



# Post Conducted Energy Device (CED) Assessment Form for Forensic Clinicians

This is an aide memoire and not all sections need to be completed, however all sections should be considered.



Royal College of Nursing



COLLEGE OF paramedics  
leading the development of the paramedic profession



## General Details

Location		Cell	Reason for Arrest
Name		Arrest date/time	
Address		Request Time	
		Time Commenced	
		Time Completed	
DOB		Detainee's Occupation	
Registered with GP? Y <input type="checkbox"/> N <input type="checkbox"/>	GP Details		
Examination Location: Medical Room <input type="checkbox"/> Cell <input type="checkbox"/> Other (please specify) <input type="checkbox"/>			
Persons Present:			Risk assessment read? Y <input type="checkbox"/> No <input type="checkbox"/>

## Consent

**Mental Capacity Present?** Y  N  If no, is lack of capacity temporary  or permanent  (document reasons for lacking capacity)

**Consent Obtained For (explain each point individually):**

Medical assessment including history & examination? Y <input type="checkbox"/> N <input type="checkbox"/>	Injuries being documented for & provided to police or court? Y <input type="checkbox"/> N <input type="checkbox"/>	Information sharing with other clinicians e.g. GP? Y <input type="checkbox"/> N <input type="checkbox"/>
		A statement being written for police & court? Y <input type="checkbox"/> N <input type="checkbox"/>

**DP Signature:** \_\_\_\_\_ **Verbal Consent?** Y  N

## Summary of events leading up to CED deployment

Information provided by officer (name)	Collar number
Clinicians should consider the detainees demeanour prior to CED discharge, the environment, history of intoxication etc here	

**CED Deployment Information**

Time of discharge : Date of Discharge / / Mode of Discharge Probe / Drive Stun / Angled Drive Stun

Number and duration of discharges:

Probes Removed? Y  N  Who by?

Other restraint used? Irritant Spray? Y  N  Baton? Y  N  Spit/Biteguard? Y  N  Dog? Y  N  Cuffs? Y  N

Other restraint or relevant information (please specify)? Y  N

**Immediate Concerns expressed by detainee?**

**Acute symptoms?**

Pain or injury?	History of	If yes to any please elaborate here in addition to any other relevant history disclosed:
Head: Y <input type="checkbox"/> N <input type="checkbox"/>	LOC: Y <input type="checkbox"/> N <input type="checkbox"/>	
Neck: Y <input type="checkbox"/> N <input type="checkbox"/>	Amnesia: Y <input type="checkbox"/> N <input type="checkbox"/>	
Right UL: Y <input type="checkbox"/> N <input type="checkbox"/>	Seizure: Y <input type="checkbox"/> N <input type="checkbox"/>	
Left UL: Y <input type="checkbox"/> N <input type="checkbox"/>	Vomiting: Y <input type="checkbox"/> N <input type="checkbox"/>	
Chest: Y <input type="checkbox"/> N <input type="checkbox"/>	Visual disturbance: Y <input type="checkbox"/> N <input type="checkbox"/>	
Abdomen: Y <input type="checkbox"/> N <input type="checkbox"/>	Dyspnoea: Y <input type="checkbox"/> N <input type="checkbox"/>	
Pelvis: Y <input type="checkbox"/> N <input type="checkbox"/>	Paraesthesia: Y <input type="checkbox"/> N <input type="checkbox"/>	
Right LL: Y <input type="checkbox"/> N <input type="checkbox"/>	Weakness: Y <input type="checkbox"/> N <input type="checkbox"/>	
Left LL: Y <input type="checkbox"/> N <input type="checkbox"/>		
Back: Y <input type="checkbox"/> N <input type="checkbox"/>		

**Past Medical History**

PPM: Y  N  ICD: Y  N  IHD: Y  N  Diabetes: Y  N  Epilepsy: Y  N  Asthma: Y  N  Allergies: Y  N   
 Implanted device: Y  N  Pneumothorax: Y  N  Pregnant: Y  N  Osteoporosis: Y  N  Spinal/Neurosurgery? Y  N

If yes to any of above or relevant other history please elaborate here:

**Prescribed Medication – specifically enquire re anti-coagulants**

Drug	Dose	Frequency	Last Taken	Next Due	In Property?	Boxed and Labelled?
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
					Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

**Substance Misuse/Dependence Issues – please use continuation sheet if necessary and pay particular attention to stimulant use**

Smoker? Y  N  Alcohol Misuse Issues? Y  N  Other Substance Misuse Issues? Y  N  Currently intoxicated? Y  N  withdrawing? Y  N

Details if yes

**Examination – please use continuation sheet if necessary**

Heart Rate:	Rhythm: regular / <b>irregular</b>	BP: /	RR:	Equal air entry? Y <input type="checkbox"/> N <input type="checkbox"/>
Sats: %	Alertness: A <input type="checkbox"/> C <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U <input type="checkbox"/> or GCS	/15 E: V: M:	BM:	Ketones if ↑BM: Temp: °C

**Mental State Examination**

Appearance & Behaviour (gen. appearance, social interaction, movements etc)	Thoughts (delusions, paranoia, hallucinations etc)
Speech (Normal, slurred, pressured etc)	Concentration & Cognition (focussed, distracted, Serial 3's, 'WORLD' backwards)
Mood (Normal, elated, flat, irritable etc)	Insight (Present or absent)

**Physical Examination:**

Barb site 1	Head			Neck	
	Pupils	Size	Reactive	Paraesthesia?	Y <input type="checkbox"/> N <input type="checkbox"/>
Barb site 2	Right	mm		Midline tenderness?	Y <input type="checkbox"/> N <input type="checkbox"/>
	Left	mm		ROM flex/extend	
	Eye movements			ROM rotation R/L	
	Diplopia			Y <input type="checkbox"/> N <input type="checkbox"/>	ROM lat flex/extend

<b>Chest</b>	<b>Abdomen &amp; Pelvis</b>
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**Examination Continued**

**Limbs**

		<b>Right upper</b>	<b>Left upper</b>		<b>Right lower</b>	<b>Left lower</b>
Normal	Tone	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
	Power	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
	Sensation	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Normal movements at</b>						
	Shoulder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Hip	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
	Elbow	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Knee	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
	Wrist	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Ankle	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
	Hand	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Foot	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Please note, a complete body diagram should be considered for all individuals assessed post CED exposure

**Additional Information (if required)**

**Conclusions**

Health issues identified with potential to impact on custody stay & criminal justice process

Large empty box for recording health issues identified with potential to impact on custody stay & criminal justice process.

<b>FTD?</b> Y <input type="checkbox"/> N <input type="checkbox"/>	<b>FTT?</b> Y <input type="checkbox"/> N <input type="checkbox"/>	<b>FTI?</b> Y <input type="checkbox"/> N <input type="checkbox"/>	<b>AA?</b> Y <input type="checkbox"/> N <input type="checkbox"/>	<b>FTC?</b> Y <input type="checkbox"/> N <input type="checkbox"/>
If no to any of above, measures to be taken?:				<b>Self Harm/Suicide Risk</b> Std <input type="checkbox"/> Med <input type="checkbox"/> High <input type="checkbox"/>
				<b>Level of Observation</b> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<b>FTR?</b> Y <input type="checkbox"/> Y with measures documented in advice below <input type="checkbox"/> N next steps documented in advice below <input type="checkbox"/>				

**Advice to Custody Staff** including details of any referrals made (CDAT/CILT/A+E etc)

Large empty box for providing advice to custody staff, including details of any referrals made (CDAT/CILT/A+E etc).

Visit <a href="http://www.fflm.ac.uk/CEDHub">www.fflm.ac.uk/CEDHub</a> or scan the QR code below for additional information (including videos with guidance on barb removal) and the latest guidance	Produced by the CED Working Group (members listed on the CEDHub) ©Faculty of Forensic & Legal Medicine CED Joint Working Group, August 2021  Send any feedback and comments to: <a href="mailto:forensic.medicine@fflm.ac.uk">forensic.medicine@fflm.ac.uk</a>
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