CED Joint Working Group

Conducted Energy Device (TASER™): At a Glance Guidance for Police Custody

FFLM, UKAFNP, NPCC, RCEM, CoP, RCN

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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.
This guidance was produced in collaboration with UKFANP, NPCC, RCEM, College of Paramedics & the RCN

August 2022 Review prior to August 2026 - check www.fflm.ac.uk for latest updates

The clinician should always be called & made aware at the earliest opportunity by the Custody Officer, that a detainee subjected to CED discharge requires a clinical assessment for their fitness for detention.

The clinician should triage such cases in their workload as a high priority on that person's arrival to the custody suite.

Pre-Assessment

The clinician should discuss with the Custody Officer any relevant information disclosed by the detainee during the risk assessment. The suitability of where to conduct the examination should also be agreed.

Alongside the examination of the detainee, it may be beneficial to gather additional information from the arresting officers (If available) to establish:

- Where the probes penetrated
- Number of probe strikes / drive stuns or discharges of CED
- Have the probes been removed?
- The direction the detainee landed and onto what surface (e.g. pavement).
- Other uses of force – restraint/PAVA
- Any findings from the assessment by Paramedics (if attended the scene).
- Any comments by the detainee during transit such as injuries sustained or medical complaints they have.
- Any observations by the officers such as increased drowsiness, sudden changes in behaviour, presentation & demeanour.

Aide-Memoire

We recommend that clinicians use the Post-CED assessment pro-forma to ensure that all relevant information is recorded post CED exposure

Assessment

Before conducting any examination, the detainee should fully understand the independent role of the clinician & the assessment. Valid consent must be obtained. In some circumstances like a refusal, an assessment of the individuals overall capacity to make such decisions at the time will be required & the examination may be conducted acting in the best interests of the detainee if they are found to lack capacity.

Any interaction with the detainee (regardless of duration) must be documented in full as contemporaneous clinical notes.

If possible, aim to record observations at the start of the assessment & ascertain from the individual their recall of events & how the CED has affected them. This may help establish a presenting complaint & mechanism of injury.

The clinician should conduct a full history & examination of the detainee utilising a top to toe survey & body system examination which must include assessment & documentation of the following elements:

History

- Past medical history
- Psychiatric history
- Medication history
- Allergies
- Alcohol / Drug use
- Family / Social history
- Self-harm & suicide ideation

Examination

- General survey
- Physiological observations
- Mental state examination
- Injury documentation
- Respiratory
- Cardiovascular
- Abdominal
- Neurological
- Musculoskeletal & skin
- Genito-urinary (where applicable)

Post Assessment

Consideration of transferring the detainee to an Emergency Department (ED) may be indicated following the examination. A copy of relevant assessment documentation/referral form **must** be sent with the patient. A pre-alert or verbal referral should be considered in addition to this for unstable patients.

Clinicians, should, however, wherever possible refer direct to an appropriate speciality (e.g. Obs & Gynae for pregnancy, paediatrics for juveniles, medicine/cardiology for pacemaker checks) rather than simply defaulting to an ED transfer.

Below are some factors that should lead you to consider transfer to ED, this list is non-exhaustive. **Please note, not all of the mandatory referral criteria will require urgent or ambulance transfer.**

INDICATORS FOR MANDATORY REFERRAL TO HOSPITAL

- Threat to airway, breathing or circulation
- Suspected Acute Behavioural Disturbance
- Chest pain, palpitations, irregular pulse.
- Pacemaker / Internal cardiac defibrillator or other implanted device
- Head Injury symptoms meeting the NICE guidance criteria for ED assessment
- Pregnancy
- Probe in-situ - sensitive area such as neck, face, eye, genitalia, axilla.
- Reduced GCS
- Drunk & incapable
- Probes/barb that may have been swallowed

INDICATORS FOR CONSIDERATION OF REFERRAL TO HOSPITAL FOLLOWING CLINICAL ASSESSMENT (NON-EXHAUSTIVE)

- Significant burn injury at probe site
- Children & young people (<18)
- Previous spinal & neurosurgery
- MSK injuries that may require x-ray / CT
- Wounds requiring closure (that cannot be managed in custody).
- Where a probe has penetrated, but no longer remains embedded in a sensitive area (note periorbital injuries likely to require ophthalmology review)

Refusal for examination & behaviour of the detainee

The full examination of a detainee exhibiting aggressive or agitated behaviours can be complex. **However, such behaviours could be a sign of significant head injury or acute behavioural disturbance.**

Therefore, it is important the clinician (with support from custody staff) attempts to form a rapport via the hatch & aim to utilise verbal de-escalation techniques with the detainee to safely conduct an examination.

Any decision made by the clinician to defer or refuse to attempt examination for detainees with agitated or aggressive behaviours could be detrimental or fatal to the detainee.

If verbal de-escalation techniques are unsuccessful & a refusal for examination continues, the clinician can still document a basic observational assessment with the following information:

- Verbal responses to questions
- Tone of voice & speech
- Gait & balance
- Behaviour
- Injuries seen

The detainee should be informed, if they feel unwell at any stage during their detention or they wish to be assessed at a later stage, that they can request this via the custody staff.

Handover to Custody Officers

In all cases, the clinician must handover to the Custody Officer any relevant findings from their examination & clear decisions made on the detainee`s subsequent fitness to detain & interview with a suggested level of observation. This must be provided in verbal & written form.

If there are no other risk factors, the minimal level of observation advised should be level one & a frequency of every thirty minutes whilst they are in custody.

Aftercare

The detainee should be advised of potential worsening symptoms & how to request the clinician whilst they are in custody. Considerations should be made by offering analgesia (if appropriate). The detainee should be provided with a post CED advice sheet which can also be accessed via the QR code below.

Visit www.fflm.ac.uk\CEDHub or scan the QR code below for additional information (including videos with guidance on barb removal) & the latest version of this guidance

Produced by the CED Working Group (members listed on the CEDHub)

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

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