Custody Officer Training Outline

The medico-legal guidelines and recommendations published by the Faculty are for general information only. Appropriate specific advice should be sought from your medical defence organisation or professional association. The Faculty has one or more senior representatives of the MDOs on its Board, but for the avoidance of doubt, endorsement of the medico-legal guidelines or recommendations published by the Faculty has not been sought from any of the medical defence organisations.

Role of the Forensic Physician (Police Surgeon, Forensic Medical Examiner)

This package is designed for use by doctors asked to have an input into a custody officer training course. It is estimated that the content can be delivered over a two hour session allowing time for discussion.

Introduction

The Police and Criminal Evidence of 1984 and Codes of Practice 9.5 last revised in July 2006 give the custody staff guidance as to when to call or consult a doctor or appropriate health care professional.

If an individual (detained person – DP) at a police station:

- appears to be suffering from physical illness
- is injured
- appears to be suffering from a mental disorder
- appears to need clinical attention
- is suffering the effects of alcohol or drugs (consider comorbidities and dependence)
- requires medication
- is suffering from an infectious disease or condition
- comes directly from hospital
- or if the DP requests a medical examination

Who do you call?

Forensic Physicians (Forensic Medical Examiners [FMEs], police surgeons, forensic medical officers) are:

- registered medical practitioners
- independent contractors to police authority/ commercial providers
- role is to be courteous, professional and non-judgmental
- to obtain the best possible evidence in the interest of the DP
- but also in the interests of the Criminal Justice System as a whole
- examine complainants of assault (physical/ sexual); DP to see assess fitness to be detained/fitness to be interviewed (FTD/FTI); take forensic samples; examine police officers injured on duty; or do anything else when requested!
- examination of patients detained under section 136 MHA.
- provide statement of findings for police, social services and the courts
- be prepared to attend court

➯ *The Role of the Independent Forensic Physician*

Training for Forensic Physicians

- initial – theoretical training course organised by the Faculty of Forensic and Legal Medicine in conjunction with the National Police Improvement Agency) and supervised, workplace-based training
- initial – specialist areas – adult sexual offences/child sexual abuse/mental health
- development/update training
- preparation for the postgraduate qualifications

Definition of the Health Care Professional (HCP)

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

PACE Code C. Notes for guidance 9A.

ARCHIVED 30 NOV 2015

When to call an FP (as opposed to a Nurse or Paramedic)

- Examinations under Section 4 of the RTA
- To supervise the self-administration of certain controlled drugs
- Assessment of detainees subject to TASER – other HCPs can and should administer first aid
- Police officers post shooting incidents
- Terrorist detainees
- Complex assessments where the HCP requests the FP's advice
- Formal Mental Health Act assessments

Custody Suites

- Clinical room which is appropriately stocked with basic first aid items, kept locked when not in use and kept clean
- Lockable drug cupboard
- Standard restocking procedure with a named responsible person
- Only used for clinical purposes
- In an ideal situation a separate room for specific Forensic Examination.

Operational guidance and equipment for medical rooms

Liaison with the Forensic Physician / HCP regarding the reason for attendance

- Ideally the person with the query regarding a DP should call the doctor/HCP
- The doctor/HCP will enquire why they are being called e.g. FTD/FTI/Medication and whether there are any other particular concerns in order to assess the urgency of the call
- Priorities will be given to head injuries (HI), drunks with HI, victims, medical problems, suspicious deaths, drink-drive procedures, etc.

Briefing on arrival

- Discuss reason called – physical, mental illness, medication, injury
- Obtain details from the custody record including reason for arrest
- Other info from custody sergeant and where appropriate arresting officer re circumstances of arrest
- Whether any force was used such as handcuffs, CS or PAVA spray, batons etc.
- Whether anything found in the DP’s property or when searched (medication, illicit drugs)
- PNC checks re mental illness, violence, drugs
- Information from GP, hospital, friends, relatives as appropriate
- Any concerns re DP behaviour re personal safety
- Any information given by fellow detainees may be useful as also from relatives /friends.

Practical aspects to the Examination

- Examination should be carried out in a suitable clinical room
- Presence of chaperone? Decide on an individual basis but always when male doctor with female detainee and when personal safety an issue
- Obtain consent – verbal/written
- Children – issue of parental responsibility as opposed to AA
- Consent intimate samples (PACE guidelines), investigating officer to be present to brief HCP
- Consent intimate searches (BMA/Faculty guidelines ethical issues)
- History and examination as appropriate
- FP/HCP will keep confidential notes
- Complete paperwork as appropriate to the particular force leaving enough information for the custody staff to care for that individual
- May use body diagrams – remain part of confidential clinical notes

ARCHIVED 30 NOV 2015

- Consider conditions of detention – temperature and ventilation of the cell, cleanliness of cell and bedding
- Personal hygiene, food and fluids

Management Plan

- Fitness for detention
- Fitness for interview
- Medical advice to DP (written and oral)
- Medical advice to custody staff (written and oral)
- Rousing (in accordance with PACE Code of Practice Annex H)
- Medical advice to colleagues
- Need for AA
- Information re medication

Appropriate Adults (AA)

- Juvenile
- Mentally vulnerable
- Intellectual disabilities
- Custody officer's responsibility
- HCP may make a recommendation

Administration of medication

- DP's own medication should be obtained if at all possible (from home) – easy/confirmation (ideally collected prior to HCP attendance)
- HCP should leave clear instructions preferably verbally and in writing
- Giving medication to DP should be witnessed by another officer
- DP should be observed taking medication – to prevent hoarding
- Consideration should be given to supervision of all injections by HCP
- Medication logged in custody record when given
- Refusal should be logged and the doctor informed
- Unused medication should be disposed of as instructed
- Medication should be kept in a locked cupboard
- Private prescriptions will be issued as required
- Controlled drugs under schedule 2 & 3 (e.g. methadone, buprenorphine, and including temazepam) must be supervised by a doctor

⇨ *Safe and Secure Administration of Medication in Police Custody*

Persons detained under the Terrorism Act

- Different powers and periods of detention apply
- Consider personal safely
- Medical assessment on detention, measure weight, and complete body surface examination for injuries
- Medical assessment before release or transfer
- Daily medical assessment
- Consider dietary and exercise requirements
- Consider specialist medical assessments occurring at the police station

⇨ *Medical care of persons detained under the Terrorism Act 2000*

Home Office Prisoners – Operation Safeguard

- Provisions of PACE do not apply but are minimum standards
- On arrival in police custody a risk assessment must be performed
- Communication between prison medical staff and HCPs in police custody is essential, especially with regard to any medication required
- HCPs have a responsibility for the welfare of detainees and must be satisfied that a detainee is fit for detention and that the conditions of detention are acceptable

⇨ *Home Office Prisoners Recommendations for Forensic Physicians*

ARCHIVED 30 NOV 2015

Common Problems

- Epilepsy
- Asthma
- Claustrophobia
- Diabetes
- Heart disease
- Sickle cell
- Injuries
- Alcohol
- Drugs
- Mental health
- Infectious diseases
- Fitness for interview
- Often combination of above

Epilepsy

- May need regular medication
- Epilepsy or fits associated with alcohol/drug withdrawal
- First ever fit = hospital assessment

Asthma

- Allow to keep inhaler (after risk assessment and search of inhaler)
- Instructions on other medication if required

Panic Attacks/Claustrophobia

- Diagnosis on history (avoidance behaviour)
- Reassurance
- Rarely medication
- May affect FTI

Diabetes

- Using insulin – obtain if possible and other medication
- Access to appropriate food
- Consideration to the supervision of insulin injection
- Awareness of hypoglycaemia (cf. hyperglycaemia)

Heart Disease

- Access to medication such as GTN tablets or spray
- If chest pain does not settle hospitalisation may be required
- If you suspect a detained person is having a heart attack, administer two puffs of GTN spray and dial 999 immediately.

Sickle cell

- Disease or trait
- Access to regular fluids (avoid dehydration)
- Avoid cold
- May need painkillers

Injuries

- Use of personal safety equipment – CS or PAVA spray, handcuffs, batons, Taser.
- Complete accurate documentation important for medical and legal reasons
- Dog bites – may need hospital treatment, tetanus, antibiotics, follow-up

Head Injury

- Important to get accurate history from arresting officer before he/she disappears!
- Was there loss of consciousness?
- If DP becomes increasingly sleepy or drowsy, has persistent or increasingly severe headache, complains of any visual disturbance, vomits, or has a fit – need to contact FP urgently
- Remember combinations dangerous e.g. head injury and
- Alcohol and or drugs and other medical problems such as diabetes

Head Injury Advice Leaflet for custody officers, gaolers & detention officers

ARCHIVED 30 NOV 2015

Alcohol – Intoxication

- Consider use of drugs and other medical problems including a head injury
- If in doubt call HCP
- Check and rouse every half an hour as Annex H
- If dependent may sober up very quickly and develop withdrawal

Alcohol – Withdrawal

- May be complicated by confusion – delirium and fits
- May need treatment depending on length of detention

Drugs

- Knowledge of drug trends in your area
- Be aware that substance use and mental illness may co-exist

Opiates – Heroin/Methadone

- Main problem medically intoxication (drowsy, decreasing level of consciousness, pin-point pupils, respiration level falls, snoring, nodding)
- Combination with other drugs and alcohol potentially dangerous
- Withdrawal less of a problem but can be treated in custody, may affect FTI

Benzodiazepines

- Intoxication similar to alcohol
- Fits may occur with withdrawal

Stimulants – Cocaine/Amphetamine

- Death may occur from cardiac problems, stroke, cocaine agitated delirium
- Withdrawal – risk of self-harm

Mental Health

- s136
- Call doctor if concerns re mental health
- Call approved mental health professional (AMHP)(possibly also Crisis worker)
- Consider voluntary admission*
- Consider admission under s 2,3,4, under MHA 1983
- Risk of self-harm – history of previous attempts and past psychiatric history important
  - remove articles that could be used to self-harm
  - may occur soon after arrest – or after charge if bail refused
  - if intention clear call doctor
- May need constant supervision
- Cell design consideration
- Liaison with other agencies when DP transferred
- Consider times of increased risk during detention i.e. on first going into cell, after any contact with outside (telephone calls), after seeing solicitor, after seeing FP, after interview, after being refused bail, after release.
- Consider risk assessment as ongoing process.

Infectious diseases

- Hepatitis B vaccination for officers
- Risks mainly needle stick injuries
- High risk population for HIV, hepatitis B & C (iv drug abusers)
- Observe good clinical practice – wear gloves, beware when searching
- Tuberculosis, other infectious diseases continue treatment, consider hospitalization
- Scabies can be treated in custody
- Cells and bedding cleaned professionally

* Unable to section DP who has capacity to consent to a voluntary admission

ARCHIVED 30 NOV 2015

Fitness for Interview Definition
(PACE Code C, Annex G)

- A detainee may be at risk in an interview if it is considered that:
  a. conducting the interview could significantly harm the detainee's physical or mental state
  b. anything the detainee says in the interview about their involvement or suspected involvement in the offence about which they are being interviewed **might** be considered unreliable in subsequent court proceedings because of their physical or mental state
- There are therefore TWO aspects to the assessment and it is dynamic, circumstances may change and it may be appropriate to say that someone is fit now but may not be after a period of time and would require reassessment.

Risk of Unreliability

- Definite – unlikely to be fit for interview at any stage
- Major risk – unfit for interview at present – reassessment later
- Some risk – precautions advised e.g. presence of appropriate adult
- No discernible risk at this time

Permanent Conditions

- Severe dementia and severe learning disability

Substantial Risk – Temporary

- "Drunkenness" – intoxication with alcohol
- Intoxication by drugs
- Severe drug withdrawal
- Severe exhaustion or physical pain
- Severe physical illness
- Severe mental illness that may be amenable to treatment such as an acute organic reaction or mania
- a state of fear induced by oppressive police practices

Significant Risk

- Hypomania
- Schizophrenia and related disorders
- Depressive illnesses
- Mild or moderate learning disability
- Mild or moderate dementia
- Inability to handle interrogative pressure
- Significant anxiety induced by custodial environment and other anxiety states and phobias, such as fear of being locked in a police cell

AA would be required.

When to Hospitalise

- Difficult to give clear guidance for every situation (see below)
- If in doubt trust your instincts and call an ambulance
- If not sure call the doctor for advice

Remember

- Chest pain
- Breathing difficulties
- Level of consciousness
- Severe injuries – head injuries with LOC, deformed limbs, wounds that obviously need suturing

May need hospitalisation

Resuscitation Equipment

All custody staff should have received appropriate training in first aid resuscitation methods, use of automated defibrillator and where present the use of oxygen and oximeters.

Resuscitation equipment should be safely store where it is immediately available to all staff not in a locked clinical room as when it is most needed the FP or HCP may not be present.

Communication

- HCP MUST provide a verbal report as well as completing the NSPIS medical page
- Ensure that you make time to receive any information from the HCP regarding a detainee and that you understand any instructions given, especially with regard to medication and observations.
- You can delegate on to DDO or gaolers but the overall responsibility is yours!

NSPIS Medical Page

- Should have a general summary of how to care for the detainee in custody
- Advice on level of checks - 30/60, rousing, constant supervision if indicated
- Whether a MHA assessment is required or an AA recommended
- An opinion on fitness to detain/interview/transfer charge or whether a review is required
- Includes instructions for medication from FP for custody staff.

Prepared by Dr Bob Cowan, Dr Margaret Stark and Professor Ian Wall
on behalf of the Academic Committee of the Faculty of Forensic and Legal Medicine

© Faculty of Forensic & Legal Medicine, July 2011