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. The number of apparent suicides recorded in 2021/2022 was 57 and only slightly lower at 52 in 2022/2023'. [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 such 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 healthcare professionals (HCPs) are asked to perform an assessment.

Good practice dictates that the HCP must 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, risk is dynamic, so 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 or other substances, then it is not possible reliably to 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 substance(s) 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 because of, intoxication.

In the most recent report from the National Confidential Inquiry into Suicide and Safety in Mental Health[9] all UK countries showed a fall in rates of suicide in 2020. However, the number of deaths in patients with a diagnosis of personality disorder (PD), including antisocial and emotionally unstable/borderline PD, has increased between 2010 and 2019 and the report's authors estimated a continuing rise in 2020.

Another important area to consider is suicide-related internet use where the most common diagnoses were depressive illness (37%) and personality disorder (16%). Five per cent had a diagnosis of autism. Between 2011 and 2020, there were 73 deaths per year in patients with evidence of suicide-related internet use, 8% of all patient suicides. The number has generally been increasing since 2011 though figures for 2019-20 suggest a recent fall.[9]

## 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 use disorder/intellectual disability/autistic spectrum disorder (ASD), and attention deficit hyperactivity disorder (ADHD)
- 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 their 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

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|---|---|
| Appearance | Self-neglect (clothing, hygiene) |
| Behaviour | Altered motor behaviour such as restlessness, agitation, retardation<br>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<br>Impaired short-term memory |
| Insight | Impaired insight into nature and severity of condition |
| Other considerations:<br><br>Biological symptoms<br><br><br><br><br><br>Self-harm and suicidal ideation<br><br><br><br>Harm to, or from, others | <br><br>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<br><br>History of self-harm, type of self-harm, current thoughts, intention, protective factors, plans<br><br>Thoughts, intent, previous harm to others, concern about retaliation |

## General principles with regard to risk assessment

- It is a myth that asking about suicide increases the risk of suicide;
- 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

Male[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

Untreated short and long-term medical conditions.

### 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 (see Appendix)

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, s6, 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] (see Appendix) or if the detainee is in need of a mental health assessment.[8]

## References

1. Independent Office for Police Conduct
*Annual deaths during or following police contact report - 2022/23*
July 2023

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

3. British Medical Association
*Mental Capacity Act Toolkit*
April 2023

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

6. World Health Organization
*Public Health Action for the Prevention of Suicide. A Framework*
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7. College of Policing
*Authorised Professional Practice - Risk of self-harm and suicide after release*
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8. Webley v St Georges Hospital NHS Trust & MPS [2014] EWHC 299 (QB); and
*MS v UK* (2012) 55 EHRR 23.

9. University of Manchester
National Confidential Inquiry into Suicide and Safety in Mental Health
Annual report 2024: UK patient and general population data 2011-2021
https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

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

# APPENDIX

## Risk of self-harm and suicide after release

## College of Policing - Authorised Professional Practice:

- ***Options when there is no legal authority to hold a vulnerable detainee that requires further support***
- ***Risk of self-harm and suicide after release***

'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). This risk may not always be apparent during the early stages of detention, leaving the custody officer very little time to make an urgent referral.

An adult detainee charged with an offence can be refused bail and kept in custody under section 38(1)(a)(vi) of PACE if the custody officer has reasonable grounds to believe detention is necessary for his/her own protection. Other grounds for keeping a person in custody may also apply.

The custody officer has no explicit powers to detain a high-risk detainee before/without charge once their detention can no longer be authorised, in accordance with Part 4 of PACE or any other lawful power. They may consider using section 135 or 136 of the Mental Health Act 1983 (if the legislative criteria is met at point of release). Where section 136 is applied in the case of children, this relates specifically to the powers of a police protection order, while section 136A specifies that children may not be taken or kept in police stations as a place of safety. Section 43 of The Children Act 1989 also confers emergency police protection powers to remove or keep children in safe accommodation.

The custody officer responsible for the duty of care for that detainee has to make a decision on the best course of action for the detainee on release and, under exceptional circumstances, the safest course of action to protect the life of that individual.

Custody officers should take into consideration the duty of a police officer to preserve life. Under section 6 of the Human Rights Act 1998, the police service is prohibited from acting in a manner incompatible with the European Convention on Human Rights (ECHR). One of the obligations under the ECHR is to take feasible operational steps (within the lawful power of the officer) to avert any real or immediate risk of death of which the officer is aware or should have been aware. As such, it may be appropriate in some circumstances to extend the detention period of the detainee for a minimal and limited period.

Similarly, a person may be detained if they are in need of mental health assessment and thus detention in custody after the criminal matter has been dealt with. The relevant case law includes:

- Webley v St George's Hospital NHS Trust & MPS [2014] EWHC 299 (QB)
- MS v UK (2012) 55 EHRR 23

The reasons for not releasing someone are:

- police have a common law duty of care to the detainee
- police have a duty to release into a safe environment

Forces should have clear escalation procedures up to the rank of superintendent where a custody officer has retained a person beyond the expiry of the provisions of PACE.

A person may also be kept for a minimal and limited period to allow for the transfer of care to other appropriate care services, for example transfer into social services or local hospital care facilities.

It is unlikely that a referral will be legally permitted without the explicit consent of the detainee unless there is a legal obligation to inform others. Where there is a legal requirement to make a referral but the referral has been made without the consent of the individual, officers should record the reason and justifications for this in the custody record.'