

LEARNING THE LESSONS

Bulletin 3

February 2008

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Custody

This bulletin summarises reports of investigations carried out by the Independent Police Complaints Commission (IPCC) or police forces into police custody matters. These reports have been chosen because they provide learning opportunities for other police forces facing similar situations and may help them improve their policies and practices.

This bulletin is issued by an inter-agency Learning the Lessons Committee. Its members all have a role to play in enhancing the service provided by the police:

- Independent Police Complaints Commission (IPCC)
- Association of Chief Police Officers (ACPO)
- National Policing Improvement Agency (NPIA)
- Association of Police Authorities (APA)
- HM Inspectorate of Constabulary (HMIC)
- The Home Office

This bulletin should be used to alert relevant officers and staff to the serious consequences of simple oversights or failures to follow procedure. In some cases, changes may be needed, in policy or practice, or training, to the physical environment or otherwise. Forces should ensure the bulletin is brought to the attention of those who need to see it for these purposes.

It is also a tool to help police authorities, in their oversight role, assess the risks their force faces, whether resources are adequate to deal with them and to monitor the force's performance in the areas highlighted.

1. Key Issues

1.1 Removing risk items

Items removed because of the risk of self-harm should not be left outside the cell door - a scarf was accidentally returned in one case and used by the detainee to hang herself.

1.2 Transporting safely

A detainee was left alone in the rear of a police van where he could not be observed and without being searched first (he had matches with him). Another detainee put in the back of a police car, with escorting officers in the front, poisoned himself.

1.3 Rousing

Detainees died after PACE requirements to use a series of questions and instructions when rousing a detainee were not followed.

1.4 Medication

Information about a detainee's medication needs to be passed to

the Custody Officer; medication should also be dispensed in accordance with guidance.

1.5 Risk assessments

A range of issues on risk assessment - downgraded without further medical input; lack of supervision by Custody Officer; incomplete recording; inadequate communication of risks on handover to the new shift when Custody Officers and detention officers were briefed separately.

1.6 Record keeping

Failure to record important information - in the custody record, Prisoner Escort Record or on the Police National Computer - ranging from mental health concerns to details of a caller who was allowed to speak to a detainee on the telephone.

1.7 CCTV

Inadequate coverage, sound and quality of image and differences in timings between contemporaneous recordings.



2. Case Summaries

2.1 Chunni used as noose

Following an altercation with their landlady, a man and woman of Asian origin were arrested on suspicion of causing actual bodily harm and taken to the police station. The landlady gave police a passport in a different name she had found in the woman's handbag.

The woman was agitated and spoke only broken English when she was booked in. Shortly after, the Detention Officer realised the woman still had her chunni (scarf) with her, so he took it from her and put it in an alcove outside the cell.

Later that morning, she was arrested again, this time on suspicion of being an illegal immigrant. A man who said he was a friend of the woman called the custody suite, and she was given a cordless phone in her cell to take the call. The caller's name and contacts details were not recorded.

Not long afterwards the woman activated the buzzer in her cell. When an officer went to check on her, she was lying on the bench and could not be roused. The Forensic Medical Examiner (FME) recommended that she be transferred to a camera cell and checked every 15 minutes. When she was moved, the officer retrieved her chunni from the alcove outside her cell and took it with her tracksuit top into the new cell. (She was a student officer with minimal training in custody area duties.) The FME then advised she was fit for interview and did not need to be checked every 15 minutes.

Over the next half-hour, she sat on her bed and pulled her chunni tight round her neck until she lost consciousness. A check was made when the shift changed and she was found on the floor. Officers had difficulty in finding a device to cut the chunni from her neck. She was taken to hospital but died four days later of a heart attack.

Key lessons are to collect details of people who call detainees in custody, consider whether need to call back to check purpose of call; document decision-making process when requesting that personal items or clothing be removed from a detainee; need to store items removed from detainee safely eg in sealed property bags and preferably not outside cells; do not use staff without appropriate training in detention officer roles; consider issue of ligature cutters to all permanent custody staff, supported by appropriate training.

[Click here for a link to the full learning report](#)

2.2 Lethal dose of poison taken in a police car

Police called at the house of a man alleged to have made a racist comment to a postwoman. He only half-opened the door, keeping the chain on, and refused to let them in. He was arrested for a racially aggravated public order offence and, as he was not wearing any shoes, was asked to put some on. He asked for a moment to do this and shut the door, so he was alone in the house until he came out a minute later with a rucksack. He was put in the back of the police car, with the officers in the front.

In the car he took a bottle out of his rucksack; he said it was just 'Coke' and took swigs from it. He then began breathing deeply. The officers asked what was wrong and he said they should take him to hospital as it wasn't 'Coke'. They stopped immediately and called an ambulance, but he was unconscious by the time it arrived and died the next day in hospital.

The contents of the bottle contained lethal doses of cyanide. The man had worked for 30 years in a factory where he had access to chemicals.

Key lessons are the need to search detainees before they are put in a police vehicle; if in the back of the vehicle they should not be allowed to sit behind the driver and an officer should sit in the back with them, people arrested at their homes should not be left alone at any time after arrest until detained at the police station, detainees should not be allowed to drink until safely in custody at a police station.

[Click here for a link to the full learning report](#)

2.3 When a 'drunk' is in fact ill

A homeless alcoholic, who was well-known to the police, was arrested for shoplifting. The arresting officers did not demonstrate or record the need for the arrest, nor did they search him. He had matches on him and was left alone in the back of the police van taking him to the police station.

The man's hat had fallen off while they were waiting for the van, revealing head injuries. When he was booked in at the station, he did not appear to be drunk but he was incoherent, difficult, swearing and mumbling. The Custody Officer did not risk assess him or inform him of his rights on the basis he was too drunk. The Custody Officer did not demonstrate or record the need to detain him either.

The man was not put in a special cell for drunks and only hourly checks were arranged, not the half-hourly checks prescribed for drunks. When the custody shifts changed there was no formal handover. An hour later the man was found unconscious and he was declared dead shortly afterwards. He had died of heart failure.

Key lessons are the need under Serious and Organised Crime Act 2005 for carrying out and documenting necessity test both when arresting and detaining suspect; suspects should be accompanied until it is practical to search them; need for proper handover on change of custody shifts; ensure custody training is fit for purpose and up to date on new legislation; need for custody record format to prompt comprehensive risk assessment.

[Click here for a link to the full learning report](#)

2.4 Checking for pregnancy

A woman was arrested and detained at the police station after a neighbour complained she had damaged her fence in a dispute over parking. When booking her in, the Custody Officer found she had tried to kill herself the year before because of problems with

alcohol and depression. To assess risk, the police asked, among other questions, whether there was anything to tell a doctor. She answered 'No'.

After a while, she started insisting on release. She threatened to 'top' herself. The other Custody Officer decided to move her to a video cell so she could be watched (there was however no sound recording there or in the passage). She refused to go, so he and another officer took her by the arm and walked her to the cell. There she screamed and struggled. Force policy permitted handcuffing where the detainee tried to escape or 'offered violence', so the officers, seeing a risk of her harming herself as well as police, handcuffed her and started to put her into Emergency Response Belts. She then shouted out she was pregnant so they stopped. She was released on bail as not fit for interview.

She claimed she had miscarried while in custody. There was in fact no evidence that she had been pregnant or lost a baby.

Key lessons are to consider including a question on pregnancy on medical risk assessment forms; where practicable consult the Custody Officer booking in the detainee when making a change in the detainee's circumstances (and record the consultation); CCTV to cover all cells and passages at custody centres; policy on Emergency Response Belts to make specific reference to the risk of self-harm and to take into account a variety of medical conditions.

[Click here for a link to the full learning report](#)

2.5 Vital role of Prisoner Escort Record

A man was arrested on suspicion of burglary in the area of a neighbouring force. He said he was depressed and suicidal, so he was put on half-hourly checks. Later that day he was transferred to a police station of the neighbouring force and copies of the custody record and PER (Prisoner Escort Record) created by the detention officer at the first force were passed on with him. The custody record showed that he was depressed and suicidal and also that he had been seen by a psychiatric nurse while in custody. The PER, however, indicated there were no known risks as regards self-harm. This PER was then used and added to throughout his detention.

On arrival, he denied being depressed but the second force did not pick up the discrepancy between this and the custody record, although the Custody Officer did record an old attempt at self-harm on the PER. The next day the detainee was charged and refused bail and the day after that he was handed over to a prisoner escort service for transport to court. On his return to police custody, he denied previous suicide attempts and, again, the discrepancy between this and the information in the custody record was not picked up. Inspectors reviewing his detention did not notice the failings in the PER.

Later that morning he removed all his clothing and told an officer he had nothing to live for. Observation was increased to every 15 minutes but reduced to 30 minutes when he was calmer. None of this was recorded in the PER. The next day he was due in court and was handed over to the prisoner escort service with the PER.

He was remanded into prison custody and the prison used the PER to make its own risk assessment. A nurse who saw him assessed him as low risk. Two days later he was found dead in his cell. He had killed himself.

No attempt was made following his death to secure CCTV footage at the first police station. At the second station the wrong footage was secured.

Key lessons are the need for a clear policy on and adequate training - with an emphasis on practical exercises - in the purpose and use of the PER; Custody Officer, not detention officer, to be responsible for completion and review; training for inspectors to include review duties; custody manager responsible for securing CCTV footage.

[Click here for a link to the full learning report](#)

2.6 All risks to be recorded on transfer

A man on medication for depression and with a history of self-harm was arrested and detained for theft. He was assessed as needing constant supervision and an FME called. He told the FME that he 'would be better off dead'. The FME assessed him as high risk and this form was attached to the custody record. But the next day the Custody Officer, without further medical advice, cancelled the constant supervision.

Later that day he was handed over, with the Prisoner Escort Record (PER), to a company for escort to court. The escort officers already knew something about him from previous contacts.

The PER identified drugs and self-harm as risk factors but did not include the medical assessment or other risk factors identified on the custody record. Nor did it include the warning markers 'suicide', 'drugs' and 'offends on bail' on the Police National Computer (PNC). The officer completing the PER had not been formally trained in completing it and was unaware of force policy on PERs or discussions about it at shift meetings.

The CCTV system at the custody suite did not record constantly and the sound was poor quality.

The man was taken to prison from court and, on his fifth day there, he was found dead in his cell. He had killed himself.

Key lessons are the need for escort services to record incidents and feed them back to their own staff and police; for prisons, and possibly escort services, to use the PNC when assessing risk; all custody staff to be aware of force procedure on PERs and trained in their completion; Custody Officer at time of handover of detainee to be responsible for ensuring PER is complete and all relevant documentation is attached; those absent from team meetings to be sent minutes and advised of any important issues; risk assessments by a doctor not to change without further medical advice; need for adequate CCTV coverage.

[Click here for a link to the full learning report](#)

2.7 Police cell not for the mentally ill

A man was arrested when he used a set of shears to threaten the man living with his ex-partner. He showed signs of mental disorder when he was taken to the police station; a psychiatrist diagnosed a mental illness and the paperwork was prepared to section him that day. The police tried without success to find a high dependency bed for him.

He was bailed the next morning because he was not fit for interview. However, the force could not release him because they were advised he was a danger to the public and over the next three days the police made strenuous efforts to find a bed for him. They approached first Social Services and the local mental health Trust, then other providers, trying to deal with their sometimes conflicting requirements, but no bed was available. Two officers on their rest day were brought in to monitor the man's welfare; the local Trust first promised a nurse would care for him at the station but this offer was then withdrawn a couple of hours later.

On the fourth day, the force instructed their solicitor to apply for judicial review. A bed then became available, but by then the amount of time the man had spent in the cell amounted to unlawful detention.

Key lesson is for a protocol, backed up by an effective working partnership, between the force and the local health service to ensure people with mental health problems receive appropriate care while under investigation.

[Click here for a link to the full learning report](#)

2.8 Acknowledging mental vulnerability

A young man of 18 was arrested on suspicion of criminal damage. Officers failed to record indications/concerns that he was mentally vulnerable and did not include them in the request made for a medical examination. The same had happened on the seven occasions he had been detained previously - no warning markers had been recorded on the PNC or entered on the custody record, despite there being similar concerns.

He was not treated as needing an appropriate adult, despite information from a social worker and his mother suggesting he did. He tore up his tracksuit bottoms, so he was given a paper suit and, when he was released without charge, he was still wearing this. Police contacted a social worker as he could not return to his home, but Social Services indicated they were unable to help with accommodation. Subsequent calls from him to the police station were treated as nuisance calls. He was arrested the next morning when he was reported as brandishing pieces of concrete and wood in a shopping centre and, after assessment, he was detained under the Mental Health Act.

Suggested practice: The force now keeps 'street clothing' at the station, to avoid having to issue paper suits to vulnerable people.

Key lessons are the need to document mental health concerns/risks fully - in any request for a medical

examination, on the custody record and on the PNC - and the need for close working arrangements with local social and housing authorities to meet the needs of vulnerable adults in police detention (including the provision of appropriate adults and support on discharge).

[Click here for a link to the full learning report](#)

2.9 Overdosing in custody

The police were tipped off that a woman was dealing in crack cocaine from her house. They had had a stream of information over the previous three years that she was supplying hard drugs, as well as handling stolen goods, though no drugs had been found on searches of the property. They had also been told that she hid drugs in her body when she needed to.

The police obtained a search warrant and forced entry to the house. It took them about a minute to find the woman. From her stance when found, they suspected she had been hiding drugs on her.

Only stolen goods, not drugs, were found at the house. She was arrested and, once at the police station, she asked to go to the toilet. When she used it she made a noise as if in pain. She was strip searched but no drugs were found and the officers involved asked for authority for an intimate search.

In the interim she was left unsupervised for brief periods and spent a lot of time under blankets. At one point she seemed to be moving something under the blanket. She was allowed to transfer her mattress when moving cells even though all the mattresses were the same. The doctor also left her alone briefly during the intimate search, which was only vaginal. No drugs were found on her, or in the room (which the police searched afterwards), and supervision ceased.

She was found in the early hours of next morning unconscious and bleeding from the mouth. She had swallowed a packet of cocaine - impossible to say when. This had ruptured and, resuscitation attempts failing, she died of acute cocaine toxicity. There was a delay in informing her family because the force was waiting for one of the two trained family liaison officers they had appointed to arrive.

CCTV was turned off immediately in order to secure the tapes, but this meant the scene was not monitored. Moreover, the six video recorders in the unit displayed different times and the sound quality was poor.

Key lessons are the need for intimate searches to be carried out at a medical facility - what this is to be clarified by BMA; custody record (and force's annual report) to contain details of search and all orifices should be searched unless the hiding place is known; detainee only to be advised of intimate search immediately before to limit opportunities to hide items; need for guidance on level of supervision and a new risk assessment after intimate search; CCTV to be reliable, with times aligned with the speaking clock, and policy on switching off recording should allow for monitoring of the scene; mouth to mouth kits

to be considered for issue to all custody staff and training given in resuscitation; need for family to be informed immediately.

[Click here for a link to the full learning report](#)

2.10 Keeping custody records up to date

A woman who had failed to appear at court on drink driving charges was arrested and detained at the police station. She was drunk when booked in and told the police she was on methadone for a previous drug habit and diazepam because she was an alcoholic. She had two diazepam tablets on her. The arresting police officers thought these were black market pills, but did not advise the Custody Officer and this was not therefore entered on the custody record. The pills were sealed with her property.

She was placed in an ordinary cell for a few minutes before transfer to a cell for intoxicated detainees but this was not recorded on the custody record. She was to be visited half-hourly and this was recorded on the whiteboard facility within the electronic custody record. It was removed from the whiteboard an hour later when her condition had improved. The whiteboard does not, however, save information or time entries meaning that when the custody record is printed the entries made on the whiteboard are not recorded.

The FME had assessed her as fit for detention, but not for interview for three to four hours. He had prescribed a methadone substitute and the two diazepam tablets. The custody assistant was alone when she gave her the tablets, though best practice requires two people to be present.

The sound was not working on the CCTV at the custody suite. She was checked regularly through the night. But when the custody officer checked about 8 o'clock in the morning she had stopped breathing and when a paramedic arrived he pronounced her dead. She had died of alcohol and drug poisoning.

Key lessons are the need to record all significant information in the custody record, including information put on the whiteboard facility; CCTV should be fully operative; medication to be dispensed in pairs; medication in detainee's possession to be placed in medical bags.

[Click here for a link to the full learning report](#)

2.11 Rousing detainees

A man suffering from depression, alcoholism and complaints associated with drug abuse had been drinking and went into a shop with a large knife in his hand. He was arrested for possession of an offensive weapon and detained. At the custody suite an officer described on the property sheet a prescription he had on him simply as "prescription" without recording that it was a repeat prescription for, among other things, drugs for depression or telling the Custody Officer this.

Although the detainee smelt of alcohol he was calm, compliant and fully co-operative and a decision was made not to call a doctor. He was placed on half hourly checks because he had

consumed alcohol and methadone. The instructions were written on a white board which was a clear indication the Custody Officer considered him to be at risk but the Custody Officer overlooked the need to record this assessment.

He was checked five times over a space of two hours. On each occasion the civilian detention officer spoke to him, putting him in the recovery position if he was on his back. Sometimes the only response he got was an audible groan or 'I'm fine'. However, the PACE codes were updated in 2004 to require such checks to include an answer to questions such as "what is your name" and asking the detainee to lift an arm. The civilian detention officer was not aware of these requirements.

On the sixth visit the civilian detention officer found him lying face down. Officers tried without success to resuscitate him and an ambulance was called, but shortly after the paramedics arrived he was pronounced dead. He had died primarily from the combined toxic effects of alcohol, methadone and drug abuse.

Key lessons are to draw attention to the possession of a repeat prescription to enable the Custody Officer to consider the effects of alcohol/drug combinations; complete custody records to show where a detainee is at risk; staff to be informed of PACE code updates/legislation; importance of officers being aware of the risks of methadone and alcohol combination.

[Click here for a link to the full learning report](#)

2.12 When to get a doctor in

A homeless man was arrested for being drunk and incapable and taken into custody. He was known to Social Services and had been arrested several times before.

When he was booked into custody, this was not supervised by a Custody Officer as required by PACE codes of practice. He remained in custody for nearly 12 hours and was roused every half hour. However, he was not seen by a doctor although force policy was to call one if a detainee who was drunk showed no signs of improvement after four hours.

His trousers had been changed when he was booked in as they were wet. On release, he was given his wet clothes back in a bag and a pair of 'slippers', as he had no shoes when arrested. The custody record showed he had been told his rights and cautioned before he was released, but this was not the case.

The clocks on the CCTV cameras recording his detention were wrong and the quality of the recordings was poor.

He was found dead in a park the next day. The likely cause of death was heart disease.

Key lessons are the need for medical help for people found drunk and incapable; information on rights should only be withheld from drunk detainees in exceptional circumstances; suitable stocks of clothing to be stored at custody suites; need for leaflet on hostel/shelters for homeless people on release;

need for suitable training/refresher training for custody staff; custody records to be monitored for compliance with PACE codes and force policy; CCTV to be upgraded.

[Click here for a link to the full learning report](#)

2.13 Getting medical needs right

A homeless alcoholic, arrested on suspicion of stealing a bottle of spirits, was charged and bailed. He was on chlordiazepoxide to help him stop drinking and, on release, he went to his GP who gave him a prescription for 90 tablets to be taken over a period.

Two days later he was found collapsed and semi-conscious in the street with a one third full bottle of Vodka in a bag with his medication. He was taken to hospital, examined and kept under observation for a few hours, then shown out of the hospital, with his bag, and told where the bus stops were.

He stayed outside the hospital drinking and, when he became obstructive, the police were called and he was arrested for being drunk and incapable. At the custody centre he could not walk without assistance and was unsteady even when sitting. Nor did he respond to questions. He was searched and put in a cell.

The FME who examined him there concluded he needed constant supervision and rousing every 15 minutes. Neither instruction was referred to in the custody record. It was not clear whether the doctor had told custody staff of these requirements - the custody staff did not check with him what they were. Nor was it clear whether the FME knew of the chlordiazepoxide the detainee had in his bag.

The detainee was observed through the cell hatch not more than twice in the next 95 minutes and he was not roused. Only when an inspector looking at camera images from the cell spotted that he was not moving did an officer go into the cell. By this time the detainee was dead, due to the effects of alcohol and chlordiazepoxide, combined with chronic alcohol abuse.

Over two hours footage was missing from the CCTV tape recording the charge area, as it did not have a warning buzzer when it was not recording and the tape had not been fully rewound when inserted.

Key lessons are for anyone unresponsive to be taken to hospital for medical examination; the need for the FME and Custody Officer to discuss any medical requirements/needs and record the discussion on the custody log (to be signed by both); video tapes must be checked to ensure they have been fully rewound prior to use.

[Click here for a link to the full learning report](#)

2.14 Secure waiting room not a cell

A man arrested for drunk driving in the early hours of the morning was taken to a custody centre, where he was assessed as intoxicated and therefore needing to be checked every half hour.

At the time there were 35 other detainees for the 36 cells in the custody centre. The Custody Officer decided to keep one free for any violent prisoners there might be and decided to place him in one of the two secure waiting rooms at the centre for four hours. There was a toilet at the back of the secure waiting room used which had several points from which detainees could hang themselves. Some items were taken from him for safe keeping before he was taken into the secure waiting room, but not his shoes, shoe laces or coat.

About three hours later the custody assistant noticed that the detainee was not in the secure waiting room. The custody assistant went into the toilet and found the detainee lying on the floor unconscious. He had a shoelace round his neck. He was not dead, however, and subsequently made a full recovery.

Key lessons are the need to remove door closers on the inside of toilet doors in custody centres; not to use secure waiting rooms as cells; not to allow shoes, ties, belts or cords from clothing in cells

[Click here for a link to the full learning report](#)

3. Recurring Issues

The cases in this bulletin concern the handling of people in custody, either at the police station/custody centre or on the way there. Some of the investigations date back to 2004 but some have only just concluded. These cases - chosen for their significant lessons for policing - represent only a small proportion of all investigations concerning custody. There were 64 deaths in custody between April 2004 and March 2006, which were all investigated either by the police or by the IPCC and there are likely to have been a far greater number of investigations into custody where there was no fatality.

Significant progress has been made in recent years in improving custody practice. The Safer Detention and Handling of Persons in Police Custody Guidance (the Guidance), identifying the standards expected in the handling of people who are arrested and detained, was introduced in 2006 to complement PACE and ACPO and NPIA are currently working with forces to implement the Guidance and help ensure they comply with the standards. A national custody training programme, based on the Guidance, was launched on 8 January 2008 and is available to all forces via the National Centre for Applied Learning Technologies (a collaboration between NPIA and the Metropolitan Police Service which assists forces in adopting new learning technologies).

Some issues still crop up with frequency, however, and this section outlines the most common of these.

Risk Assessments

As in the first bulletin (on domestic violence) failings in risk assessment figure prominently:

- Where a doctor assesses a detainee as at risk of self harm, the detainee should not be reassessed as not needing supervision without medical input
- Custody staff needed to be aware of the dangers of methadone
- Officer carrying out a visual risk assessment was not supervised by the Custody Officer

Record keeping

This picks up a recurring theme in the last two bulletins and once again was a factor in several cases:

- Information and time of entries are not saved on whiteboard facilities on custody IT systems
- No arrangements were made to minute team meetings/briefings
- Mental health concerns were not documented on the custody record
- The name and number of a telephone caller allowed to speak to a detainee were not recorded
- Risk assessments needed to be recorded and warning markers should have been entered on the PNC
- Custody IT system should be able to record who is making entries
- Doctor's instructions not entered on the custody record

Specific issues arose around completion of Prisoner Escort Record forms. The Guidance emphasises the importance of the form and its completion where a detainee is escorted to another police station or elsewhere, a court cell or prison, for example. In two cases forms were not properly completed when handed over to those receiving the detainee. It appeared that officers had not been trained in completing the forms and responsibility for their completion needed to rest with the Custody Officer.

A revised Prisoner Escort Form is currently being piloted in two areas, by HM Prison Service and the police service respectively. Subject to evaluation when the pilot is complete, the new form will be rolled out nationally later this year.

CCTV

CCTV was an issue in most of the cases:

- Coverage and quality of image were not adequate
- Where there were different CCTV recordings in a custody suite, they needed to be synchronised
- CCTV evidence was not secured properly
- The sound was poor or not working
- CCTV tape not rewound fully so the tape ran out and there was no record of a period that was relevant

Training

Lack or inadequacy of training was at the root of many of the problems:

- Officers involved in custody duties had had no training in their responsibilities
- There was no pass or fail marking in training so it was unclear how custody competency was monitored
- No refresher training was provided after the initial training and custody staff were unaware of changes in the law affecting their role

Handling detainees with mental health issues

Some of the most serious cases revolve around mental health. Responding effectively to people who have mental health issues presents very real challenges for the police and is a significant factor in increasing risk to a detainee.

- Need to record and communicate concerns over mental health
- A police cell is not a safe and appropriate place for a person with mental health problems

Handling Medication

Detainees sometimes have medication with them and it is important there are effective systems in place to record, dispense and store this. Failings in handling medication were a feature in two cases:

- It was not recorded that medication had been obtained on the black market
- Medication was dispensed by a single officer rather than in pairs as provided in the Guidance
- A repeat prescription for anti-depressants was not drawn to the attention of the Custody Officer

Rousing

PACE Code C, Annex H came into effect on 1 August 2004 and elaborated on what a custody officer must do to rouse a detainee, including asking them to give their name and lift an arm. In one case officers failed to do this and other concerns were identified:

- Update training on changes in legislation and practice was not provided to custody officers and staff
- A detainee identified as drunk was not checked every half hour as required by PACE Code C

Taking risk items from detainees

Items that put detainees at risk should be removed and when a decision has been made to take items from a detainee it is important to record and securely store them:

- In one case, a scarf was accidentally returned after being removed and used by the detainee to hang herself (similar to a case featured in the last bulletin)
- A detainee was not searched on arrest and left alone in the police van with matches on him
- Another detainee not searched on arrest poisoned himself in the police car

Clear understanding of responsibilities

The Guidance warns that clear lines of responsibility and accountability must be established for the supervision and management of custody staff, custody suites and detainee and provides that where multiple Custody Officers are on duty it is essential that each is aware of their individual responsibilities.

- In one case this clarity was lacking, as the sergeant responsible for bail took on the role de facto of the Custody Officer during quiet periods
- Training needed to
 - Reflect the importance and relevance of the Prisoner Escort Record and the responsibilities of the Custody Officer
 - Increase knowledge of PACE
- Designated first aid trainers needed to have sufficient and up-to-date training
- Staff involved in transporting detainees needed training in the risks involved in transporting vulnerable and restrained detainees

Transporting detainees safely

The Guidance provides that detainees should not be left alone and unsupervised in vehicles, as an officer needs to be able to observe and monitor the individual and react to any situation which may arise.

- A detainee was left alone in the back of the police van, still in possession of matches
- A detainee was put on his own in the back of a police car and poisoned himself

Many of these issues are reflected in the experience of the Prisons and Probation Ombudsman who, where non-police custody is concerned, has a similar role to the IPCC in relation to deaths. In the course of investigations into deaths in custody within the prison service over the last four years, the Ombudsman has made a variety of recommendations - running to several hundred in total - on training, record keeping, communicating risk factors, medication and the mental health services.

An inspection into police custody jointly led by HMIC and HM Inspectorate of Prisons is planned for 2008/9. Three pilot inspections have been carried out which will inform the development of an inspection framework and the findings fed back to the individual forces. The scale of the inspection is yet to be determined.

4. Suggested Practice

Street Clothing - Summary 2.8

Since this incident, the force has ensured that custody officers will now have access to 'street clothing' comprising tee shirt, jogging bottoms and slip on plimsolls to reduce the risk of a detainee being released in a paper suit.

You can access the bulletin and related learning reports on the Learning the Lessons Committee website at www.ipcc.gov.uk/learning

If you have any enquiries about the Learning the Lessons Committee or the cases in this bulletin, please contact the IPCC on learning@ipcc.gsi.gov.uk

Bulletin 3 February 2008

Custody

This bulletin focuses on the detention of people in police custody. In addition to containing summaries of cases it highlights the major issues in those cases and provides a brief analysis of the common factors.

These cases have been chosen because they provide learning opportunities for other police forces facing similar situations and may help them improve their policies and practices. They were selected from independent, managed and supervised investigations.

A link is provided from the case summary to the full report, but you may find that access to it is limited at present. This is because there are proceedings or an inquest pending which mean the report cannot be made fully public at this stage. Names have been anonymised in the learning reports to make it possible to circulate them more widely.