Faculty of Forensic & Legal Medicine

Management of epilepsy in police custody

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Introduction

This guidance is to assist forensic physicians and healthcare professionals, working in police custody, with the management of those detainees who have a diagnosis of epilepsy.

Background

Epilepsy is a condition characterised by repeated seizures due to a disorder of the brain cells. It may be idiopathic (cause unknown) or secondary (symptomatic). Causes of secondary epilepsy may include:

- Head injury
- CNS infection
- Stroke
- Brain tumour
- Brain malformations associated with congenital/genetic abnormalities
- Birth trauma

Approximately 1 in 103 (≈1%) people in the UK have a diagnosis of epilepsy (*www.epilepsyresearch.org.uk*). Of those people with epilepsy, approximately 1 in 5 (≈20%) people will also have a learning disability (*www.epilepsysociety.org.uk/learning-disabilities*).

Classification

In March 2017, the International League Against Epilepsy (ILAE) revised the classification system for seizures *Operational Classification of Seizure Types (2017)*. The new nomenclature is based on: where seizures begin in the brain; level of awareness during the seizure; other features of seizure. For example, using the new terminology:

- Simple partial seizure = Focal, aware seizure
- Complex partial seizure = Focal, unaware seizure
- Absence = Generalised, non-motor seizure
- Tonic-clonic seizure = Generalised, motor seizure

It is important to be aware that during focal, unaware seizures the individual may exhibit odd or unusual behaviours. They may not react or respond as one would normally expect.

Key points to establish from a history

Detainees not uncommonly describe having had fits when asked. It needs to be established whether the fits have been diagnosed as epilepsy or were provoked by something else.

Other causes of fits include:

- Acute Head Injury
- Excessive Alcohol
- Alcohol Withdrawal
- Drugs
- Hypoglycaemia
- Infection
- Syncope
- Stroke
- Complex Migraine
- Non-epileptic Attack Disorder

Having established there is a diagnosis of epilepsy, important further information to obtain would include:

- Type of seizure
- Frequency of seizure
- Last seizure
- Triggers
- Warning/Aura symptoms
- Medications (for epilepsy and any other medication usually taken)
- Under specialist review?
- Do they drive?

It is also sensible to enquire about the following, as they may influence the likelihood of seizures whilst detained:

- Compliance with medication
- Intercurrent illness
- Acute Head injury
- Substance use including alcohol
- Co-morbidities which may influence epilepsy e.g. diabetic control

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Important points in examination

As with all detainees, some observations may be important simply to establish their general physical wellbeing:

- temperature
- blood pressure
- heart rate
- oxygen saturation
- blood glucose
- level of consciousness
- pupil size and reaction
- presence of disorientation or confusion

If there are concerns about the detainee's presentation, additional checks might include:

- mental state examination
- checking for neck stiffness
- neurological assessment including reflexes

General Management

The best management of a person with epilepsy is to ensure they continue to receive their anti-epileptic drugs (AEDs), as prescribed and in a timely manner. Missed doses of the usual AED may result in an increase in seizures.

If the medication is not available in custody, then in line with the *FFLM's Safe and Secure Administration of Medication in Police Custody* collecting it or confirming the medication and dose and obtaining it via the GP/pharmacy or a private prescription should be a priority.

The exception to this will be detainees who report never taking their medication as prescribed. If detainees report they take their medication in a rather ad-hoc manner, care must be taken in deciding how to proceed with the medications, whilst in custody. Giving the medication as prescribed may cause significant side effects.

The Epilepsy Society give the following advice with regard to missed doses of anti-epileptic drugs (AEDs) *Strategies and Tools for Taking Medication*. If it is a once a day AED, the missed dose should be taken as soon as possible. If it is a twice a day AED, the missed dose should be taken straight away if it is less than 6 hours late. If it is more than 6 hours late, the dose should be omitted and the next dose taken at the correct time.

In terms of risk management, ideally, a detainee with a diagnosis of epilepsy would be in a cell with CCTV and a low bench. In line with standard safety guidance in epilepsy, if showering in custody they should have a detention officer close by to listen and act if a seizure starts (*https://www.epilepsy.org.uk/info/daily-life/safety/practical-guidance#bathroom*). Simple advice to custody staff about what sort of things to look out for in relation to seizures is helpful, particularly in someone who does not have the classic 'generalised motor (tonic-clonic)' seizures.

Acute management of epileptic seizure

Assessment should be done using an ABC approach as taught in immediate life support (ILS).

Clear the immediate area to reduce the chance of injury. If feasible, cushion the head using soft material or hands. Do not attempt to put anything in, or remove anything from the person's mouth.

If a generalised motor (tonic-clonic) seizure is prolonged (>5 minutes), **this is a medical emergency**. Treatment with either 10mg rectal diazepam or 10mg buccal midazolam* (5mg in elderly detainees or those weighing less than 50kg) should be initiated. A repeat dose can be given after 10 minutes if necessary. If seizures are persistent (3 or more of any duration in 60 minutes) administration of rectal diazepam or buccal midazolam should also be considered. In both scenarios immediate transport to hospital by ambulance, for further review, is a priority. See: *Nice CG137*

Once a seizure has stopped, the detainee must be put in the recovery position, their ABC frequently observed until they regain consciousness, and then examined for signs of injury. SUDEP (sudden unexpected death in epilepsy) is a death occurring during or shortly after a seizure, for no obvious reason; therefore a period of constant observation directly after a seizure has finished, is essential.

In the case of a single, short, self-terminating seizure, it must then be considered whether it is appropriate for a detainee to remain in custody or be transferred to hospital. This can only be done on a case-by-case basis but the decision should include consideration of the following:

- Was there a trigger for the fit?
- If so, is there an increased likelihood of further seizures?
- Does the person regularly experience fits?
- Was there anything atypical about this seizure?
- Do they need a period of being closely monitored? If so, police custody is **not** a suitable environment, even if there is an embedded HCP.
- Are there any new signs e.g. neck stiffness, fever, weakness?
- Were injuries sustained during the seizure that require review or treatment in the Emergency Department (ED)?

If it is decided that it is safe and appropriate for the detainee to remain in custody, it is worth considering:

- Does there need to be a change in the level of observations, and if so, to what?
- Is the detainee's usual medication available and in custody?
- The detainee's fitness for interview, taking into account the post-ictal phase
- Making an ongoing plan for the custody staff, so they are clear how to act should the detainee have a further seizure

*Note: buccal midazolam is licenced for use in epilepsy for children and young people under 18 years of age, only

Epilepsy and driving

The DVLA produces clear guidance regarding this which is accessible online (*Epilepsy and driving*). It is the legal responsibility of the person with epilepsy to inform the DVLA about their condition. People with epilepsy, who are seizure free for a year (though this may vary depending on individual circumstances and licence type held, e.g. HGV), are usually issued with short-term licences, for periods of up to 3 years. However, if at any point during that time, they have a seizure, they must cease driving and inform the DVLA, who will revoke their licence until certain criteria are met.

Epilepsy management involving cannabis

The Legalisation of Cannabis (Medicinal Purposes) Bill is before Parliament; if passed it will *'allow the production, supply, possession and use of cannabis and cannabis resin for medicinal purposes; and for connected purposes'*. At the time of writing this document, the bill is due for Second Reading in the House of Commons on a date yet to be announced.

Currently, only specialist clinicians can apply to the Home Office Expert Panel should they wish to use a cannabis-based medicine in the treatment of a patient. Non-licenced medicinal cannabis is CBD – cannabidiol – a chemical which occurs naturally in cannabis and has been licensed in the United States. It contains no THC (tetrahydrocannabinol) the compound which produces the psychoactive effects of cannabis.

Useful Resources

GMC
Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA

World Health Organization
Epilepsy

Epilepsy Foundation
2017 Revised Classification of Seizures

NHS
https://www.nhs.uk/conditions/epilepsy

NICE
cks.nice.org.uk/epilepsy
Epilepsies: diagnosis and management

www.parliament.uk
Legalisation of Cannabis (Medicinal Purposes) Bill 2017-19

www.gov.uk
Cannabis and cannabis-based medicinal products

S. Jones et al
A protocol for the in-hospital emergency drug management of convulsive status epilepticus in adults
Practical Neurology (2014), 14: 194-197

E. Galizia et al
Seizures and Epilepsy in the acute medical setting: presentation and management
Clinical Medicine (2018), volume18 (5): 409-413

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