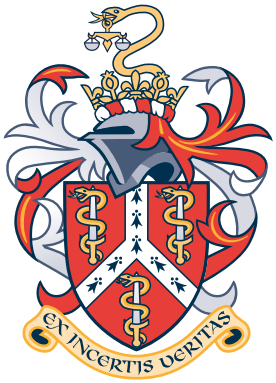
United Kingdom Association of Forensic Nurses & Paramedics

College of Paramedics



Faculty of Forensic & Legal Medicine

Custody Officer training outline

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Role of the Forensic Health Care Professional (HCP)

This package is designed for use by HCPs 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 (as revised) 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?

A 'healthcare professional' defined in PACE (Code C Notes for guidance 9A) as 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.

The HCP may be a doctor, nurse or paramedic working in a multi-professional team practising in partnership working to deliver a quality clinical service in the custody environment.

Equivalence of healthcare and confidentiality in the custodial setting as compared to that enjoyed by patients in the outside community.

HCPs must only share information with custody staff on a 'need to know' basis.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Standard should be noted that the detainee has 'the right of access to a doctor, including the right to be examined, if the person detained so wishes, by a doctor of his own choice (in addition to any medical examination carried out by a doctor called by the police authorities).'

For more information see the following documents:
The Role of the Healthcare Professional

Quality standards in forensic medicine

These have been developed by the Faculty of Forensic & Legal Medicine of the Royal College of Physicians of London and the UKAFN & Paramedics for doctors, nurses and paramedics to cover

- Recruitment
- Initial training and induction support
- Work-placed based supervision/ongoing mentoring and supervision
- Continuing professional development
- Service level standard

For more information see the following documents:
Quality Standards in Forensic Medicine
Quality Standards for Nurses and Paramedics General Forensic Medicine

When to call an FP (as opposed to a nurse or paramedic)

- Assessment of detainees subject to TASER – other HCPs can and should administer first aid
- Assessment of police officers post shooting incidents
- Terrorist detainees
- Complex assessments where the HCP requests the FP's advice
- Formal Mental Health Act assessments
- Examine child victims of alleged neglect, physical or sexual abuse

Custody suite facilities

- Clinical room which is appropriately stocked with basic first aid items, kept locked when not in use and kept clean
- Resuscitation equipment including automated external defibrillator (AED) and Oxygen
- 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.

For more information see the following documents:
Operational guidance and equipment for medical rooms

Liaison with the HCP regarding the reason for attendance

- Ideally the person with the query regarding a DP should call the 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
- Calls should be triaged and priorities will be given to head injuries (HI), those intoxicated with a HI, victims, medical problems, suspicious deaths, drink-drive procedures, etc.

Briefing on arrival

- Discuss reason called – physical, mental illness, medication, injury, etc.
- Obtain details from the custody record including reason for arrest
- Other information from custody sergeant and where appropriate arresting officer re circumstances of arrest e.g. mechanism of road traffic collision
- Whether any force was used such as physical restraint, handcuffs, irritant sprays, batons, TASER® etc.
- Whether anything found in the DP's property or when searched (medication, illicit drugs)
- PNC checks re mental illness, violence, drugs
- Previous police computer entries on NSPIS/NICHE
- 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
- In considering the presence of a chaperone the CPT Standards state 'All medical examinations of persons in police custody must be conducted out of the hearing of law enforcement officials and, unless the doctor concerned requests otherwise in a particular case, out of the sight of such officials.' Although the standard cites doctors only, it is also the expected standard for all healthcare professionals working in the custody environment.
- PACE requirement for same sex chaperones
- The General Medical Council guidance requires the doctor to take the detainee's views and wishes into account in the matter of chaperones. A doctor should give serious consideration to the use of a chaperone particularly when undertaking intimate examinations, the detainee is of the opposite sex and the doctor's own safety may be at risk. In such cases, the presence of custodial staff in close proximity to the patient/detainee may be unavoidable.

  For more information see:
  DNA Anti-Contamination – Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities
- Obtain consent – verbal/written
- Children – issue of parental responsibility as opposed to AA
- Issue of mental vulnerability would need an AA
- History and examination as appropriate
- Consent intimate samples (PACE guidelines), investigating officer to be present to brief HCP
- Consent intimate searches (BMA/Faculty guidelines ethical issues)
- HCP will keep confidential notes
- May use body diagrams – remain part of confidential clinical notes
- Complete paperwork/computerised records as appropriate to the particular force/constabulary leaving enough information for the custody staff to care for that individual
- 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)
- Levels of observation (APP) and rousing (in accordance with PACE Code of Practice Annex H)
- Clinical advice to colleagues
- Need for AA
- Information re medication
- Safguarding referral as required (adult/children)

Appropriate adults (AA)

- Children (up to 18 years)
- Mentally vulnerable
- Intellectual disabilities
- Custody officer's responsibility
- HCP may make a recommendation

Administration of medication

- All injections should be given under the supervision of the HCP unless the situation is life-threatening (anaphylaxis - use of Epipen) or it has been advised by the duty FP on the ground of clinical need (IDDM).
- Medication logged in custody record when given
- Refusal should be logged and the HCP informed
- Where refusal of medication is of concern to the HCP this should be discussed with the duty doctor
- Unused medication should be disposed of as instructed in the local policy
- Medication should be kept in a locked cupboard
- Private prescriptions may be issued as required
- Controlled drugs under schedule 2 & 3 (e.g. methadone, buprenorphine, and including temazepam) must be supervised by a registered medical practitioner authorising their use or other appropriate healthcare professional.

For more information see the following document:
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

For more information see the following document:
Medical care of persons detained under the Terrorism Act 2000

Common problems

- **Epilepsy**
- **Claustrophobia**
- **Heart disease**
- **Injuries**
- **Drugs**
- **Infectious diseases**
- **Asthma**
- **Diabetes**
- **Sickle cell**
- **Alcohol**
- **Mental health**
- **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 access to 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 spray
- If chest pain does not settle call an ambulance and refer to HCP if on site
- If you suspect a detained person is having a heart attack, administer two puffs of GTN spray and dial 999 immediately.
- Chest pain may also indicate a pulmonary embolism

Sickle cell

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

Injuries

- Use of personal safety equipment – irritant sprays, handcuffs, batons, Taser. For more information see the following documents:

  Irritant Sprays: Clinical Effects and Management

  TASER®: Clinical Effects and Management of Those Subjected to TASER® Discharge
- Complete accurate documentation important for medical and legal reasons
- Human/Dog bites – may need hospital treatment, tetanus, antibiotics, follow-up. For more information see the following document:
  Management of Injuries Caused by Teeth

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 arrange urgent hospital transfer by ambulance
- Remember combinations dangerous e.g. head injury and alcohol and/or drugs and other medical problems such as diabetes.

For more information see the following document:
Head Injury Advice Leaflet for custody officers, gaolers & detention officers

Stroke

Symptoms of stroke can be remembered with the word F.A.S.T.:

- Face – the face may have dropped on one side, the person may not be able to smile, or their mouth or eye may have drooped.
- Arms – the person with suspected stroke may not be able to lift both arms and keep them there because of weakness or numbness in one arm.
- Speech – their speech may be slurred or garbled, or the person may not be able to talk at all despite appearing to be awake. (my emphasis)
- Time – it's time to dial 999 immediately if you notice any of these signs or symptoms

Alcohol – intoxication

- Consider use of drugs and other medical problems including a head injury, diabetes
- If unable to walk or talk refer to ED
- 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 with a substantial risk of death if left untreated
- 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
- Consider concealment of illicit substances
- Differentiate between body stuffers and packers
- Novel psychoactive substances (NPS)

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, acute behavioural disturbance. See:

  Guidelines for the Management of Excited Delirium/Acute Behavioural Disturbance

  Acute behavioural disturbance
- Withdrawal – risk of self-harm
- NPS

Mental health

- s136 (rarely assessed in police custody)
- Call HCP if concerns re mental health
- Consider referral to the Criminal Justice and Liaison Service if available
- Call approved mental health professional (AMHP)(possibly also crisis worker/emergency duty team)
- 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.
- Pre-release risk assessment may be required

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 universal precautions – wear gloves, beware when searching
- Tuberculosis, other infectious diseases continue treatment, consider hospitalization
- Scabies can be treated in custody
- Cells and bedding cleaned professionally

For more information see the following document:
Managing blood-borne virus exposures in custody

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

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 as assessed by HCP

- 'Drunkenness' – intoxication with alcohol
- Intoxication by drugs
- Drug withdrawal
- Exhaustion or physical pain
- Physical illness
- 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

- Bipolar disorder
- 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

It is difficult to give clear guidance for every situation (see below). If in doubt trust your instincts and call an ambulance. If you are not sure call the HCP for advice.

Remember, the following may need hospitalisation:

- Chest pain
- Breathing difficulties
- A change/deterioration in the level of consciousness
- Severe injuries – head injuries with LOC, deformed limbs, wounds that obviously need suturing

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 stored 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 relevant medical page in computerised custody records

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!

Computer medical page

- Should have a general brief 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.

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Send any feedback and comments to forensic.medicine@fflm.ac.uk