



Head injury warning

Advice to custody officers, gaolers & detention officers

Oct 2026 Review date Oct 2029 – check www.fflm.ac.uk for latest update

Although the forensic physician or other appropriate healthcare professional considers that

(Name and date of birth)

is at present fit for detention, complications from a head injury are not always immediately obvious.

You are requested to **rouse** the detained person (obtaining a comprehensible verbal response) every 30 minutes (in accordance with Annex H to Code C of PACE Codes of Practice).

If the detained person:

- becomes UNCONSCIOUS
- becomes INCREASINGLY SLEEPY or DROWSY
- complains of PERSISTENT OR INCREASINGLY SEVERE HEADACHE
- complains of ANY VISUAL DISTURBANCE SUCH AS BLURRED or DOUBLE VISION
- VOMITS
- has a FIT
- exhibits behaviour that is of any concern

the forensic physician or other healthcare professional must be contacted urgently. If an immediate response from the doctor or healthcare professional is not obtained, the detained person **must be immediately transported**, via an ambulance, to the nearest Emergency Department. When released from custody the detained person should be released to the care of a responsible adult and both should be given the attached guidance.

Produced by Professor Jason Payne-James & Professor Paul Marks on behalf of FFLM

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Advice to patient

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The following advice must be followed after you have sustained a head injury to ensure your safe recovery and to minimise the risk of complications safety:

- DO make sure you stay within easy reach of a telephone and medical help
- DO have plenty of rest and avoid stressful situations
- DO NOT take any alcohol or drugs
- DO NOT take sleeping tablets, sedatives or tranquillisers unless they are given by a doctor
- DO NOT play any contact sport (e.g. football) for at least three weeks without taking advice from your doctor first
- DO NOT return to your normal school, college or work activity until you feel you have completely recovered
- DO NOT drive a car, motorbike or bicycle or operate machinery unless you feel you have completely recovered

Complications are not always immediately obvious following a **head injury**. Therefore (although you have been examined by a doctor or another healthcare professional) you are advised to stay with a **responsible** adult for the next **48 hours** and that person should be shown the guidance on the *Advice to responsible adult* card.

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Head injury warning

Advice to forensic physician (FP) or other healthcare professional (HCP)

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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.

Undiagnosed head injury remains a common cause of death and morbidity.

FPs and other HCPs should be aware of and take into account the NICE head injury clinical guideline [Head injury: assessment and early management](#) (NICE guidelines [NG232] Updated 18 May 2023).

A head injury is defined as any trauma to the head other than superficial injuries to the face. The term includes both closed head injuries and penetrating head injuries.

A head injured patient should be referred to the emergency ambulance service (that is, 999) **for emergency transport to the emergency department** if there are any of these risk factors:

- Unconsciousness or lack of full consciousness (*for example, problems keeping eyes open*)
- Any focal neurological deficit since the injury (*problems restricted to a particular part of the body or a particular activity, for example, difficulties with understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking*)
- Any suspicion of a complex skull fracture or penetrating head injury (*signs include clear fluid running from the ears or nose, black eye with no associated damage around the eyes, bleeding from one or both ears, bruising behind one or both ears, penetrating injury signs, visible trauma to the scalp or skull of concern to the HCP*)
- Any seizure ('convulsion' or 'fit') since the injury
- A high-energy head injury (*or example, pedestrian struck by motor vehicle, occupant ejected from motor vehicle, fall from a height of greater than 1 metre or more than 5 stairs, diving accident, high-speed motor vehicle collision, rollover motor accident, accident involving motorised recreational vehicles, pedal cycle or e-bike collision, or any other potentially high-energy mechanism*)
- There is no other way of safely transporting the person to the hospital emergency department.

A head injured patient should be **referred to a hospital emergency department** if there are any of these risk factors:

- Any loss of consciousness ('knocked out') because of the injury, from which the person has now recovered
- Amnesia (*problems with memory*) for events before or after the injury
- Persistent headache since the injury
- Any vomiting episodes since the injury
- Any previous brain surgery
- Any history of bleeding or clotting disorders
- Current anticoagulant or antiplatelet (except aspirin monotherapy) treatment

- Current drug or alcohol intoxication
- Any safeguarding concerns (*for example, possible non-accidental injury or a vulnerable person is affected*)
- Irritability or altered behaviour (*easily distracted, not themselves, no concentration, no interest in things around them*).

In the absence of any risk factors as listed above, **consider referral to an emergency department** if any of these factors are present, depending on judgement of severity:

- Irritability or altered behaviour
- Visible trauma to the head not covered in recommendations above but still of concern to the professional
- No one is able to observe the injured person at home
- Continuing concern by the injured person, or their family or carer, about the diagnosis.

If you decide that a detainee needs referral to hospital in connection with a head injury, the following is the minimum information that should be provided:

- History
- Pupillary size/reactions
- Glasgow Coma Score (*base monitoring and exchange of information about patients with a head injury on the 3 separate responses on the GCS [for example, describe a patient with a GSC score of 13 based on scores of 4 on eye opening, 4 on verbal response and 5 on motor response as E4, V4, M5]*)
- Any obvious limb weakness
- Pulse
- Injuries documented
- Blood pressure
- Blood glucose

Post-Concussion Syndrome

Post-Concussion Syndrome (PCS) refers to a constellation of symptoms that may persist for several weeks or months, even after a minor head injury. Symptoms include, disturbance of normal sleep patterns, fatigue, dizziness, low mood, intolerance of noise or bright lights, difficulties with concentration and ringing in the ears, to name but a few. It has long been recognised that the duration of symptoms can be significantly reduced by carefully explaining to patients that they might experience PCS and that the condition is benign. **The provision of head injury leaflets in which an explanation of PCS is given will serve as a written record and document to which the patient can subsequently refer.**



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Advice to responsible adult

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Most head injuries do not lead to serious complications.

However, you must ensure the patient is taken immediately to hospital if they exhibit any of the following:

- UNCONSCIOUSNESS or LACK OF FULL CONSCIOUSNESS
e.g. problems keeping their eyes open
- Any CONFUSION *not knowing where they are, getting things muddled up*
- Any apparent DROWSINESS or SLEEPINESS, which goes on for more than 1 hour when they would normally be wide awake
- DIFFICULTY WAKING the patient up
- Any PROBLEMS UNDERSTANDING OR SPEAKING
- Any LOSS OF BALANCE or PROBLEMS WALKING
- Any WEAKNESS in one or more arms or legs
- Any PROBLEMS WITH VISION
- VERY PAINFUL HEADACHE that won't go away
- Any VOMITING

- Any FITS *collapsing or passing out suddenly*
- CLEAR FLUID COMING OUT OF THEIR EAR OR NOSE
- BLEEDING from one or both ears
- NEW DEAFNESS in one or both ears

When the patient is sleeping, you should arrange to observe them at two-hour intervals to establish:

- Do they appear to be breathing normally?
- Are they sleeping in a normal posture?
- Do they make the expected response when you rouse them gently?
- If you cannot satisfy yourself that the patient is sleeping normally, they should be wakened fully to be checked.
- Further information can be sought at [Head injury and concussion – NHS](#) (www.nhs.uk).

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