Faculty of Forensic & Legal Medicine

Pre-Release Risk Assessment – Recommendations for Healthcare Professionals working in the custody environment

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Introduction

In recent years concerns have been raised about the increase in 'apparent suicides' following police custody. The Independent Office of Police Conduct (IOPC) collates statistics relating to all deaths during or following police contact.[1] In relation to apparent suicide these are included if they occur within two days of the person leaving police custody, or if the experience in custody may be relevant to the person's death. This is often not obvious to the police and so the total number of deaths may be greater. There are certain types of offences which are associated with an increased likelihood of going on to enact suicide, e.g., violence related offences, sexual offences, and driving offences.[1]

Police now routinely conduct pre-release risk assessments. If there are concerns the healthcare professionals (HCPs) are asked to perform an assessment.

Good practice dictates that a HCP should consider the risk of self-harm at the start of the period of detention and when they first assess detainees for fitness for detention. However a detainee may become more vulnerable during the period of detention and so at any stage prior to release the HCP may have to make an assessment or reassessment.

If the detainee is intoxicated with alcohol and/or drugs then it is not possible to reliably assess suicide risk. The priority must be whether the detainee is fit for detention, or needs to be transferred to the emergency department for appropriate supervision until the effects of the substances have worn off. Furthermore careful consideration should be given to safeguards to prevent the detainee acting on suicidal thoughts which may co-exist with, or be more likely to be acted upon as a result of, intoxication.

What is the initial role of the HCP?

- Perform a comprehensive initial assessment (using the FFLM proforma or equivalent[2])
- Check for previous mental health problems/substance misuse
- Perform a mental state examination (MSE) (see below)
- Assessment of capacity[3] (decision specific)
    a. capacity to consent to forensic examination; and
    b. capacity to disclose results of the assessment;
    c. capacity of a detainee to consent to undergo examination in contemplation of admission to hospital under the (relevant) Mental Health Act.

It is important to have regard to the judgment of the court in *Re T (Adult: Refusal of Medical Treatment*)) [1993] Fam 95, that the required capacity has to be commensurate with the gravity of the decision and so '[t]he graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision'.

This means that where the decision is one which relates to the risk of the detainee taking his/her own life, a relatively high level of competence will be needed for the HCP to be satisfied that it is more probable than not that the detainee has the capacity to refuse to undergo such an assessment.

Where there are factors indicative of a significant risk and where the HCP concludes that a detainee has the capacity to refuse such assessment, the HCP may need to be able to explain why they concluded that these risk factors could be discounted as evidence of the state of mind of someone not competent to make the decision as to undergoing such an assessment.

- Consider the reason for arrest: Is it a serious offence? Does it involve child pornography or child abuse? Is it a 'cold' case with immediate ramifications? Are there likely to be charges that will impact on the detainee's life significantly – drink driving where occupation relies on driving, police officers, etc.
- Set up a management plan with appropriate referral for ongoing treatment e.g. general practitioner (GP), crisis team, liaison and diversion services, substance misuse services.
- Consideration of discharge letter to GP using the 'Referral to Outside Agency Proforma' or equivalent
- Consultation between HCPs - doctors, nurses, paramedics as appropriate
- Referral to acute psychiatric services/liaison and diversion services as required

Mental State Examination - abnormalities suggestive of a depressive disorder and/or suicide risk

Appearance	Self-neglect (clothing, hygiene)
Behaviour	Altered motor behaviour such as restlessness, agitation, retardation Withdrawn
Speech	Hesitancy, delayed responding, slow speech, low volume.
Thought content	Feelings of life not being worth living, hopelessness, guilt, shame, suicidal thoughts, low self-esteem, worthlessness, loss of confidence
Mood/affect	Depression, anxiety, irritability
Abnormal beliefs/perceptions	Hallucinations and / or delusions reflecting depressed mood
Cognition	Impaired concentration Impaired short term memory
Insight	Impaired insight into nature and severity of condition
Other considerations: Biological symptoms Self-harm and suicidal ideation Harm to, or from, others	 Anhedonia, early morning waking, depression worse in the morning, objective evidence of definite psychomotor retardation or agitation, marked loss of appetite, significant weight loss, marked loss of libido History of self-harm, type of self-harm, current thoughts, intention, protective factors, plans Thoughts, intent, previous harm to others, concern of retaliation

General principles with regard to risk assessment

- risk can be assessed and managed but cannot be eliminated;
- risk varies over time;
- risk varies according to circumstances;
- some risks are general, others more specific;
- interventions can decrease or increase risk;
- assessment requires information from many sources;
- assessment of risk should involve colleagues whenever possible;
- the outcome of the assessment process should be shared with others and recorded adequately;
- assessment of risk should lead to a plan of management;
- the management plan should aim to reduce risk;
- management varies with time and circumstances;
- management should aim to reduce the personal distress of the individual;
- if necessary dates or times for review should be made and recorded.

'Red Flags'[4] (as adapted)

A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time.

Demographic and social

Perception of lack of social support, living alone, no confidants

Males[5] (may not disclose extent of distress or suicidal thoughts)

Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)

LGBTQ/Ethnic minority group.

Personal background

Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship

Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)

Use of suicide-promoting websites or social media

Access to lethal means (If unable to remove lethal means ensure mitigation within a robust Safety Plan).

Clinical factors in history

Previous self-harm or suicide attempt(s) (regardless of intent, including cutting); previous *repeated (especially when worsening)* self-harm or suicide attempt(s) as at risk of accidental death

Mental illness, especially recent relapse or discharge from in-patient mental health care

Disengagement from mental health services

Impulsivity

Long-term medical conditions; recent discharge from a general hospital; pain.

Mental state examination including suicidal thoughts

High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden'); remembering that hopelessness correlates better with suicide risk rather than degree of depression

Sense of being trapped/unable to escape (sense of entrapment) and/or a strong sense of shame

Suicidal ideas becoming worse

Suicidal ideas with a well-formed plan and/or preparation

Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).

Factors associated with an act of DSH that indicate a high risk for suicide are

The writing of a suicide note or other preparatory acts such a change in testamentary dispositions

Precautions having been taken against being found

Stated wish to die

Belief that the act would have proved fatal

Expressed regret that the act failed.

Assessing an act of DSH

- attempt to establish an adequate rapport with the detainee;
- try to gain an understanding of recent events;
- enquire about personal and social circumstances;
- take a history of any substance misuse (including alcohol);
- take a psychiatric history and conduct a mental state examination.

Protective factors[6]

- strong connection to family and community support i.e. social connectedness
- skills in problem solving, conflict resolution and non-violent handling of disputes
- restricted access to the means of suicide
- seeking help and easy access to quality care for mental and physical ill health
- personal, social, cultural and religious/ spiritual beliefs that support the self
- less severe index offence (provides hope for the future if willing to undergo rehabilitation to minimise re-offending).

The HCP must provide clear advice to police

- High risk - the detainee should be under constant supervision (close proximity) and a request should be made for an urgent psychiatric assessment.
- Moderate risk - consider advising the police to:
    - move the detainee to a cell that can be closely monitored (e.g. by CCTV if available);
    - remove any objects from the cell that could be used to self-harm;
    - make frequent checks of the detainee at irregular intervals so that the detainee cannot anticipate when the next check will be made;
    - arrange for a further psychiatric assessment where appropriate.

- Remember that risk is dynamic
- Assessment should be ongoing
- Offer advice and options to support the detainee's welfare on release

Police responsibilities

An adult charged maybe refused bail and kept in custody under *section 38(1)(a)(vi)* of Police and Criminal Evidence Act 1984 (PACE) if the custody officer has reasonable grounds to believe detention is necessary for his/her own protection. Guidance is provided for police in the College of Policing Authorised Professional Practice - Custody and Detention, *http://www.app.college.police.uk/app-content/*

The National Decision Model (NDM) used by police can be accessed *here.*

Obligation under the European Convention on Human Rights

Under the Human Rights Act 1998, s 6, the police service is prohibited from acting in a way which is incompatible with a right protected by the European Convention on Human Rights. There is an obligation to take feasible operational steps (within the lawful power of the officer) to avert any risk of death of which the officer is, or should have been, aware.

It may be appropriate to extend the detention period of the detainee for a minimal and limited time to allow for the transfer of care to other appropriate care services[7] or if the detainee is in need of a mental health assessment.[8]

References

1. IOPC
   Deaths during or following police contact: Statistics for England and Wales 2019/20
   October 2020

2. FFLM
   Pro forma – Fitness for detention and interview
   Pro forma – Mental Health Act Assessment

3. BMA
   Mental Capacity Act Toolkit
   October 2020

4. Royal College of Psychiatrists
   Self-harm and suicide in adults CR 229
   July 2020

5. HM Government
   Preventing suicide in England: Fifth progress report of the cross government outcomes strategy to save lives
   March 2021 Accessed 06/04/2021

6. WHO
   Public Health Action for the Prevention of Suicide. A Framework
   2012

7. College of Policing
   Authorised Professional Practice - Risk of self-harm and suicide after release
   Accessed 06/04/2021

8. Webley v St Georges Hospital NHS Trust & MPS [2014] EWHC 299 (QB); and
   MS v UK (2012) 55 EHRR 23.

Produced by Prof Margaret Stark, Prof Keith Rix and Dr Yvain Rumalean
on behalf of the Faculty of Forensic & Legal Medicine

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

APPENDIX

Options when there is no legal authority to hold a vulnerable detainee that requires further support *College of Policing - Authorised Professional Practice*

There are occasions when it becomes apparent through pre-release risk assessment that a detainee is extremely vulnerable and that there is a real and credible risk to that individual on release (including the risk of suicide).

If an MHA 1983 assessment has been completed in police custody and no hospital or mental health trust bed is available for the person's admission, the custody sergeant must decide whether or not to release the detainee (under *section 34(2) PACE*). Before this decision can be made, however, the custody officer is likely to require a period of discussion with the investigating officer and their supervisor. They may also need to refer the matter to the Crown Prosecution Service for a statutory decision about whether to bring charges.

If, following this discussion and referral period, no application for admission has yet been made, and if the AMHP cannot or will not make the application, the custody officer must legally release the person from police detention. The custody officer should advise the investigating officer and AMHP of their legal position so that they may then take whatever action is deemed necessary.

Officers may consider use of s136 MHA on release from custody. Where a MHA assessment has been conducted during detention, this would require a change of risk or circumstances to justify a new assessment.

Forces may take the view that, based on a risk assessment and for the dignity and safety of the person concerned, they will allow the individual to remain in the police station (although the individual will not be subject to legal detention) while escalating the problem to managers on all sides for resolution.