custody. They are also considering the possibility of making the PER form an electronic document.

Action taken by this police force:

- The force has introduced an envelope to house the PER form and all associated documents.
- The force has introduced two processes of dip sampling to monitor the consistency of PER forms. Firstly, the respective custody inspectors dip sample the PER form submissions for relevance and quality, and secondly, they are checked by the professional standards department.
- The force has delivered refresher training to staff which has included learning from this case and other similar cases.

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10 Investigating a death following contact

A 17 year old was arrested on suspicion of driving a motor vehicle with excess alcohol.

On arrival at the custody suite he was taken to the intoxilyser room so a reading of his alcohol level could be taken. He was briefly seated in the room before the CCTV cameras were turned on. He was found to be over the prescribed limit.

The investigation found that during the risk assessment process he was asked questions which were found to be closed. This may have resulted in a negative and limited response to the questions.

The risk assessment process led to the custody sergeant noting there were no concerns in respect of self-harm, no injuries or medical conditions, no drugs, that the man had drunk eight bottles of lager, and no doctor was required. As a result the custody sergeant decided he should be observed every 30 minutes on level 1 observations.

The 17 year old was provided with his rights and entitlements and asked if he wanted anyone to be told about his whereabouts. He said "not really, there's nothing they can do".

He was kept in custody, and was visited throughout the night where he was recorded as sleeping or resting. There was no change to his health or wellbeing during his time in custody, which was reported to the custody officer. During the investigation it was found that two visits during his detention fell outside the 30 minute time period.

He spent less than eight hours in police custody and at 8.20am he was charged and released on bail to appear at the Magistrates Court four days later.

Two days after his arrest his father told the police that his son had taken his own life. Letters that were left for family and friends had no reference to his time or treatment in custody.

The force referred the matter to the IPCC which decided that the circumstances of the police contact would be suitable for a local investigation by the force. Following concerns raised by his father, the force re-referred this matter to the IPCC. These concerns were around relevant CCTV footage not being secured in a timely manner; conflicting information provided around the availability of CCTV footage; and conflicting information about the provision of items such as transcripts to the family.

The IPCC decided to conduct an independent investigation into the police contact with the 17 year old to consider these matters.

Key questions for policy makers/managers:

- Do you carry out regular checks to make sure that the time on all CCTV cameras is accurate?
- Are all your CCTV cameras linked to a main recording system?
- Do you make sure there is early contact with complainants and interested persons and a culture of openness in local investigations?

Key questions for police officers/staff:

- What advice do you give to officers on carrying out/scheduling checks to make sure that detainees do not go unchecked while a handover between shifts is taking place?

Action taken by this police force:

- Regular checks to establish accuracy of the time of the CCTV cameras in the custody suite are carried out weekly by the custody inspector responsible for that suite. A record of this check is made and is checked weekly by the chief inspector.
- A circulation telling officers from the professional standards branch to check the accuracy of seized CCTV to decide any potential time differences was circulated to all staff.
- A reminder was sent to all professional standards department staff to remind them about the importance of early contact with interested persons to the investigation to help identify any issues or concerns which may impact on the CCTV retrieval policy.
- The force is exploring the costs of linking the CCTV in the intoxilyser room to the main recording system throughout their custody suites.
- All custody staff were made aware of the existing custody operating procedures and best practice involving the activation of intoxilyser recording equipment before the detainee entering the room. The role of a custody inspectorate managed by an inspector was created. The role was created to drive up standards and monitor working practices to make sure the branch is doing its utmost to promote detainee safety.

- Custody inspectors conducted a dip-sampling exercise for six weeks of handovers and visit regimes. This was to make sure handovers are made in a professional manner and to make sure the visits regime is effectively maintained in the time before and after handover.

Click here for a link to the full learning report

Related reading

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The **College of Policing** has identified the relevant **national learning standards and training resources** to support the case studies contained within this bulletin. A supporting document is available on our website.