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Arrest and ‘near miss’ in police custody
Devon and Cornwall Constabulary

Independent Investigation
Learning Report

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Summary

1. At 10:45am on Thursday 10 March 2011, Mr A was arrested on suspicion of burglary by officers from Devon and Cornwall Constabulary at a flat in Torquay, belonging to a friend. He was taken to Torquay police station and booked into custody, where he was assessed by a healthcare professional (HCP). Despite denying that he had consumed any drugs or alcohol that day, the HCP decided Mr A was possibly under the influence of a substance, so he was placed on a regime of 30-minute rousal checks during his detention in custody. Mr A was placed in a cell monitored by CCTV at 11:34am.

2. During Mr A's detention, his condition deteriorated. He was subject to checks every 30 minutes by the custody staff, but from 2:18pm these were conducted via the cell hatch and no detention officers entered his cell. From 2.18pm, he is seen to be lying on the floor of his cell and makes no visible movements from this point on.

3. At 3.33pm, a check was conducted on Mr A and he was found to be unresponsive in his cell. He was taken to Torbay District Hospital where he was diagnosed to be suffering from the effects of a methadone overdose and suspected pneumonia. He later admitted to having taken three 100ml doses of methadone just prior to his arrest.

Findings and recommendations

Finding 1 – Training

4. Mr A was placed on 30-minute rousal checks following an examination by the on duty healthcare professional, who believed he was showing signs of possibly being under the influence of a substance.

5. Both the ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody and the Police and Criminal Evidence Act (Code C, Annex H) state that rousal checks require the detention officer to go into the cell (although common sense dictates that there may not be a need for this if the detainee is observed through the spy hole or hatch to be awake and moving around the cell. In this case, this should be noted in detail on the custody record.)

6. The custody sergeant's check on Mr A at the start of the late shift consisted of the sergeant opening the door to the cell and tapping his hand several times with his foot. Mr A was not seen to move. The next three checks conducted on him by a detention officer were through the hatch in the cell, during which time his position of lying on the cell floor did not change. Very little detail of Mr A's alleged responses to any of these checks was recorded on the detention log, and there was no reference to any implied threat or aggressive verbal reply.

7. During the time between this incident and the IPCC investigation, a new version of the ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody was released. Both the custody sergeant and the detention officer interviewed as part of this investigation stated they had since received further training on how to conduct rousal checks and to correctly annotate the custody log, and had revised their working practices as a result of this.

8. However, it is unclear whether there has been specific training provided to custody staff on the newly revised aspects of the ACPO Guidance.

9. The investigation also identified the requirement for custody sergeants to supervise the work of their detention officers, both in terms of checks conducted and entries made on the custody record. It is accepted there is an element of trust involved, in that sergeants should expect competence and diligence from the detention officers; nonetheless, the sergeants are responsible for ensuring the quality of their work.

Local recommendation

10. Measures should be taken to ensure all custody staff are aware of the relevant revisions to this Guidance. If this is to take place in the form of specific training, audits should be kept detailing this and regular refreshers scheduled where necessary.
11. In relation to the supervisory aspects of the sergeants' role, some form of dip sampling process (in terms of overseeing the checks and reviewing entries on the custody record) should be considered in order to ensure the standards specified by the policies and guidance are consistently being met.

Finding 2 – Handovers

12. This investigation identified that shift handovers in Torquay custody centre only take place between the sergeants. No official handover process exists for the detention officers, nor between sergeants and detention officers.

13. In terms of this incident, this meant that the detention officer conducting the checks on Mr A did not know the reasons for him being on rousal checks and was unaware of the healthcare professional's opinions regarding his welfare.

14. This is in contravention of the ACPO Guidance to the Safer Detention and Handling of Persons in Police Custody, which emphasises the importance of comprehensive and effective debriefing and handover between custody staff.

Local recommendation

15. Measures should be taken to implement a scheduled, structured handover process, involving both sergeants and detention officers, to be conducted at every shift change. It is accepted that custody centres can be extremely busy and there are many time pressures on the staff working within them, but this process should be viewed as an integral part of the shift change and not simply as something to be conducted only if time allows.

16. Although this investigation related to Torquay custody centre, it is recognised that other custody centres may also not conduct handovers of this sort. Steps should therefore be taken to identify any custody centres which do not currently undertake handovers for both sergeants and detention officers at shift changes, and to ensure that this recommendation is implemented force-wide.

Finding 3 – Cell CCTV monitoring

17. This investigation found there was a lack of proactive responsibility in Torquay custody centre in terms of monitoring the CCTV from video cells. The commonly-held view was that all members of staff were expected to do this, and there is no process in place for ensuring this is done.

18. The main purpose of CCTV in cells is to continuously monitor those detainees considered to be at risk of self-harm or suicide attempts. Although it does not appear Mr A was considered a self-harm or suicide risk, the sergeant who booked him in clearly had concerns regarding his welfare such that he believed Mr A needed an extra level of monitoring. However, as none of the custody staff appeared to notice his deterioration despite this being shown on the CCTV in an

area actively used by all, there arise queries as to the effectiveness of this measure and how this can be improved.

Local recommendation

19. When the decision is taken to place a detainee who does not fall into the category of potential self-harmer or suicide risk in a video cell, the sergeant making this decision should stipulate the expectations he or she has as to the monitoring of the CCTV; who will do this and how often. Again, it is accepted that custody centres can be busy and there are many other time pressures on the staff, but cell CCTV is a valuable commodity in the prevention of incidents of this nature and needs to be utilised effectively as such.

Consultation

20. A draft learning report was sent to Detective Superintendent Iain Grafton at Devon and Cornwall Constabulary on 25 June 2012 in order to allow the appropriate authority an opportunity to provide a response to the findings and recommendations.

Response from Appropriate Authority

21. Devon and Cornwall Constabulary responded to the report on 6th July 2012. Chief Inspector Claire Armes is currently in the process of drafting an Action Plan in relation to the issues highlighted in this report. This Action Plan will be forwarded to the IPCC and approved in due course.

Conclusion

22. The IPCC is keen to ensure that the lessons arising from this matter are learned by Devon and Cornwall Constabulary so that similar incidents are avoided.

23. The IPCC considers that the actions proposed by Devon and Cornwall Constabulary are appropriate in the circumstances. This will be reviewed following receipt of the Action Plan.

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Independent Police Complaints Commission