LEARNING THE LESSONS

ASK YOURSELF: Could it happen here?

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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?"

Bulletin 29

31 March 2017

Custody

Issues covered in this bulletin:

Custody and detention — Cases 1–9

Mental health — Cases 4, 7

Personal safety — Case 4

Professional standards — Cases 2, 6

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Foreword

This bulletin sets out learning from cases covering a range of issues. These include self-harm, sudden illness and hidden injury within the custody setting. Some of these issues were raised in bulletin 23, published in March 2015. In particular, the supply of relevant information to custodial providers, adequate risk assessment and appropriate rousing.

The custody environment is dynamic and high pressured. Custody officers and staff are responsible for reviewing and monitoring a significant number of people, with differing needs, risks and vulnerabilities. This is often a complex balancing act between ensuring the smooth running of a busy custody suite and effectively delivering the care required to ensure people's health and wellbeing. Especially those who may be unwilling, or unable, to provide the information needed to identify risks and deal with their needs effectively.

The cases in this bulletin reflect circumstances that will be immediately familiar to those who work in custody.

The learning from our investigations feeds into, and draws from, the development of best practice and guidance by other policing bodies. This includes the National Strategy for Police Custody, launched by the National Police Chiefs' Council in January 2017, the Expectations publication produced in 2012 for the joint police custody inspections carried out by Her Majesty's Inspectorates of Prisons and Constabulary, and the guidance developed by the College of Policing. Together they aim to provide a consistent approach that safeguards the most vulnerable while recognising the particular challenges of the police custodial setting.

Rachel Cerfontyne
Deputy Chair

Tom Milsom
Associate Commissioner

Case summaries

1 Concealment of items prior to detention in custody

An officer responded to a report of theft in a shop and arrested a man. The man was having difficulty standing and appeared to be drowsy. The officer searched the man and asked him what he had taken. The man told the officer he had taken heroin. Two other officers attended and took the man to custody.

On arrival, the man was struggling to stand and was unresponsive to questions asked by the police sergeant at the custody desk. A forensic nurse practitioner arrived. The man was unresponsive to a number of questions asked by the nurse.

The nurse decided to give the man medication to reverse the effects of the drugs he had taken. He was led, supported on each arm, into the medical room.

At about 2.30am, an ambulance was called, following a request from the nurse. About ten minutes later, paramedics arrived. At this stage, the medication, which can cause aggressiveness, began to have an effect on the man.

The man began standing up and swearing. He refused to go with the paramedics or to have any medical observations carried out.

The man was taken back to the custody desk. He tried to walk away and made threats to an officer when he was asked to stand still. Two other officers escorted the man, who had been placed in a restraint position, to a cell. His clothing was removed.

The nurse advised the sergeant that the man should be placed in a cell with a CCTV camera, and that he should receive rousing checks every 15 minutes. The sergeant said later that, in his opinion, healthcare professionals (HCPs) do not understand the required levels of observation set out in the Police and Criminal Evidence Act 1984 (PACE).

The door of the man's cell was closed. He stood up and threw items (a lighter and tobacco) at the cell door. Officers believe that these items may have been hidden between the man's buttocks. The items were removed from the cell.

The sergeant at the custody desk said later that he did consider if other items might be concealed and if a strip search might be required. However, he did not record these considerations.

Shortly after 3am, the nurse saw the man on a CCTV monitor behind the custody desk. She said he should be on his side as he appeared to be on his back. It was confirmed later that the CCTV system does not allow officers to monitor cells that have CCTV without losing the views of other areas of the custody unit.

The nurse and a number of officers entered the cell and moved the man onto his side. The nurse saw a package fall from his buttock area. There was blood on the man's buttocks. There was also a plastic bag inserted in his anus.

The nurse was unable to rouse the man and an ambulance was called. The paramedics arrived to find the man unresponsive, but breathing. He was taken by stretcher to the ambulance and to hospital. Four days later, he returned to custody.

One of the sergeants during this period can be seen on CCTV playing a game on his mobile phone. It was explained that officers take informal breaks in custody rather than formal breaks away from the custody desk.

Key questions for policy makers/managers:

- Does the CCTV system used in custody suites allow officers to monitor cells that have CCTV without losing views of other areas in custody?
- What steps does your police force take to make sure that those working in custody can take formal breaks away from the custody desk?
- What action does your police force take to check that custody healthcare professionals HCPs understand the different levels of observation set out in the Police and Criminal Evidence Act 1984 (PACE)?

Key questions for police officers/staff:

- If you work in custody, in what circumstances would you consider there was a need to carry out an intimate search of a detainee?

Action taken by this police force:

- The force reviewed how CCTV in custody could be used to monitor vulnerable detainees.
- The force has provided guidance to all healthcare professionals (HCPs) on the levels of observation set out in PACE.
- Staff in custody no longer take informal breaks.

Outcomes for the officers/staff involved:

- The custody sergeant and sergeant who removed an item from the man's cell received management advice and an action plan on decision-making and recording decisions. This was due to the lack of discussion or recording of the decision not to intimately search the man.

Click here for a link to the full learning report

2 Illness following unsupervised detention in custody

PSD

At about 10.20am, three police constables and a police community support officer (PCSO) went to an address to make arrests for shoplifting. At 10.25am, a woman and two men were arrested. While supervising them, one officer saw the woman, and one of the men, open blister packs and put capsules in their mouths.

The officer asked what they had taken and was told it was medication. The officer told them they should not take anything else. The other man, being supervised by a second officer, also took some tablets, saying this was prescribed medication.

The officers and the people they had arrested left the flat. The second officer performed a 'pat down' search of one of the men before they got in the police car. The other two detainees were not searched. No evidence was collected about the tablets that had been swallowed.

At about 11.30am, the officers and the people they had arrested, arrived at the police station. The officer who had arrested the detainees escorted the woman and one of the men to the custody suite and told them to sit in the first of two holding areas. The woman had her handbag with her.

The arresting officer gave the custody sergeant details of the arrest, but did not say that those arrested had taken tablets at home before being taken to the police station. While supervising the detainees in the first holding bay, both the first and

second officers used their personal mobile phones. The CCTV watched later showed that the woman and the man put something in their mouths. When the arresting officer was asked to help search another woman detainee, the other officer was left on his own. The CCTV, which was viewed later, showed the woman taking something from her handbag and putting it into her mouth. The officer believed the PCSO was watching the woman, although this is not the role of a PCSO.

A detention officer (DO) saw the PCSO standing outside the holding bay. The DO spoke with the woman detainee and brought her a cold drink and cereal bar. The DO was not aware that the force policy did not allow PCSOs to enter the custody suite or to supervise detainees before they are booked in, or that food and drink should not be provided to a detainee before being booked in.

The DO decided that the woman detainee was not behaving normally and was falling asleep. The DO notified the custody sergeant who decided she should be taken to hospital. At about 1.30pm, the arresting officer drove the woman to hospital.

There was a change of custody staff because a shift ended. The HCP told an officer that the woman's rapid deterioration must be due to taking something after leaving her home.

The new custody sergeant was informed that the woman and one of the men may have taken tablets while in custody. The new custody sergeant watched the CCTV footage. This showed the woman and the man swallowing something while in the first holding area.

The new custody sergeant told the custody inspector, who had started a shift at 4pm. The inspector authorised a strip search of both men. When the woman returned to the police station from hospital at about 5.10pm, the inspector also authorised a strip search of her.

As a result of the strip search the officer found a plastic bag containing tablets hidden in the woman's bra. At about 5.20pm, the woman was further arrested on suspicion of possessing a controlled substance. She was released on bail. The two men were released. No further action was taken in relation to their arrest for shoplifting.

The IPCC received a referral from the force five days after the incident. Deaths or serious injury matters (DSIs) must be referred to the IPCC without delay, and in any case not later than the end of the day after the day it first becomes clear that the matter must be referred.

Key questions for policy makers/managers:

- What steps has your force taken to make sure that the professional standards department (PSD) refers relevant matters to the IPCC without delay?
- Does your force provide clear guidance on when police officers and staff can use personal devices at work?
- How does your force make sure that people working in custody are aware of their responsibilities for detainees before they have been booked into custody?
- Does your force provide officers and staff with clear guidance about who is allowed into the custody suite to perform specific roles, such as monitoring detainees? If so, how do you make sure that this guidance is followed?

Key questions for police officers/staff:

- Are you clear about who is, and is not, allowed into custody areas, and their roles?
- If you work in custody, are you aware of your responsibilities for detainees brought into a custody suite before they are booked in?
- Following an arrest, do you know when it is appropriate to conduct a search of a detainee? And when the possessions of a detainee should be seized and retained?
- Do you make sure that you provide all relevant details to the custody sergeant when booking in a detained person?

Action taken by this police force:

- Custody supervisors were reminded to identify and report all death and serious injury cases.
- Custody staff and managers were reminded that only those with a legitimate reason should be present in the custody suite.
- All officers and staff were reminded that the responsibility for a detainee remains with the arresting or escorting officer until the detainee is accepted into custody.
- Training and guidance have been provided to remind officers to pass on all relevant information about the detainee to the custody officer.

- Staff and officers were reminded about the importance of supervising detainees – in particular, those being held in holding areas before a thorough risk assessment has been completed.

Outcomes for the officers/staff involved:

- The officer who arrested the woman and two men was subject to misconduct proceedings. The officer who supervised the women and one of the men in custody was subject to misconduct proceedings. These related to their failure to search and retain items from the detainees. No further action was taken.
- The detention officer was subject to management action in the form of refresher training on the provision of food and drink to detainees.

Click here for a link to the full learning report

3 Completing Person Escort Records

A man was stopped and searched following a report that he was acting suspiciously. Officers found a blister pack of pills, which the man said was his medication, and allowed him to go on his way.

About two hours later, the man was seen acting unusually outside a police station. The man was known to the PCSOs.

Concerned by his behaviour the PCSOs took him to the local police enquiry office. The man sat in the enquiry office. He appeared to be asleep and could not be roused.

Officers were concerned for the man's wellbeing and an ambulance was called. When it arrived, the man refused assistance and paramedics left him in the care of officers.

When the station was about to close, officers spoke to the man to ask him to leave, but he was unresponsive. The PCSO called for assistance and two police officers attended the police station. At 9.55pm, the officers took responsibility for the man.

One of the officers contacted the custody sergeant at a nearby custody suite to ask if the man could be brought into custody for disorderly conduct. Based on the behaviour described to him, the custody sergeant advised that the man should be taken to hospital.

The Authorised Professional Practice (APP) guidance on arrest, detention and transportation, and the force custody operations manual, state that a detainee is taken directly to hospital if they are, or have been:

- unconscious
- believed to have taken a drugs overdose
- suffering from any other medical condition requiring urgent attention
- suffering any condition that the arresting officer or transporting staff believe requires treatment prior to detention in custody

An ambulance was requested. Officers attempted to rouse the man. They moved him outside as the station had closed. The man became more responsive and said he wanted to leave. However, an officer persuaded him to wait until he had been seen by ambulance staff.

The man was placed in the back of the ambulance but became aggressive and verbally abusive towards the police. Paramedics were unable to examine him.

He was removed from the ambulance. He resisted and was restrained and arrested for a section 4 public order offence. The man was handcuffed with his hands behind his back. He began to spit at the officers and lash out with his legs. Leg restraints were applied and a police van was called to take the man to the local custody suite.

Officers searched the man after he made a threat to kill himself and claimed to have a knife. Officers found a blister pack containing eight yellow tablets. A knife was not found.

The man was handed over to officers in the police van, and taken to the custody suite. On arrival, one of the leg restraints was removed and the man was helped to walk to custody. The man's movements were slow and erratic.

The custody sergeant accepted the man into custody because he was now responsive and could

talk and walk. He became aggressive. He was taken straight to a cell where he was searched. The custody sergeant tried to carry out a risk assessment and confirmed there were no injuries.

The man became drowsy and told the custody sergeant that he had taken 30 sleeping tablets. One of the officers who had stopped and searched the man at 6:50pm noted that the tablets were not the same as those found on the man earlier in the day.

An ambulance was called. When paramedics arrived, they examined the man and gave him an anti-narcotic drug.

The custody sergeant should have completed a Person Escort Record (PER) form for the man, and this was not done. College of Policing APP guidance on arrest, detention and transportation says that PER forms should be completed and accompany a detainee who is moved from a custody suite. This includes taking them to a hospital.

Two officers stayed with the man when he went to hospital, and remained with him throughout his stay. The man was discharged from hospital a few hours later, and was taken back into police custody. He was still unable to walk and an officer had to use a wheelchair to move him.

The man arrived back at custody around 3.30am. The custody sergeant asked the forensic medical examiner (FME) to examine him as he still appeared unwell, but the man was too drowsy for a standard examination.

The FME decided to allow the man to sleep, while observed by officers. Less than ten minutes later custody staff asked the FME to re-examine the man. The FME asked for the man to be taken to hospital immediately.

The man was admitted to hospital where he remained under arrest. Police officers stayed with him at the hospital. He was discharged and escorted back to the police station at about 11.00pm, having made a full recovery.

Key questions for policy makers/managers:

- What steps has your force taken to make sure that staff are kept informed about the latest Authorised Professional Practice guidance?
- What guidance have you given to officers about their responsibility to complete the Person Escort Record (PER) form?

Key questions for police officers/staff:

- Are you aware of your responsibility to complete the PER form?
- Do you know when detainees should be taken to hospital immediately, rather than being taken to a police station?

Action taken by this police force:

- Authorised Professional Practice (APP) guidance on arrest, detention and transport is now referenced in custody refresher training and a regular training day will be arranged.
- All force policies are now fully compliant with APP guidance and a link to APP guidance is posted on the force intranet in the custody pages.
- PER forms are audited monthly by custody inspectors. The officers who complete them receive feedback.

Outcomes for the officers/staff involved:

- The custody sergeant was subject to management action for failure to complete the PER forms, and an entry was made on their personal development record.

Click here for a link to the full learning report

4 Self-inflicted injury following police restraint

Shortly before 11.00pm, two police officers attended an incident at a train station where a man was being threatening and verbally abusive. When the officers arrived, the man was with a paramedic and station staff. The members of staff had been unable to remove the man from the station.

The officers identified themselves to the man, who was speaking on a phone in a foreign language and did not respond. One of the officers called for further assistance. The other officer asked the man

to end his call and was met with a response the officer found aggressive. Further officers arrived and the man was arrested for a public order offence at approximately 11.20pm.

Following his arrest, the man attempted to walk away from the officers. One of the officers took hold of his left arm to prevent this. He became aggressive and shouted for help. An officer placed the man's left hand in handcuffs but, due to the man's strength, was unable to secure his right hand in the handcuffs.
The officers lowered the man to the ground and he was handcuffed to the front. He was then escorted out of the station. He continued to struggle and shout. On leaving the station, he tried to run into the road. Officers brought him back to the pavement. They decided to again take him to the ground.

One of the officers called for a police van to take the man to custody. The van arrived and the man was put in leg restraints. Following the incident, the officers should have completed a use of force form, but did not do so.

The man remained unco-operative and was saying, "They are trying to kill me," in English and speaking in another language.

The officers recognised the man was suffering from mental health issues and agreed he should be taken to a place of safety. At about 11.30pm, he was de-arrested and sectioned under Section 136 of the Mental Health Act.

The man was told he would be taken to hospital and receive medical care. It was decided that he should be taken in a caged police van. Due to his erratic behaviour it was thought impractical to have the man detained on the floor while waiting for an ambulance.

A further two officers arrived and helped to put him in the rear cage. He continued to be aggressive and strongly resisted being put in the van. When secured in the caged area, one officer sat in the rear of the van to watch the man.

The leg restraints had been removed. He was kneeling in the caged area of the van and head-butted the edge of one of the seats repeatedly. An officer called for assistance from the two officers at the front of the van. He then approached him to try to prevent him continuing to injure himself.

At approximately 11.36pm, the man was removed from the van and placed on his side. He continued to try to injure himself and officers restrained him. One officer tried to provide first aid and found the medical kit in the vehicle was not fully stocked. The man then started hitting his head on the ground. His head was bleeding. One of the officers called an ambulance.

Additional officers arrived, including a medically trained officer and an officer wearing a body-worn camera. The officers tried repeatedly to reassure the man and to consider how best to protect his head, which he continued to try to injure by banging on the ground.

At about 12.10am, four paramedics arrived and took over care of the man. Ten minutes later, he was taken to hospital by ambulance, with three of the police officers. On arrival at hospital, the police officers provided a briefing to a consultant and psychiatrist.

The man was discharged later that day to attend a psychiatric assessment.

Key questions for policy makers/managers:

- Who in your force is responsible for ensuring that medical kits on response vehicles remain fully stocked? How is this monitored?
- Does your training on use of force include information on the importance of accurately recording use of force on those who have been arrested (including those detained under section 136 of the Mental Health Act 1983)?

Key questions for police officers/staff:

- If you were required to use force when detaining someone, are you aware how this use of force should be recorded?
- Do you have responsibility for medical kits on response vehicles? If so, how do you ensure that these kits remain fully stocked?

Action taken by this police force:

- The force learning and development department has been reminded to stress the importance of accurate recording in use of force training.
- All those in charge of police posts and all drivers have been reminded about the

importance of ensuring that medical kits are fully stocked.

Outcomes for the officers/staff involved:

- There were no disciplinary or criminal outcomes for any of the officers involved in this case.

Click here for a link to the full learning report

5 Care of a man in custody

A man was arrested for being drunk and disorderly after a resident reported that he had asked for help and become aggressive.

The resident believed that the man had fallen over. The man thought that his drink had been spiked when he had visited a pub earlier that evening.

On arrival at the police station, the man was met by two custody detention officers and escorted to the custody desk. The man was heard to say that he had a broken jaw and that he wanted to spit blood.

Due to his aggressive behaviour, and what was believed to be his intoxication, the man was taken to a cell before the booking in process and risk assessment were completed.

The custody detention officers did not tell the custody sergeant that the man claimed to have a broken jaw.

A risk assessment was completed in the man's absence, and no injuries were recorded. The custody officer answered 'yes' to a question about whether the detainee was drunk.

Due to a computer error the custody officer did not complete the second part of the question on the risk assessment, which asked if medical assistance was required.

The man was placed on 30-minute checks. A HCP was not asked to attend. Over the next few hours the man was checked regularly and provided with a drink and a blanket.

Several hours later, while being checked, the man again complained that his jaw had been broken. Following an examination by a HCP he was taken to hospital where he was found to have a fractured jaw.

Key questions for policy makers/managers:

- Does your risk assessment ask the arresting officer and/or escorting officers if they have seen, or are aware of anything, that should be included in the risk assessment?

Key questions for police officers/staff:

- Do custody officers routinely ask the arresting officer and/or escorting officers if they know of anything that might be relevant to the risk assessment?
- Do arresting officers routinely provide all relevant information about a detainee to the custody officer for inclusion in the risk assessment?

Action taken by this police force:

- The learning recommendations were shared with custody staff to ensure all staff were aware of their responsibilities and the importance of information sharing in custody.

Outcomes for the officers/staff involved:

- The custody detention officers were dealt with under unsatisfactory performance procedures for failing to provide relevant information to the custody officer.

Click here for a link to the full learning report

6 Failure to refer complaint and DSI

PSD

A man was arrested at night by a roads police officer on suspicion of driving while under the influence of alcohol. He ran away from the arresting officer and hid in the gardens of a public house.

Following a search by a number of officers who responded to a call for assistance, he was apprehended and taken into custody where he complained of having been struck unnecessarily by a police baton to his neck and leg.

On arrival in custody, the man was booked in by the custody sergeant. The man's complaint was

recorded in the custody record. He was seen by paramedics and taken to hospital where he was diagnosed with a fracture to his neck.

No further action about the allegations of excessive force was taken by the custody sergeant. He should have referred the complaint to an inspector. He did not think the injuries to the man were serious. The custody sergeant went off duty before a diagnosis was received from the hospital.

The incoming custody sergeant updated the custody record with the hospital diagnosis. They noted that an inspector had been updated and would inform the on-call, out-of-hours PSD. They also arranged for a doctor to examine the man's injuries, and completed a Near Miss/Self-Harm Form. This was sent to custody services, the custody inspector and the PSD.

The man told a duty inspector that he wanted to complain about being hit with a baton, and about his injury. The inspector informed the PSD and reviewed the officers' statements about the arrest. No action was taken to seize all the attending officers' batons. An assumption was made that the duty inspector on the following shift would deal with this.

The in-coming duty inspector took no further action, other than to review the man's custody record. He had been told by the previous duty inspector that a referral to the IPCC had been completed and was with the custody sergeant.

The Self-Harm/Near Miss Form was emailed to the PSD on the day after the man's arrest. However, this was not seen for another day. The form was forwarded to a general enquiries mail box where it was placed in a completed folder. This is because near misses are not dealt with by the PSD.

This failure to look at the form meant that there was further delay in dealing with the matter. The incident was picked up and highlighted to the PSD almost a month later.

The chain of events, and failures to take early action at appropriate times, led to the loss of potential evidence, such as the officers' batons. Photographs were not taken of the injuries that officers said they had received.

Key questions for policy makers/managers:

- What guidance for custody staff do you have in place for referral of serious injury incidents, reported in custody, to the PSD?
- How does your force make sure that complaints made in custody are captured and followed up?

Key questions for police officers/staff:

- Are you aware of the criteria for referring a matter to your PSD?
- Are you aware of the IPCC mandatory referral criteria and what constitutes a serious injury?

Action taken by this police force:

- The force amended its deaths and adverse incidents in custody policy to provide clarity on the responsibilities of custody staff to report incidents directly to the PSD. This is in addition to notifying an appropriate supervisor.

Outcomes for the officers/staff involved:

- The original custody sergeant received management action to address his failure to record and refer the complaint and the incident to the PSD.
- The duty inspector's role in the incident was raised as a performance issue due to his failure to secure evidence and make a referral to the out-of-hours PSD.

Click here for a link to the full learning report

7 Appropriate adult

A woman was arrested at about midnight and taken to her local police station.

A custody sergeant booked her into custody and started the risk assessment. The woman became agitated, was shouting and refused to answer questions. There was a marker on her Police National Computer (PNC) record to show that she had a personality disorder.

The custody sergeant decided to remove the woman's clothes and provide her with a safety suit. The reason given was the woman was agitated and shouting.

The custody sergeant did not consider the possibility that the woman's behaviour may be due to her mental health condition. They also did not consider if an appropriate adult was required. In any event, the appropriate adult service was not available beyond 11pm. The service could not be guaranteed beyond 9pm.

College of Policing: Authorised Professional Practice. Mental health – detention. Appropriate adults

Whenever a custody officer has any suspicion, or has been told in good faith, that a suspect may be mentally disordered (as defined in section 1 of the Mental Health Act 1983) or otherwise mentally vulnerable, they must request an appropriate adult to be present.

The woman refused to undress or wear the suit. Her clothes were removed by women officers in a cell and she was placed on 30-minute rousing checks in a cell monitored by CCTV. A risk assessment was not completed at this point.

At 2.30am, the woman became difficult to rouse and was seen by a HCP. An ambulance was called. However, by the time it arrived the woman was responding normally and the paramedics left after speaking with her.

The HCP was unable to carry out an examination as the woman refused. The HCP recorded on the detention log that an appropriate adult was not required.

At 3.43am, the woman became unresponsive. An ambulance was called and she was taken to hospital.

The woman returned to custody at 8.03am. A new shift had started. The new custody sergeant completed a risk assessment and noted on the detention record that the woman had a personality disorder.

A HCP examined the woman's restraint injuries. Following a conversation with the woman about her wellbeing and her care plan, the HCP recorded that there was no reason to ask an appropriate adult to attend.

When asked if he had considered the requirement for an appropriate adult, the custody sergeant said that he had not done so because the woman presented well. He said she had told him she was up to date with her medication.

The woman complained that she was not provided with appropriate support. The matter was referred to the IPCC and we carried out an independent investigation.

Key questions for policy makers/managers:

- How do you ensure your staff recognise how the symptoms for mental disorders may affect behaviour (and may be mistaken for intoxication)?
- In a similar situation, at what point would an appropriate adult be called by your force, and who would take responsibility for doing this?
- Does your force have arrangements in place to provide 24-hour access to appropriate adults in all cases where they are required by the Police and Criminal Evidence Act 1984 (PACE), and the Codes of Practice?

Key questions for police officers/staff:

- Do you know when an appropriate adult is required as set out in PACE, and the Codes of Practice?

Action taken by this police force:

- The force now works with local authority partners to provide timely access to appropriate adults.

Outcomes for the officers/staff involved:

- There were no disciplinary or criminal outcomes for any of the officers or staff involved in this case.

Click here for a link to the full learning report

8 Suspicion a detainee had ingested drugs

Officers working with a neighbourhood policing team stopped a car because intelligence suggested that the driver was visiting the area to associate with drugs users.
One of the officers approached the passenger door and recognised the passenger as a known drug user. The driver of the car was searched, and officers found £100 in cash. A bag of cannabis was found in the car, which the driver admitted was his. Officers also found a mobile phone and a fizzy drink can in the centre console.

Officers were aware that it was sometimes the practice of drug dealers to keep a drink with them so they could swallow drug wraps.

The driver of the car was arrested on suspicion of supplying class A drugs and taken into police custody. Although officers suspected that the man had swallowed drugs, force policy was to take people suspected of swallowing drugs into custody unless they showed signs of being unwell.

College of Policing: Authorised Professional Practice guidance on custody and detention

If officers know or suspect that a detainee has swallowed or packed drugs, either for the purpose of trafficking or to avoid imminent arrest or detention by the police, they must treat the person as being in need of urgent medical attention and transfer them straight to 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 follow quickly, particularly when the person has swallowed crack cocaine.

Officers continued to search the vehicle and found two yellow Kinder Egg containers.

The driver was booked into custody and strip-searched, but nothing was found.

In the cell, officers noticed that the driver tried to make himself sick. Officers suspected that he may have swallowed drug wraps in the interval between officers signalling to the car to stop, and speaking to the man.

The driver was placed on constant observations. A decision was made to take him and his passenger to hospital. At about 4.30pm, the two detainees were taken to hospital for medical examination. However, no stomach x-ray was taken.

The driver returned to the police station at about 7pm. The driver was interviewed, but denied swallowing drugs, being a drug dealer, or that the phone seized belonged to him. The phone contained messages that suggested it was used by a drug dealer to communicate with customers.

The driver remained on constant observation while in custody and was examined regularly by a HCP. Wraps recovered from faeces were examined and found to contain heroin and crack cocaine. During this period, the man made repeated attempts to conceal drugs expelled by re-swallowing the wraps and by concealing some in his clothing.

Following his conviction, the driver's mother made a number of complaints on behalf of her son. She alleged that her son had not been provided with the correct medical treatment while in custody, and that if police believed that he had swallowed drugs then he should have received medical treatment immediately.

The IPCC review of the investigation appeal found that draft policies and protocols were in place which, under APP, set out what to do if a detainee has swallowed drugs. These draft policies had not been finalised and were available only to custody staff, however.

Key questions for policy makers/managers:

- Do you train all your officers to call an ambulance, or take a person directly to hospital, if they suspect someone has swallowed something that could be harmful, even if they appear to be well?

Key questions for police officers/staff:

- Do you know when detainees should be taken to hospital immediately, rather than to a police station?

Action taken by this police force:

- The force ensured that the relevant protocols

and policies in place were distributed to operational as well as custody staff.

Outcomes for the officers/staff involved:

- There were no disciplinary or criminal outcomes for the officers or staff involved in this case.

Click here for a link to the full learning report

9 Providing accurate information on detainees who are taken to hospital

A 21-year-old woman who appeared to be under the influence of drink or drugs was arrested and taken to a police station.

She was booked into custody, where it was identified that she needed an appropriate adult. It was also noted that she had concealed items in her vagina previously. A strip search was carried out and nothing was found.

The woman was taken to a cell and the detention officer was instructed to carry out rousing visits every 30 minutes.

These visits were made approximately every 30 minutes through the cell hatch and the woman was seen to move a little. Officers did not enter the cell or make efforts to rouse the woman, as stated in APP.

Approximately six hours after being placed in the cell, the woman appeared unresponsive and a custody nurse provided medical help.
The woman was taken to hospital and a PER form was completed. The form included basic information. Although a box was ticked to indicate that the woman was known to conceal items, no further detail was provided.

While in hospital, the woman's health continued to deteriorate. During a medical intervention, a plastic bag was removed from her vagina. This was found to contain prescription drugsThe woman's condition improved and she was moved to a ward.

She was guarded by a number of officers, but not supervised while using the bathroom. In addition, she received a number of visitors, some of these visits were not recorded on the PER form.

Two days later, the woman appeared to be under the influence although she denied taking anything. Before another strip search could be carried out, the woman's condition deteriorated sharply and medical help was required immediately.

An intimate search was carried out by medical staff who found a carrier bag concealed in the woman's vagina. This contained prescription and class C drugs in tablet form. The bag was removed.
The woman's condition improved over the following days.

Key questions for policy makers/managers:

- What guidance do you give to officers supervising a detainee in hospital?
- What guidance have you given to officers about recording visitors, and other significant events, and for completing the Person Escort Record (PER) form?

Action taken by this police force:

- Officers have been provided with training based on APP guidance on supervising detainees.
- An instruction was given to custody officers on the need to complete PER forms and provide adequate information.
- With reference to paragraph 11(c) Annex A of the Police and Criminal Evidence Act 1984 (PACE) Code C, a reminder was given to custody officers about when an appropriate adult is required before a strip search is carried out.

Outcomes for the officers/staff involved:

- There were no criminal, misconduct, or disciplinary outcomes for any of the police officers or staff involved in this incident.

Click here for a link to the full learning report

Related reading

The Learning the Lessons pages on our website contain links to a variety of research and other publications relating to the cases featured in this bulletin, as well as previously published bulletins, and copies of the more detailed learning reports which accompany each case.