

Learning Report

**External managed investigation
by Thames Valley Police
into the death of
Michael Spencer following
his release from
Wiltshire Police custody**

IPCC MANAGED INVESTIGATION FOLLOWING THE DEATH OF MICHAEL JOHN SPENCER ON 16 JULY 2006

Introduction

This investigation concerns the death of Michael John Spencer in a fatal road traffic incident at Shrivenham, Oxfordshire, on 16 July 2006 shortly after his release from custody at Gablecross Police Station, Swindon, Wiltshire.

There are no recorded complaints for this investigation.

As the fatal collision occurred in the area policed by Thames Valley Police, the Thames Valley roads policing department dealt with the investigation of the collision and will report on this to HM Coroner.

It was clear from details found on Mr Spencer at the scene of the collision that he had recently been released from police custody. As a result an investigation was started into Mr Spencer's time in police detention and was initially conducted by Wiltshire Police professional standards department and supervised by the IPCC.

As facts emerged the mode of investigation was re-determined by the IPCC to a managed investigation to be undertaken independently of Wiltshire Police by Thames Valley Police professional standards department. Eight officers/staff members were issued with Regulation 9 Notices or their equivalent. Misconduct allegations were substantiated against four officers and one civilian staff member. The investigation made 15 local recommendations to Wiltshire Police.

Overview of Incident

On 25 June 2006 an ambulance attended an address in Swindon where it was reported that a male (Mr Michael Spencer) had taken an overdose of paracetamol. It was also reported that the male may possibly be violent. This resulted in the police being notified and attending. Mr Spencer was taken to hospital where he was admitted before being discharged on 28 June 2006. No police action was taken.

During the late evening of Saturday 15 July 2006 Mr Spencer was at his home address. Mrs Spencer had been out with friends and returned home around midnight. Sometime after midnight into Sunday 16 July 2006 Mr Spencer had a disagreement with his wife and hit her in the face. At 2.08am Mr Spencer telephoned the police and told the operator what had happened. Police Officers attended the address together with an ambulance crew and paramedics. Mr Spencer was arrested for assaulting his wife. Mrs Spencer was taken to hospital.

Mr Spencer was taken to Gablecross Police Station which is located on the outskirts of Swindon, Wiltshire. He was in his slippers due to an unsuccessful search for other suitable shoes. Mr Spencer told the arresting officers that he suffered from depression and felt suicidal. Mrs Spencer told the police that he was on anti-depressants. Soon after he was booked into custody an officer brought his medication to the custody suite; however, the details of the medication were not brought to the custody sergeant's attention or entered on the custody record and it was placed in a secure locker. The arresting officers told the custody sergeant that Mr Spencer had said he was depressed and suicidal and they were told to put a

warning marker on the Police National Computer. The custody sergeant then asked Mr Spencer if he had ever harmed himself. Mr Spencer showed the officers some old self-harm cuts to his body and he stated that he had thought about jumping in front of a lorry.

The fact that he was on anti-depressants, had taken an overdose a couple of weeks before and had suicidal thoughts was entered on the custody record. His comment about jumping in front of a lorry was not entered on the record. No risk assessment was either made or recorded and his file was not initially placed in a red folder to indicate a high risk detainee. Nor did the custody sergeant request a doctor or other medical assistance for him. No arrangements were made for him to receive his medication. His detention was authorised and he was placed in a CCTV-monitored cell.

The custody sergeant responsibility for Mr Spencer's detention was not documented in the custody record despite this being a requirement of the force's custody policy. Handovers were held separately for custody sergeants and detention officers and the custody sergeant did not highlight Mr Spencer's comment about walking in front of a lorry.

The two custody sergeants taking over at 7am did not reassess Mr Spencer's care package or increase the frequency of checks to be made to him. The times given for two of the visits were wrongly recorded and in one case the detention officer who made the visit was wrongly identified.

At about 11.30am Mr Spencer's brother-in-law rang the custody unit to warn them about Mr Spencer's mentally unstable condition. He asked the officer to tell Michael Spencer to ring him if he needed anything. The officer did this but did not document the nature of the call or the concerns Mr Spencer's brother-in-law had raised. This meant that no-one else was made aware that a concerned family member, who could have collected Mr Spencer on release, had made contact. When Michael Spencer was interviewed he confirmed that he was on anti-depressants.

At 2.08pm, following advice from the Crown Prosecution Service, Mr Spencer was charged with an offence of assault, contrary to section 39 of the Criminal Justice Act 1998. He was given bail with the conditions not to contact his wife, directly or indirectly, or to go to his home address, except for one visit accompanied by a police officer to collect belongings. He was released from police custody at 2.15pm. At the time of his release he was wearing slippers. He was not in possession of any money or a mobile phone. No arrangements were made for any person to collect him.

After leaving the Police Station at 2:18pm Michael Spencer walked along the main A420 road away from Swindon and towards Oxford. At approximately 3.45pm (1½ hours after being released from custody) at a location on the A420 Michael Spencer was in collision, as a pedestrian, with an articulated large goods vehicle. Michael Spencer was certified dead at the scene. The fatal collision occurred within the Thames Valley Police Area.

In November 2003, 2½ years prior to the death of Michael Spencer, Colin Holcombe died in police custody at Swindon Police Station. This occurred in the custody unit

within the Police Station at Swindon, known as Westlea, which preceded Gablecross. As a result of the death there was a Police Complaints Authority (PCA) supervised investigation into the death of Colin Holcombe. An inquest was held in May 2005. Fifty-seven recommendations were made as a result of the 'Holcombe' investigation, a number of which are relevant to this investigation. Consideration has therefore been given to whether or not they had been implemented and what, if any, effect they had on the death of Michael Spencer.

Early in 2005 Wiltshire Police adopted a new custody procedural document. A number of the recommendations from the Holcombe inquiry and the inquest were incorporated into the new document. ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody was published in early 2006. The wording within the Wiltshire Police Custody Policy generally reflects this guidance.

The investigation found that Wiltshire Police failed to properly implement custody policy from the time Mr Spencer was spoken to by the first custody officer, through to being released by another custody officer. In particular there was a failure to effectively assess and manage the risks which Mr Spencer brought with him into custody and took with him when he left it. The following list highlights the key facts found by the investigation:

- Mr Spencer demonstrated signs of suicidal thoughts and mood on presentation at custody;
- Mr Spencer confirmed that he self-harmed, drawing attention to recent injury, and was on anti-depressant medication;
- Mr Spencer made specific reference to having considered jumping in front of a lorry;
- Despite all these factors and the recent log highlighting a previous suicide attempt, Mr Spencer was not referred to a nurse or doctor at any time when in custody;
- Initially Mr Spencer's custody record was not placed into a red custody folder to highlight him as of exceptional risk;
- Though he was put in CCTV monitored cell, none of the three custody sergeants who were responsible for Mr Spencer required more frequent visits to him than hourly;
- His prescribed medication for depression was brought into custody for his use but this was not recorded properly, no referral or advice about it was sought from a medical practitioner and no medication was administered to him;
- A call made into custody by a family member expressing concern as to Mr Spencer's mental health was not correctly recorded and was not utilised in the reassessment or management of the presenting risks;
- Wiltshire Police policy on management of risk on release states that supervised (police or family) release to an address on bail would be expected for vulnerable detainees.

Type of Investigation

From 18 July 2006 this case was supervised. On 13 September 2006 the decision was made to manage an investigation independent of Wiltshire Police.

Findings and Recommendations

Finding- Completion of Risk Assessments Errors and omissions were identified in the custody record relating to Michael Spencer. The custody records of persons in detention at Gablecross Police Station at the same time as Michael Spencer were also examined. In response to the result of this review a further decision was made to undertake a desk-top analysis of 26 custody records respectively from the custody units in Melksham and Salisbury. A number of errors/omissions/breaches of Custody Policy or PACE codes of practice were noted. Of particular concern is that the risk assessments of Detained Persons were not carried out and/or not recorded.

Local Recommendation

Wiltshire Police to ensure that all its custody staff are trained and competent in the completion and documenting of risk assessment.

Finding - Training of Custody Staff

The investigation established that all of the sergeants, who were deployed in the custody suite at Gablecross during the time Michael Spencer was in detention, had received some custody training. However, one of the officers had not received any formal custody training since 1995 and another had not received any formal custody training since 1999 and that was a one or two day course. Wiltshire Police sergeants are trained out of force, currently at Netley, Hampshire. While there is no criticism of the quality of the custody training that Hampshire Police provide, it became clear that it is not fit for purpose for Wiltshire Police. It does not cover Wiltshire Custody Policy and Procedures or the use of the Wiltshire Police IT system. While Custody Policy states that sergeants will be mentored for two weeks duration on returning to force, documentary evidence provided by Wiltshire Police indicates that on occasions new custody sergeants are not being afforded appropriate training, mentoring and support as outlined in their Custody Policy. Custody officer training is an ideal vehicle and opportunity to introduce and examine the expectations of the Custody Policy.

Local Recommendation

Wiltshire Police review the provision of training for custody sergeants. They should ensure that sufficient importance is placed on the provision of refresher training for custody sergeants, not only at regular intervals but also when training needs are identified as part of an individuals performance review or where there are significant changes to Custody Policy.

Finding - Training Delivery Methods

During the investigation it became apparent that there was an over reliance attached to distance learning or learning by e-mail. While such learning may be appropriate in certain circumstances there are occasions when policies, procedures and legislation which carry significant importance and accountability, should be delivered by a qualified trainer who has the experience and ability to identify individual training needs.

Local Recommendation

Wiltshire Police review its training procedures to ensure that the style of training reflects the importance and/or complexity of the subject matter.

Finding - Dip Sampling of Custody Records

Current Custody Policy states that custody records will be checked by way of dip sampling and that this will be carried out by the divisional custody inspector in an effort to ensure good quality and consistency. Firstly, this assumes that there is a divisional custody inspector. The investigation identified that at the time Michael Spencer was in custody there was no divisional custody inspector in post at Gablecross but there were two inspectors who shared the role and decided among themselves how they split the work. Secondly, this will result in some inspectors checking their own actions, a process which is not good practice and is unlikely to benefit the organisation. The local examination of custody records should allow for discrepancies and shortcomings to be identified at an early stage. Despite the assurances given by the custody inspectors during this investigation, the desk-top analysis of the 78 custody records from all three of the custody suites revealed there was little or no evidence of the errors/omissions being identified, let alone being brought to the attention of the staff involved. A more corporate approach together with detailed guidance should allow an opportunity to analyse the actions of staff at all three designated custody stations and therefore bring about uniformity.

Local Recommendation

Wiltshire Police review their Custody Policy regarding the dip sampling carried out by the divisional custody inspectors and consider that such a process should be carried out centrally.

Finding - Accessing TROVE IT System

During this investigation many staff made comment about difficulties in accessing documents from the TROVE Information Technology system. The problems are acknowledged by Assistant Chief Constable Vaughan who confirmed that TROVE was a particularly difficult system to navigate. Such a system is likely to result in officers/staff having hard copies printed and therefore when any policy is updated the hard copies will not reflect the updates. This was relevant to this case.

Local Recommendation

Wiltshire Police review their TROVE Information Technology system to ensure that staff can easily access the Custody Policy.

Finding - CCTV Records

There was an honest held belief that CCTV recordings held at Gablecross were retained for a period of 90 days. This is not the case. Such a belief is likely to result in relevant evidence being deleted within a shorter period of time and therefore not being available for any future requirement.

Local Recommendation

Wiltshire Police to ensure its staff are aware of the limitation and availability of CCTV images at Gablecross Police Station and the fact that the recordings are not automatically kept for 90 days.

Finding - Custody Policy in respect of Responsibility for Individual Detainees

The investigation highlighted a breakdown within Wiltshire Police as to expectations of custody staff in relation to the area of policy relating to responsibility for detainees. The Custody Policy is very clear and one of the paragraphs states:

'When more than one Custody Sergeant is working within a unit it is important that each is aware of which detainees s/he has overall responsibility for. It is not satisfactory for this responsibility to be shared'.

This Policy came about following a recommendation made in the 'Holcombe' report which states:

'That Wiltshire Constabulary reviews their policy in respect of how the 'responsibility' for detainees' is determined. It is evident that when there is more than one custody sergeant on duty there is no clear ownership/responsibility for individual detainees in respect of decisions made and the accuracy of the custody record.'

The problem according to staff at Gablecross, the only custody suite in Wiltshire which appears to have more than one custody sergeant at a time, is that the system is not workable. It appears that senior management at Gablecross, and at police headquarters via the strategic custody group meetings, were made aware of the problem and the fact that the policy was not being complied with. It appears they did not resolve the problem and staff continued to ignore the policy, with the apparent agreement of senior management. In the case of Michael Spencer the custody sergeants did not document in the custody record who was responsible for his detention.

Local Recommendation

Wiltshire Police review the current Custody Policy headed 'More than One Custody Sergeant' to ensure that any policy is workable and that the custody sergeant is readily identified and documented.

Finding - The Use of Red Folders in Custody

The receiving custody sergeant failed to place Mr Spencer's custody record in a red folder. The correct use of the red folder is a valuable tool in encouraging and establishing the individual risk factors for each detained person. In addition to studying the Custody Policy the concerns of officers who are practitioners of the system have been noted. They are concerned that if the current policy is implemented in full then an exceptionally high number of detained persons require a red folder. This detracts from the importance and significance that the red folder should have on the custody staff. The current policy instructs that in cases where there is a current PNC warning marker against the detained person then the Custody Record will be placed within a red folder. This would appear to apply to all PNC warning signals no matter how relevant they are at the time. It is totally correct for a red folder to be used where a person is identified as an exceptional risk. However, a subtle change to the wording of this part of the policy should allow for greater autonomy and enhanced decision making by the custody officer.

Local Recommendation

Wiltshire Police consider changing the wording of Custody Policy where it refers to Red Folders. Under the heading of 'Exceptional Risk Prisoners' in the first sentence of the final paragraph the word 'current' should be changed to 'relevant'.

Finding - Custody Handovers

The custody handover between outgoing and oncoming staff is vital to the welfare of a detainee. It is imperative that this is structured in order to reduce the chances of losing vital information on handover. During the investigation it became apparent that handovers were held separately between custody sergeants and detention officers. This was the case during the 7am handover on 16 July 2006 when Mr Spencer was in custody. Separate handovers increase the risk of information not being shared appropriately and in this case it was a clear missed opportunity for all custody staff to be updated and fully informed about detainees in their care. The initial custody sergeant failed to mention that Mr Spencer said he had considered walking in front of a lorry. The other person who was aware of this information was a detention officer and he was having a separate discussion with his detention officer colleagues. Had this detention officer been present at the handover with the custody sergeants he may have added this important information. This may have also have led to all the custody sergeants being made aware there was medication in the property store relating to Michael Spencer.

Local Recommendation

Wiltshire Police consider an instruction to staff that all custody handovers of detained persons between custody sergeants should also include detention officers being present.

Finding - Custody Policy and Risk Assessments

As part of the investigation consideration was given to the standards contained in the ACPO Safer Detention Guidance and how these can be put into operation in the case of persons at risk of suicide. The new guidance puts a greater emphasis on the subject of risk assessment and therefore Wiltshire Custody Policy should reflect this guidance. One area which needs to be reinforced is the guidance in relation to the risk assessment of a person released from custody. This case has highlighted the need for the custody officer to continually review the risk assessment of a detained person particularly on release from custody. All risk assessments should be recorded in the custody record.

Local Recommendations

Wiltshire Police ensure that the advice contained in the ACPO Safer Detention Guidance in relation to risk assessment is wholly reflected within its Custody Policy. This includes the advice that being charged, refused bail or released on bail can alter the detainees risk assessment and, therefore, the custody officer must review the risk assessment at this stage.

Wiltshire Police ensure that all risk assessments, including the rationale for such assessment, are documented in the Custody Record.

Wiltshire Police ensure that all officers and staff who are responsible for a detainee's custody are properly trained in and understand the relevant advice contained in the ACPO Safer Detention Guidance.

Wiltshire Police conduct a review to consider central management of force custody provision.

Finding - Accurate Recording on Documentation

A detention officer recorded a check in the custody record timed at 4am stating 'Visit Asleep'. CCTV evidence shows that no such check was completed at this time. A check was however made by this detention officer at 4.21sm but this check is not recorded in the custody record.

Local Recommendation

Wiltshire Police emphasise to all custody staff the importance of accurate and truthful recording on all official documents including custody records.

Finding - Handling of Medication in Custody

Medication belonging to Mr Spencer was brought by police to Gablecross Police Station. Details of the medication were not entered in the custody record. It was placed in a secure prisoner's property locker and returned to Mr Spencer on his release. At no stage were details of the medication brought to the attention of a custody sergeant.

Local Recommendation

Wiltshire Police add to their Custody Policy an instruction that medication being retained on behalf of a detainee will be physically checked on handover between custody officers to ensure it is properly accounted for and listed within the custody record. The fact that it has been checked will be additionally endorsed in the custody record. Medication will only be returned to a detained person by the custody sergeant.