Near Misses in Police Custody: a collaborative study with Forensic Medical Examiners in London
Near Misses in Police Custody: a collaborative study with Forensic Medical Examiners in London

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Executive Summary
This study examined ‘near misses’ in police custody. We defined a near miss as any incident which ‘resulted in, or could have resulted in, the serious illness or self-harm of a detainee’. Our study involved Forensic Medical Examiners who are doctors employed to support the police in the care of detainees. They are commonly called to police stations to examine detainees who may have medical conditions or be intoxicated with drugs or alcohol, and decide whether detainees are fit to be detained or interviewed. We asked Forensic Medical Examiners to report the details of near miss incidents which occurred in the Metropolitan Police Service over a 12-month time period (May 2005 to April 2006). Qualitative interviews were also conducted with a sample of Forensic Medical Examiners in order to look in more depth at a range of incidents. The main findings of the study are outlined below.

Prevalence

- A total of 121 near misses were reported during the 12-month time period. The severity of the incidents varied considerably.
  - In 50 of the 121 incidents the Forensic Medical Examiners felt that if the incident had not been responded to, death was very likely or fairly likely.
  - Twelve detainees had to be resuscitated in the custody suite. These people were typically intoxicated with drugs or alcohol, and include cases where drugs had been swallowed on arrest.
  - Fifty-nine were taken to hospital as a result of the incident, and 27 were detained there for observation or treatment.

- We used the above figures to calculate an estimate of the number of near misses that occur in police custody in England and Wales.
  - Based on our definition of a near miss we estimate that there may be approximately 1,000 such incidents each year in police custody.
  - If we take a stricter definition and focus on just those cases where death was thought to be very likely or fairly likely, we estimate that approximately 400 near misses may occur each year.

- It is important to emphasise that the above figures are not presented as exact figures. They are approximate estimates which seek to give a broad national picture of near miss incidents

Circumstances of incident

- The most common incidents involved:
  - attempted suicide/self-harm (46%);
  - drugs consumption or possession (33%);
  - medical conditions (14%); and
  - alcohol consumption (7%).

- **Attempted suicide/self-harm:** Forensic Medical Examiners identified attempted suicide/self-harm as the main cause of 56 incidents.
  - Thirty-four incidents involved self-strangulation using a piece of clothing, shoe laces, belts or cords from tracksuit bottoms, blankets or paper suits issued in custody.
  - Nineteen incidents involved detainees cutting themselves with plastic cutlery, watches, jewellery, metal from a lighter or drinks cans, or razor blades.
  - Three other incidents were categorised as attempted suicide/self-harm. Two of these involved detainees injuring themselves having been intentionally banging their heads against the cell wall, and one involved a person swallowing a razor blade.

- **Drugs:** Forensic Medical Examiners identified 40 incidents as centring on drugs consumption or possession.
  - Seventeen incidents involved individuals swallowing drugs during or following arrest in an apparent attempt to conceal them from police officers.
  - Thirteen incidents were the result of intentional ingestion, for example of heroin or cocaine, prior to arrest.
  - Six incidents involved apparent accidental overdose.
  - Four cases involved detainees attempting to take drugs but being stopped by police personnel or a Forensic Medical Examiner.
**Medical conditions:** Forensic Medical Examiners identified 17 incidents as centring on medical conditions.
- Eight concerned diabetes.
- Four concerned chest pains or heart problems.
- Five concerned epilepsy, seizures, high blood pressure, pneumonia or pregnancy.

**Alcohol consumption:** Forensic Medical Examiners identified eight incidents as centring on alcohol intoxication or withdrawal. All eight detainees were sent to hospital and five were kept in hospital for observation.

Although Forensic Medical Examiners identified the main factor in a case, other factors were likely to be present and play a role in the incidents. For example:
- drug use was reported as being relevant in 34% of incidents;
- alcohol was reported as being relevant in 22% of incidents; and
- forty-one percent of detainees in incidents had a known mental illness, with seven detainees being described as having a personality disorder.

When compared to deaths in police custody, there were a number of notable differences. Firstly, our sample contained a far greater proportion of attempted suicides and cases of self-harm compared to instances of suicide contained in the national figures on deaths. Secondly, there were proportionately more near misses related to drugs and alcohol compared to deaths due to these substances. Thirdly, there were far fewer near misses related to medical conditions, organ failure or injuries compared to fatalities. In the report we discuss why these differences might exist.

Forensic Medical Examiners were asked about which factors had a negative impact on the near miss incident. The three most commonly mentioned factors were:
- poor searching of detainees;
- insufficient numbers of custody staff; and
- poor checking and rousing.

Forensic Medical Examiners were asked about which factors had a positive impact on the near miss incident. The three most commonly mentioned factors were:
- good checking and rousing;
- speed of request for a Forensic Medical Examiner; and
- sufficient numbers of custody staff.

**Conclusions and Recommendations**

Despite the large amount of existing regulations, guidance and policies, our study identified a number of areas where improvements can be made in terms of avoiding near misses and fatalities. These touch on issues concerning:

- the training given to custody staff so that they are sufficiently aware of and are able to identify certain risks and conduct appropriate assessments; and
- the need to reinforce to custody staff the importance of following procedures and training centring on the care of vulnerable detainees.

We believe that these are likely to be general issues for those managing and working in custody suites across England and Wales. As a result we outline below a series of recommendations which are written for all police forces. Recommendations One to Three address a number of different concerns about the entry of detainees into police custody. These include not addressing known risks, such as allowing someone who was known to have swallowed drugs to enter police custody, rather than sending them to hospital. They also include the misinterpretation of risk, such as assuming that a detainee has severe alcohol intoxication when they have hypoglycaemia. Recommendations Four to Eight address concerns about the care of vulnerable detainees once in the custody suite. These include the need to check cells prior to occupation to ensure items from previous detainees have been removed, through to the need for correct levels of observation, checking and rousing. Recommendations Nine to Eleven concern the broad management of police custody. They touch on the training given to custody staff, their work load capacity and the need for forces to consider creating their own system of reporting near misses.
Finally, there is little evidence that serendipity played a key role in averting these potential deaths. Instead the following of procedures, such as checking and rousing, tended to identify a risk which was responded to through medical assistance. A key message here is that adherence by custody staff to PACE and associated policies saves lives. But since in a notable number of cases this was not what happened in practice, this message needs to be reinforced to custody staff and is reflected in our recommendations. While the policies and guidance may be right, it is important that they are reflected in custody practice.

**Recommendation 1:** for those responsible for custody policy in police forces to consider whether custody staff are fully aware, or need to be reminded via guidance and training about the appropriate responses to drug swallowing and severe intoxication. Likewise the message needs to be reinforced that apparent symptoms of intoxication may in fact be the result of an injury or medical condition, and that intoxication may mask or be found in conjunction with serious health needs.

**Recommendation 2:** for police forces to consider whether Custody Officers have been provided with sufficient guidance on the management of those detainees who are either unwilling or not able to participate in a risk assessment.

**Recommendation 3:** for police forces and health service providers to ensure that Custody Officers and Forensic Medical Examiners are provided with a record of treatment for detainees returning from hospital. This may require discussion between the two organisations about the best way to communicate any treatment information, and if a method exists already, to ensure that hospital staff are aware of their role in this practice.

**Recommendation 4:** for police forces to ensure that Custody Officers are aware of the importance of checking cells when they are vacated and the need to remove items which could be used to self-harm by later occupants.

**Recommendation 5:** for police forces to ensure that Custody Officers have ready access to ligature knives.

**Recommendation 6:** for police forces to ensure that Custody Officers are aware of the requirements for the monitoring and observation of detainees as outlined in PACE Code C and national guidance on ‘The Safer Detention & Handling of Persons in Police Custody’.

**Recommendation 7:** for police forces to ensure that Custody Officers are clear that ‘rousing’, as outlined in PACE Code C, means eliciting a verbal or physical response from the detainee.

**Recommendation 8:** for Forensic Medical Examiners to be aware of the danger of detainees stealing medication during consultations and to take precautions to avoid this occurring.

**Recommendation 9:** for those responsible for managing custody suites to consider whether the flow of detainees at peak times compromises custody staff’s ability to follow PACE Code C and to plan appropriately for such occasions.

**Recommendation 10:** for police forces to ensure that Custody Officers, as part of their training, gain sufficient awareness of the symptoms of key conditions, involving substance misuse and health conditions, to be able to conduct robust risk assessments.

**Recommendation 11:** for police forces to consider developing ways in which near misses in custody can be reported to those with responsibility for managing custody policy and procedures.
Introduction
Over the last ten years there have been a number of studies that have focused specifically on deaths in police custody or care (Norfolk, 1998; Leigh et al, 1998; Bratby, 1999; Best et al, 2004). The aim of these studies has been to highlight risk factors for death or harm in custody, and to provide recommendations and guidance on how to make police custody a safer environment for detainees, as well as for custody staff. What these studies have highlighted is the inherent complexity of this issue, and the potential learning opportunities which could be furthered by additional research in this area.

It is worth noting that, despite the high profile nature and complexity of these cases, deaths in police custody are a relatively rare occurrence. According to data reported by the IPCC, there are around two police custody deaths per 100,000 arrests in England and Wales, which translates into around 31 cases a year (Teers and Menin, 2006). However, while relatively infrequent, deaths which do occur have a major impact on families and those police personnel involved. They can also be controversial and therefore have consequences for public confidence in the police. In addition, a number of these deaths in custody show strikingly similar features concerning the risk assessment and management of vulnerable individuals, suggesting that lessons have not always been learned or acted upon. This is especially pertinent given the police’s duty of care for those in custody and the obligation placed on public authorities by Article 2 (the right to life) of the Human Rights Act (1998).

While deaths in custody are a relatively rare event, there is some evidence to suggest that there are a substantial number of ‘near miss’ incidents in police custody each year (Best et al, 2004). In the context of this study the term ‘near miss’ is used to refer to incidents which result in, or could have resulted in, the serious illness, injury or self-harm of a detainee. Examples of a near miss incident might be an attempt to commit suicide by a detainee which was prevented by custody staff, or where a person found collapsed in a cell requires resuscitation and hospital treatment.

Despite initiatives in some forces, near miss incidents are generally not well documented or researched. In part, this is because some of these incidents may involve few, if any, adverse outcomes for the detainee. In addition, concerns about culpability and resulting sanctions may deter individuals from reporting such events. This has made it more difficult in the past to conduct research in this area.

**Background**

This study sought to gain a better understanding of near misses in police custody. The lack of information on these incidents represents an important gap in our understanding of what goes wrong (and what goes right) when such events occur in police custody. They therefore have the potential to develop our understanding of the risks that occur and shape policy, training and cell design, so that future near misses and deaths are prevented. In particular, these incidents have the ability to tell us more about the factors that prevent a near miss from developing into a death in custody. For example, could this be due to custody staff adhering to operational procedures or does serendipity also play a role?

In 2003, a feasibility survey was conducted by the Police Complaints Authority (the predecessor to the IPCC) in collaboration with representatives from the Association of Forensic Physicians, the Metropolitan Police Service (MPS) and a leading Forensic Physician. It required Forensic Medical Examiners (FMEs) in the London area to retrospectively report any ‘near miss’ incidents in the previous 12-month period, with the aim of estimating the prevalence and nature of any such incidents, and highlighting relevant learning points. A key finding of the study was that near miss incidents form a major and often neglected learning opportunity. The authors strongly recommended conducting a more detailed assessment of incidents in custody with FMEs recording cases as they occurred (Best et al, 2006).

Since our study began near misses in custody have gained a...
NEAR MISSES IN POLICE CUSTODY  1. Introduction
greater importance. This goes beyond what might be learnt from these incidents in the context of reducing deaths. Instead near misses have an increasing importance in terms of the State’s responsibilities for those in its custodial care and specifically the need to protect life. The relevance of these questions to the police service and other organisations has been highlighted by two recent legal cases4. These both concern young men who attempted suicide while in prison. The case of ‘D’ involved a prisoner who was known to be a suicide risk and, following a suicide attempt, was left brain damaged. The Court of Appeal decided that this case required a fully independent investigation if the State’s commitment under Article 2 (the right to life) of the Human Rights Act (1998) was to be met. This ruling means that this requirement will also apply to at least some near misses in the future. Another case, that of ‘JL’, also involves the attempted suicide of a young man in prison custody, and may further clarify what circumstances trigger the need for an independent investigation once it has been to the Court of Appeal. Overall, these cases highlight a tension between the State’s responsibilities under Article 2 with regard to near misses and the potentially high costs of investigating these incidents. Given the legal developments in this area, it is important to have some indication of the number of near miss incidents that occur in police custody and the circumstances under which they occur.

Resulting from increasing concerns about the welfare of those in police custody, a further development has been the issuing of national guidance by the Association of Chief Police Officers, the Home Office and the National Centre for Policing Excellence (NCPE). ‘The Safer Detention & Handling of Persons in Police Custody’ is an important milestone in terms of setting standards for custodial care. It remains to be seen how much of the new and more ambitious parts of the guidance will be reflected in future custody practice. The guidance was being formulated and published during the lifetime of this study, and was still being digested by police forces when the fieldwork period ended. We therefore make reference to the guidance in this report, but do not compare custody practice with the content of the guidance.

Overview of Study

This study aimed to enhance our understanding of near miss incidents in police custody by exploring the experiences of FMEs with regard to near miss incidents in custody suites in the MPS. FMEs’ work in police custody suites makes them well placed to comment on near miss incidents. The MPS is the largest of the 43 police forces operating in England and Wales and employs over 130 FMEs. In 2005/06, these FMEs conducted a total of 195,905 detainee examinations (MPS, 2007). Conducting the study in the MPS allowed us to draw on the experiences of a large number of FMEs who attend to a broad and diverse detainee population.

Aims

The primary aims of the study were:
- to determine the frequency of ‘near miss’ incidents attended by FMEs in police stations in the MPS;
- to explore the circumstances, nature and management of such incidents; and
- to identify what interventions may be implemented to reduce the risk of such incidents occurring in the future.

The study aimed to add to our understanding of near miss events by requiring FMEs to provide information on incidents at the time of their occurrence, rather than relying on staff to accurately recall circumstances sometime after the event occurred. It was intended that this would increase the accuracy and reliability of the information collected.

Methodology

The study was conducted in two stages. The first stage was a 12-month prospective survey requiring FMEs working in custody suites in the MPS to complete and return a questionnaire to the research team each time they attended a near miss incident. The second stage involved in-depth interviews with a sample of FMEs who had participated in the survey stage to explore in more detail some of the issues raised in the questionnaires.

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Questionnaire Design
The research team drew on the findings from earlier studies into deaths and near miss incidents in long- and short-term custody when designing the questionnaire. It was considered vital that while the form allowed the collection of information detailed enough to meet the aims of the project, it was also quick and straightforward to complete in order to maximise participation. During the development process, the research team piloted the questionnaire and also conducted cognitive interviews with four FMEs in order to ensure that the process, structure and meaning of the questions were interpreted as intended.

Near Miss Definition
There is no agreed definition of the term ‘near miss’ and its interpretation will differ depending on the context in which it is used and the individual concerned. For the purpose of this study, the phrase ‘near miss’, and the possible preconceived meanings associated with it, was avoided. Instead a statement was provided describing the circumstances in which the questionnaire was applicable:

“This form should be used to record any incidents which result in, or could have resulted in, the serious illness, injury or self-harm of a detainee.”

The wording of this statement was developed following consultation with six FMEs. Each was provided with a number of alternative statements and a selection of scenarios, some of which met the research team’s criteria of a near miss incident and some of which described incidents which were not considered to be relevant. The FMEs were then asked to select which of the scenarios would be included under each of the definitions provided. Following this exercise, it was decided that the definition should be left intentionally broad in order to ensure that all incidents which may be relevant were included, and the wording above was agreed. Responsibility was left to the research team to exclude any incidents which were not deemed to be relevant at the analysis stage.

An increasingly common term in this area is ‘adverse incident’; however, it was not available when this study started.

FME Involvement
All 132 FMEs who worked in custody suites in the MPS in March 2005 were contacted by the IPCC and asked if they would be willing to participate in the study. FMEs were provided with information about the study, a sample questionnaire and a pre-paid reply slip on which they could indicate their willingness to participate. While FMEs were encouraged to take part, it was also made clear that participation was entirely voluntary. Those FMEs who did not respond within a stated time period were followed up by telephone and encouraged to return the slip either by post or fax. At least three attempts were made to contact each non-responder.

Responses were received from 124 FMEs, 95% of the total sample. Eighty-nine of those who responded agreed to take part in the study and 35 declined. This equated to a 67% positive response rate for the total population of FMEs working in the MPS at that time.

Data Collection
Participants were asked to complete the one-page questionnaire each time they attended a near miss incident. In order to facilitate the timely completion of the questionnaire, participants were provided with a number of options for obtaining the document. At the start of the project, each participant was sent five copies of the questionnaire and informed of how to request further copies. A supply of questionnaires was also sent to Principal FMEs to be placed in medical rooms in police stations and an electronic version was made available to download from the IPCC website. Each participant was also provided with a supply of stamped addressed envelopes in order to facilitate the return of completed questionnaires.

Fieldwork
The survey ran for a period of 12 months, from 1st May 2005 to 30th April 2006. Fieldwork was managed by a member of the IPCC research team, who had responsibility for responding to questions from participants, sending out quarterly reminder letters, receiving completed questionnaires and inputting the
data into an SPSS (Statistical Package for Social Scientists) dataset in preparation for analysis.

Limitations
Near misses in police custody are difficult to research and we are aware that this study has a number of limitations. Firstly, we would have liked Custody Officers to have participated in the study but we were not able to get the necessary approval for this to occur. Instead the study only includes those incidents where the detainee had been seen by an FME. If a detainee was taken directly to hospital by police or paramedics without any FME contact, then the incident may not have been reported. This means that our study is likely to underestimate the number of near misses that occur. Secondly, considerable efforts were made to maximise levels of FME participation. For example, support was gained from influential professional groups and committees and the study was publicised through regional FME group meetings. However, around a third of FMEs covering the MPS decided not to participate in the study. Their non-participation could potentially skew the representativeness of the data and may have implications for our estimates of near misses.

Thirdly, the questionnaire was designed to be quick and easy to complete and regular reminders were sent to participants during the study period to encourage their continued support. However, participating FMEs may not have reported all the near miss incidents of which they were aware. This may be due to a number of reasons, ranging from forgetfulness to concerns that acts or omissions on their part may have led to a near miss. Fourthly, the close participation of FMEs in this study means that many of the conclusions and recommendations will come from an FME perspective. This has a positive aspect in the sense that FMEs will have a strong insight into the incidents reported. However, there may be other recommendations on reducing near misses not presented in this report because they would require the perspective of custody staff, or because they relate to FMEs (for example, better training of FMEs or improved clinical governance). Fifthly, the research team worked with FMEs to develop a definition of a near miss incident which would be understood by all participants. However, it is recognised that interpretation of what constitutes a near miss will vary among individuals and that this must be considered when analysing the data. Overall, the implication of most of the limitations listed above is that our study may well underestimate the number of near misses occurring in police custody.

Ethical Considerations
Participants were given the option of remaining anonymous. The option to provide personal details was included for the purpose of the follow-up study. The information provided on the form was confidential. No persons detained or arrested by the police were named in any documents in the course of the research study, even when that person was directly involved in the near miss incident. Similarly, no police staff are named and the specific details of the event, such as the date and custody suite, are also omitted from the questionnaire.

Researchers attended an NHS Research Ethics Committee in Huntingdon in January 2005 where the research proposal and all documentation were fully considered and approved in accordance with the Governance Arrangements for NHS Research Ethics (Department of Health, 2001).

Follow-up Interviews
All participating FMEs were asked if they would be willing to take part in a follow-up study, exploring in more detail some of the experiences and issues raised in the questionnaires. Twenty-nine FMEs volunteered to take part in this stage which involved an in-depth semi-structured interview conducted by IPCC researchers.

The research team decided that 14 interviews would provide the breadth and depth of information required in this stage of the research. The number of interviews would have been increased had the researchers felt that there were outstanding issues still to be explored after the initial stage of interviewing. In developing the sampling criteria, the following factors were considered:
- number of incidents reported by FMEs;
- nature of incident(s) reported by FMEs;
- severity of incident(s) reported by FMEs;
- location of FME; and
- issues raised by FME in the questionnaire(s).
Of the 14 FMEs initially contacted, 12 agreed to take part in the follow-up stage. Two additional physicians were recruited from the five FMEs who had been identified as appropriate reserves in case the target number of interviewees was not achieved.

Interviews took place at the FME’s home address or at another location convenient to the participant. None of the interviews were conducted in police custody suites. All participants gave permission for their interview to be recorded and tapes were transcribed by an external agency. The textual data was analysed thematically using an index system to identify key issues and themes. Where possible, observations made during the interviews were backed up by evidence from the survey stage of the research. The case studies used in the following chapters to illustrate specific issues in this report are based on these interviews with FMEs.

One possibility would have been to supplement follow-up interviews with FMEs with additional information about the incidents from police records. The most obvious documents here would have been the custody records providing details of detainees’ time in police custody. However, in order to get FME participation, the near miss questionnaire was designed so as to have very little information on the location of the incident. This ensured anonymity of the FME completing the form as well as the custody staff involved in the incident. This lack of detail about the location of the incident meant it was not possible to trace the custody records for specific incidents.

**Structure of the Report**

The following chapters present the findings from the research, drawing out key issues and highlighting possible areas of learning. Chapter 2 provides an overview of the reported incidents, and presents information on the background and demographics of the detainees. Chapter 3 analyses the circumstances of the incidents, identifying the potential risks and vulnerabilities of the detainee population. Chapter 4 looks at issues around the assessment, care and management of detainees, and Chapter 5 draws together the conclusions and recommendations of the research study.
Overview of Reported Near Miss Incidents
This chapter provides an overview of the near miss incidents reported by FMEs. It firstly quantifies the incidents in terms of the number, rate, type, severity and time of occurrence. It then goes on to outline the characteristics of the detainees at the centre of the incidents and any subsequent medical treatment they received.

**Number of Incidents**

During the 12-month study period, FMEs working in custody suites in the MPS reported 124 near miss incidents to the research team. Three of these incidents were excluded from the analysis as they did not fit within the definitional criteria of what constitutes a near miss. Therefore 121 incidents were included in the analysis.

The figure of 121 is likely to underestimate the actual number of incidents attended by FMEs which occurred over this period. Of the 14 FMEs who took part in the follow-up stage of the research, ten said they thought they had under-reported the number of relevant incidents they had attended, with each referring to at least two other incidents they could have reported. Two FMEs said they thought they had attended as many as five additional incidents which would have fitted the reporting criteria. The most common reason for not reporting these incidents was ‘forgetting’ or ‘not having enough time’. It is also likely that participating in the follow-up interview prompted FMEs to re-evaluate other incidents they had attended in the context of the near miss study. Where the identity of the FME was known the number of incidents reported ranged from one to 21. Overall, the average number of incidents reported by FMEs during the period of the study was one incident per FME.

**Rate of Incidents**

The 89 FMEs who agreed to participate in the study reported a total of 121 near miss incidents, a rate of 1.4 incidents per participant. If this rate was generalised across the 132 FMEs working in custody suites in the MPS, then this suggests that a total of 179 near miss incidents occur each year in this police force. Taking into account the number of people detained annually by the MPS during the 12-month period of the study, this figure suggests that there was one near miss incident for every 1,686 people detained.

Some caution should be applied to the above estimates. They do not take into account those near misses which are never brought to the attention of an FME, perhaps because the person is taken straight to hospital by police or paramedics; nor do they consider the possibility of under-reporting highlighted by FMEs. Therefore the number of near miss incidents may in fact be considerably greater than the estimates provided here. However, it should be noted that the severity of these incidents varies considerably according to FMEs’ own interpretation of what constitutes a ‘near miss incident’ so it is unlikely that all of these incidents would be potentially fatal.

**Calculating Numbers of Near Misses in England and Wales**

We are able to take the above estimates and use them to calculate figures on the number of near misses across police forces in England and Wales. Again, some caution should be applied to these estimates. A key issue here is the extent to which the picture in the MPS is reflected across other forces in terms of numbers of near misses, but also more broadly with regard to the difference between arrests for ‘notifiable offences’ and total number of detainees. However, the below calculations are not presented as exact figures. They are simply approximate estimates which seek to give a broad national picture of near miss incidents. A number of steps have to be taken to provide the estimates and these are outlined below.

**Step One: Estimating Detainees in England and Wales in 2005/06**

No figures exist for the number of people detained in police custody each year. Police forces have traditionally notified the Home Office, and latterly the Ministry of Justice, of arrests for certain types of crime. However, these figures exclude arrests for offences such as drunk and disorderly. They also exclude detentions which do not involve an arrest, such as those where a police custody suite is used as a ‘place of safety’ under s136 of the Mental Health Act 1983. To overcome this problem, Table 2.1 provides an estimate for the number of detained people in England and Wales during 2005/06 by using figures provided by the MPS on total detentions and figures on arrests for Notifiable Offences (Ministry of Justice, 2007). This estimates that the difference between arrests for Notifiable Offences in 2005/06 is approximately 136,000.
the MPS and total numbers of detentions is 34%. When this figure is then applied to overall figures for arrests, we estimate that approximately 1.8 million people were detained in police custody during 2005/06.

**Table 2.1**
Estimating Detainees in England and Wales in 2005/06

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. No. of people detained in custody in MPS in 2005/06</td>
<td>301,302</td>
</tr>
<tr>
<td>b. No. of arrests for ‘Notifiable Offences’ by MPS in 2005/06</td>
<td>200,029</td>
</tr>
<tr>
<td>c. Numerical difference between two figures (a-b)</td>
<td>101,273</td>
</tr>
<tr>
<td>d. Percentage difference between two figures (c/a)*100</td>
<td>34%</td>
</tr>
<tr>
<td>e. No. of arrests for ‘Notifiable Offences’ in England and Wales in 2005/06</td>
<td>1,353,800</td>
</tr>
<tr>
<td>f. Estimated ‘other detainees’ (e/100)*34</td>
<td>460,292</td>
</tr>
<tr>
<td>g. Estimate for all detainees in England and Wales in 2005/06 (e+f)</td>
<td>1,814,092</td>
</tr>
</tbody>
</table>

**Step Two: Estimating Near Misses across England and Wales**

Table 2.2 estimates that detentions in the MPS make up 17% of the overall figure for England and Wales. Taking the estimate of 179 near misses occurring during the study period as 17% of the total gives us an estimate of 1,053 near misses across England and Wales.

**Table 2.2**
Estimating Near Misses across England and Wales

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Estimate for all detainees in England and Wales in 2005/06</td>
<td>1,814,092</td>
</tr>
<tr>
<td>b. No. of people detained in custody in MPS during the study</td>
<td>301,828</td>
</tr>
<tr>
<td>c. MPS detainees as % of all detainees in England and Wales (b/a)*100</td>
<td>17%</td>
</tr>
<tr>
<td>d. No. of near misses in MPS during study</td>
<td>179</td>
</tr>
<tr>
<td>e. Estimated number of near misses in England and Wales (d/c)*100</td>
<td>1,053</td>
</tr>
</tbody>
</table>

A separate calculation supports this figure. In 2005/06, six people died in or following police custody in the MPS (Teers and Menin, 2006). This suggests that for every person who dies, there are around 30 near miss incidents in the MPS. There are approximately 30 deaths in police custody in England and Wales each year. If we assume that for each death there are approximately 30 near misses, this gives us a figure of 900 near misses across police forces in England and Wales each year. Therefore, these two methods give us estimates of 900 and 1,000 near misses per year.

**Step Three: Estimating Very Serious Near Misses across England and Wales**

Very serious near misses are defined here as those cases in which the FME reporting the incident thought it ‘very likely’ or ‘fairly likely’ that death would have occurred if action had not been taken. The 89 participating FMEs reported 50 such cases. Table 2.3 takes these 50 cases and calculates what the figure would be if all FMEs in the MPS had participated in the study. A figure is then produced for all police forces, based on cases in the MPS making up 17% of the total. From this calculation we estimate that there are around 400 very serious near misses every year across police forces in England and Wales.

**Table 2.3**
Estimating Very Serious Near Misses across England and Wales

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. No. of very serious near misses in study (89 FMEs participating)</td>
<td>50</td>
</tr>
<tr>
<td>b. Rate of very serious near misses per FME (a/89)</td>
<td>0.6</td>
</tr>
<tr>
<td>c. No. of very serious near misses for all 132 FMEs in MPS (132*b)</td>
<td>79</td>
</tr>
<tr>
<td>d. Estimated number of very serious near misses for England and Wales (c/17)*100</td>
<td>465</td>
</tr>
</tbody>
</table>

This figure is also supported by an alternative calculation. There were six deaths in custody in the MPS during this study, making 12 very serious near misses for every death. If we apply this ratio to the 30 deaths in custody which occur every year, then this produces an estimate of 360 very serious near misses each year across police forces in England and Wales. Therefore these two methods give us an overall estimate of around 400 very serious near misses per year.

To summarise the above calculations, we estimate that approximately 1.8 million people were detained in police...
custody during 2005/06. Taking the definition used in this study we estimate that there are approximately 1,000 near misses each year across police forces in England and Wales. We also take a narrower definition of a near miss incident and focus only on those where the FME thought death was ‘very likely’ or ‘fairly likely’ if action had not been taken. These typically involved detainees who had tried to commit suicide in their cells or who had to be resuscitated having lost consciousness as a result of drug or alcohol consumption. We estimate that there are approximately 400 of these very serious near misses each year. For reasons outlined above these figures may heavily underestimate the number of near misses that occur across the country.

Incident Type

The reported incidents covered a broad range of circumstances and it was clear that FMEs differed in their interpretation of which incidents should be reported. For example, a number of FMEs reported relatively minor self-cutting incidents. The resulting injuries alone could not have led to a fatality, but if, for example, the cut had been made in a different place or in a different direction, the result could have been considerably more serious. The purpose of reporting these incidents was to highlight issues around, for example, searching, levels of observation and the potential dangers of allowing detainees to retain possessions in their cell.

FMEs were asked which of the following factors were relevant to the nature of the near miss incident: drugs, alcohol, self-harm / attempted suicide, and / or a medical condition. Of the 121 recorded near misses:

- 60 (50%) involved self-harm or an apparent suicide attempt;
- 41 (34%) related to drug use;
- 27 (22%) were alcohol related; and
- 20 (17%) related to a medical condition.

Each incident was then coded by the research team according to the main factor in the case. For example, an incident involving self-strangulation which occurred when the detainee was intoxicated may have been reported by the FME as relating to both self-harm and alcohol. In the data below, this would be included in the figures on suicide/self-harm as it was this which required the attention of the FME. As shown in Table 2.4, in nearly half (56) of the reported incidents, attempted suicide or self-harm was the main factor in the incident, a third (40) of the cases were predominantly related to drugs, 17 referred to a medical condition and in eight incidents, alcohol use or withdrawal was the major concern.

### Table 2.4

<table>
<thead>
<tr>
<th>Main Factor</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempted Suicide/Self-harm</td>
<td>56</td>
<td>46</td>
</tr>
<tr>
<td>Drug Related</td>
<td>40</td>
<td>33</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Alcohol Related</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

To what extent do these near misses mirror death in custody cases? While the categories used are not directly the same, some comparison is possible. If we look at the known causes of death for fatalities in police custody between 2002/03 and 2005/06, the 96 cases can be categorised across the three groups presented in Table 2.5. If the categories for near miss incidents are collapsed, they too can be fitted into this table.

### Table 2.5

<table>
<thead>
<tr>
<th>Main Factor in near miss/ Cause of death</th>
<th>Near Misses %</th>
<th>Deaths %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide/Attempted Suicide/ Self-harm</td>
<td>46</td>
<td>12</td>
</tr>
<tr>
<td>Drug or Alcohol Related</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>Medical condition/organ failure/ injuries</td>
<td>14</td>
<td>57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

A comparison of the near misses and deaths presented in Table 2.5 suggests some strong differences. Firstly, our sample contained a far greater proportion of attempted suicides and cases of self-harm compared to instances of suicide contained in the national figures on deaths. Secondly, there were proportionately more near misses related to drugs and alcohol compared to deaths due to these substances. Thirdly, there were far fewer near misses related to medical conditions, organ failure or injuries compared to fatalities.
The above differences are plausible when one considers how the near misses were identified in our study. It is likely that there are a great many more instances of attempted suicide and self-harm than actual cases of suicide. Furthermore, it is likely that in cases of attempted suicide or self-harm an FME will be called to check the detainee. It is also likely that there are a great deal more cases involving drugs and alcohol where a person nearly dies compared to those where a fatality actually occurs. Again, it is likely that an FME will be called to check the detainee in such near miss incidents. The differences with regard to medical conditions involve a longer explanation. In many of these cases the detainees’ medical condition is so severe that they are taken straight to hospital or paramedics are called to the custody suite. Therefore, the numbers of such near miss incidents in our study may be an underestimate as FMEs would not be aware of these cases and therefore could not report them.

### ‘Severity’ of Incident

FMEs were also asked how likely it was that the incident would have led to a fatality, had there been no intervention. This question was asked in an attempt to gain a proxy of how serious the incident was. It was clear from the analysis that there were marked differences in how FMEs interpreted this question and so the data here need to be treated with caution. While some considered the incident holistically, taking into account the nature of the illness or injury, the response and the outcome, others focused on one particular aspect of the incident, such as the severity of the condition. For example, some FMEs reported any incident which involved an individual losing consciousness as ‘very likely’ to result in a fatality, while others would also consider the outcome, and if an FME was at the scene and the person was resuscitated promptly, making a good recovery, the incident was reported as ‘not very likely’. In the context of self-harm, some FMEs may view a relatively minor act of self-injury as an indication that the person may be likely to go on to attempt a more serious act, and therefore may be more likely than other FMEs to rate the incident as dangerous. For this reason, we have included all incidents in the analysis, including those which FMEs reported as ‘not at all likely’ to have resulted in a fatality.

As shown in Table 2.6, of the 114 incidents where this information was provided, 14 thought it was ‘very likely’ to have resulted in a fatality, 36 said it was ‘fairly likely’, 57 thought it was ‘not very likely’ and seven thought it was ‘not at all likely’ to have led to a death.

When taking into account the incident type, those relating to a medical condition were most commonly reported as ‘very likely’ or ‘fairly likely’ to have resulted in a fatality; 14 of the 17 incidents were reported as such. Attempted suicide or self-harm cases were least likely to be reported in this way, with only 14 of the 56 incidents reported as ‘very likely’ or ‘fairly likely’ to have resulted in a death had there been no intervention.

### Time of Incident

Just over half of the incidents (56%) occurred in the 12-hour period between 7pm in the evening and 7am in the morning. Incidents were fairly spread out across the week with the greatest number of incidents reported on a Wednesday and a Thursday (21 on each day).
2. Overview of Reported Near Miss Incidents

NEAR MISSES IN POLICE CUSTODY

Table 2.7
Ethnicity of Detainee by Type of Near Miss Incident

<table>
<thead>
<tr>
<th></th>
<th>Attempted Suicide/Self-harm</th>
<th>Drug Related</th>
<th>Medical Condition</th>
<th>Alcohol Related</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>White</td>
<td>33</td>
<td>61</td>
<td>26</td>
<td>67</td>
<td>10</td>
</tr>
<tr>
<td>Black</td>
<td>13</td>
<td>24</td>
<td>8</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Mixed</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Chinese/Other</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100</td>
<td>39</td>
<td>100</td>
<td>17</td>
</tr>
</tbody>
</table>

Note: Details of ethnicity missing for four detainees.

The average length of time a person had been in custody before an incident occurred, or concern was raised, was 5\(\frac{1}{4}\) hours. In 15 cases the FME reported that the incident occurred within half an hour of arrival at the police station. The majority of these cases involved individuals who had ingested drugs or alcohol prior to or during arrest. The average length of time between the incident occurring or being identified and the FME’s consultation was one hour. Many FMEs identified the concern themselves or were already at the station seeing another detainee when the incident occurred. Indeed, 37 FMEs reported seeing the detainee at the time, or within ten minutes of the incident occurring.

Demographics of Detainees

The vast majority (83%) of the 121 incidents involved male detainees. This is broadly representative of the gender breakdown of those individuals arrested by the MPS for notifiable offences.\(^8\) Ages ranged from 15 to 67 years and detainees’ average age at the time of the incident was 33 years. The majority of detainees were White (63%) compared to ethnic minority groups (37%). The proportion of near miss incidents involving individuals from an ethnic minority group is largely comparable to that which would be expected given their make-up of the general MPS arrestee population.\(^9\) Table 2.7 provides a more detailed breakdown of ethnicity by type of incident.

A third (41) of the detainees had been arrested for an acquisitive crime, such as theft, burglary or shoplifting. Twenty-one people were arrested for a violence-related offence such as actual bodily harm, possession of a weapon or threat to kill; 17 for a drink- or drug-related offence; 11 people for failing to appear at court or breach of bail; and ten people had been detained for criminal damage. The remaining 21 people were detained for various offences including breach of the peace, indecent exposure and driving while disqualified.

Known Risk Status of Detainee

A suicide or self-harm marker can be added to the Police National Computer (PNC) by police officers as a warning to colleagues, if a person has previously attempted to self-harm or there is some evidence to suggest a possible propensity to do so. Twenty-seven of the individuals were known to have a suicide or self-harm marker on the PNC, 59 did not have a marker and this information was not reported by the FME for 35 individuals. Eighty-eight individuals (73%) were known to have had a risk assessment document completed by officers prior to their contact with the FME. Twenty-six individuals had not been assessed; the majority of these (18) were reported as being intoxicated with drugs and/or alcohol, which is likely to have been the reason why a risk assessment had not been carried out. Information on risk assessments was not known for the remaining seven detainees.

FMEs were asked to report whether the detainee had any known mental illness, suicide or self-harm history, or whether

\(^8\) According to data collected by the Home Office, 159,074 (85%) of the 187,143 arrestees for notifiable offences in the MPS in 2004/05 were male (Ayres and Murray, 2005).

\(^9\) Statistics on Race and the Criminal Justice System published by the Home Office reported that 84,450 (45%) of the 187,808 arrestees for recordable crimes in the MPS in 2004/05 were from ethnic minority groups.
they were known alcohol or drug dependants. This information was provided for 105 of the 121 detainees. Seventy-three (70%) of these 105 individuals were known to have at least one of these characteristics, with 32 detainees reported as having no known history. Table 2.8 shows that a high proportion of the 105 detainees were known to have a drug dependency, a history of self-harm, or a mental illness.

Fourteen of the individuals who had a known mental illness were also known drug or alcohol dependants. Of those who had a history of self-harm or suicide attempts, 16 were also known substance misusers and 17 were known to have mental health needs.

### Medical Treatment

Nearly half (59) of the 121 detainees attended hospital as a result of the incident and 27 of these were detained there for observation or treatment. When the type of incident is considered:

- all eight of the alcohol-related incidents resulted in a hospital visit;
- 13 of the 17 incidents relating to a medical condition were sent to hospital;
- 28 of the 40 drug-related cases went to hospital; and
- ten of the 56 attempted suicides or self-harm cases involved attendance at hospital.

Twelve individuals required resuscitation in the custody suite. Of these:

- five detainees required resuscitation following drug ingestion;
- four were suffering from alcohol consumption or withdrawal;
- two had self-harmed; and
- one person had a heart condition.

### Key Factors in the Incident

We were keen to find out which circumstances led to or played an important part in a near miss. FMEs were therefore asked to describe the factors which had a negative or positive impact on the incident. Table 2.9 lists the negative factors which are best viewed as those which played a major part in a near miss occurring. The top five all related to the management of the detainee by custody staff and levels of staffing. Among these, by far the largest single factor concerned searching, suggesting that items not removed from the detainee or a cell played a central role in a near miss. Custody staffing levels was the next most common factor, suggesting that low numbers of custody personnel and high volumes of detainees may have played a part in these incidents occurring. The next most common factors related to the following of procedures under PACE and concerned checking, rousing, observation and general alertness.

### Table 2.8

**Known History of Detainee**

<table>
<thead>
<tr>
<th>Known History</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependence</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Self-harm</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td>Alcohol Dependency</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Total Known</td>
<td>105</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: A detainee may be identified as having more than one of the listed conditions. Therefore the percentages do not add up to 100%.

### Table 2.9

**Factors Having a Negative Impact on Near Miss Incident**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Searching</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>Custody staff levels</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Checking/rousing</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Alertness of custody staff</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Observation</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Speed of request for FME</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Hospital/Ambulance Service</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Actions of prisoner</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Actions of FME once called</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Plastic cutlery</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: A total of 92 factors were identified. Therefore a negative factor was not identified with each case.
'checking/rousing', presumably because this led to the identification of a detainee in need of assistance. This was followed by 'speed of request for FME', 'custody staff levels' and 'observation', all suggesting that the ability of staff to monitor detainees and follow procedures contributed to near misses being identified and managed. The issues raised by these negative and positive factors are discussed in more detail in the following chapters.

Table 2.10
Factors Having a Positive Impact on Near Miss Incident

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking/rousing</td>
<td>50</td>
<td>31</td>
</tr>
<tr>
<td>Speed of request for FME</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Custody staff levels</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Observation</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Actions of FME once called</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Searching</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Alertness of custody staff</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: A total of 163 factors were identified. Therefore more than one factor could be identified per case.

This chapter has provided an overview of the near miss incidents reported by FMEs in our study. Chapter 3 takes the main types of near miss and looks at these incidents in greater depth.
3. Types of Near Miss Incidents
This chapter looks in more detail at the main types of near miss captured by our study. Firstly, we look at those incidents which involved self-harm or an attempted suicide. We then examine those incidents that are related to drug use or a pre-existing medical condition. Finally, we look at the cases which centred on a detainee’s alcohol use or mental health.

**Self-harm or Suicide Attempt**

The National Suicide Prevention Strategy launched by the Department of Health in 2002 identified people in prison as being at particularly high risk of suicide (Department of Health, 2002). In 2001, the rate of self-inflicted deaths among male prisoners was 109 per 100,000, over six times the rate for men in the general population at 17 per 100,000 (Snow et al, 2002). Rates of self-harm are equally high. In 2003, there were 16,214 separate incidents of self-harm reported within prisons in England and Wales, a rate of 222 incidents per 1,000 of the prison population.

Although there are clear differences in the long-term and police detainee populations in terms of their place in the criminal justice process, reason for detention, length of stay and expectations, there are also many similarities in their demographical make-up which put police detainees at increased risk of suicide or self-harm. Both the prison and police detainee populations are dominated by socio-economically deprived young men, individuals who make up the most high-risk group in the community in terms of suicidal behaviour (Boyle et al, 2005). Factors associated with increased risk of suicide and self-harm in the wider population, such as previous history of deliberate self-harm, a past psychiatric history, substance misuse, a history of addiction, mental illness and social isolation, are also over-represented within the incarcerated population (Department of Health, 2002; Ingram and Johnson, 1997; Norfolk, 1998; Oyefeso et al, 1999).

Despite this, given the number of detainees who pass through police custody each year, suicides in this setting are relatively rare. Over the four-year period between 1st April 2002 and 31st March 2006, 11 people died following an apparent suicide attempt in police custody. Evidence from the few studies which have been undertaken suggests that a far greater number of suicide attempts are made, but fail or are prevented. A study of self-harm and suicide among people detained in police custody in England and Wales reported that during a six-month period in 1996, there were at least 1,131 acts of deliberate self-harm, equating to around 2,300 acts of self-harm in police custody a year (Ingram and Johnson, 1997). Taking into account the number of apparent suicides which have occurred over the last four years, this suggests that fewer than one in 800 acts of deliberate self-harm result in death.

### The Sample

In this study, nearly half (60) of the reported incidents involved an attempted suicide or an act of self-harm. In 56 cases, the self-harm or suicide was seen as central to the near miss incident. In the remaining four incidents, the act of self-harm was seen as secondary to the near miss incident, with drug misuse and medical conditions being the central factors.

Of the 56 incidents where self-harm was central to the case:
- 34 involved self-strangulation;
- in 19 cases the individual cut him/herself;
- two individuals hurt themselves after they were alleged to have intentionally banged they heads against the cell wall; and
- one person swallowed a razor blade.

Of the 34 incidents of self-strangulation:
- 13 people used an item of clothing such as a jumper, T-shirt or underwear;
- eight people used their shoe laces;
- four individuals used a belt or cord;
- four used an item of safer clothing;
- two people used a blanket; and
- one person used their hands

10 The ligature type was not reported for two individuals.

Of the 19 cutting incidents:
- six people used plastic cutlery;
- three people used a watch or other item of jewellery;
- two people used metal from a lighter or drinks can;
- one person used a razor blade; and

10 The ligature type was not reported for two individuals.
the other seven involved ‘tools’ such as a piece of glass, plastic from an unknown source, part of a zip and an asthma inhaler.

FMEs reported that 22 of the 60 individuals who self-harmed had a known history of suicide or self-harm. Nineteen of these individuals were known to have a suicide/self-harm warning marker on the PNC. Twenty-three detainees had a known history of mental illness; six of these people were reported to have a personality disorder. Twelve people were problematic drug users and seven of the individuals were dependent on alcohol.

The severity of the incidents varied considerably, and certainly for a number of detainees, it was suggested that the detainee’s motivation was to harm themselves, rather than intent to die. At least some of the acts were viewed to be suicide attempts with very real risks to life. In a number of these incidents, the prompt and appropriate actions of police and medical staff may well have helped prevent a death.

Of the 56 attempted suicide or self-harm incidents reported, five were described as ‘very likely’ to have resulted in a fatality had there been no intervention, and a further nine incidents were described as ‘fairly likely’ to have resulted in a death. In ten incidents the individual was sent to hospital; eight of these detainees had tied a ligature around their neck and two had cut their wrists. Two people required resuscitation, one of whom was found unconscious after tying his trousers around his neck while on a constant watch, and one person collapsed after he was found with his shoe laces tied around his neck.

Analysis of the data suggests that FMEs may have been more likely to report incidents of self-harm compared to other types of incidents. This is reflected in the considerably lower proportion of such incidents which resulted in hospital treatment or were viewed as likely to have resulted in a death. An increased likelihood of reporting incidents of self-harm may be because identification of an act of self-harm is less ambiguous. Other incidents such as those involving drugs or alcohol may progressively get worse and the difficulty facing FMEs is deciding at which point the incident becomes a near miss. It may also be that the term ‘near miss’ is more clearly associated with acts of attempted suicide or self-harm, rather than with those relating to substance misuse or medical conditions.

**Risk Factors**

Self-harm or suicide risk markers on the PNC and previous self-harm reported during the risk assessment are perhaps the most obvious mechanisms for identifying risk. FMEs also identified other indicators which need to be considered by Custody Officers and which should be highlighted in custody staff training, such as suspicious marks or scars on a person’s wrists, arms or neck, mental instability and substance dependency. Although this has not been explored as yet in known studies of deaths in police custody, research into suicides in prison suggested that custodial or charge-related factors should also be considered. For example, individuals who have been charged with a sexual or violent offence, particularly against a family member, are at an elevated risk of attempted suicide or self-harm in prison (Liebling, 1992). Other risk groups identified by FMEs included detained police officers, potential deportees and those who had returned from court having received a long or unexpected prison sentence.

FMEs, in their routine consultation with detainees, assess an individual’s potential risk and needs. Where such assessments highlight a risk of self-harm the FME should inform the Custody Officer and provide him or her (within the bounds of patient confidentiality) with sufficient information to allow the Custody Officer to give the necessary care to the detainee and to meaningfully communicate risk to others. Detailed assessments should be undertaken for those detainees who express a clear intention of deliberate self-harm, with attention given to any evidence of previous acts of deliberate self-harm (Royal College of Psychiatrists, 2006).

**Removal of Items from Detainees**

PACE Codes of Practice state that a Custody Officer may withhold a detainee’s “clothing and personal effects” where they consider that “they may use them to cause harm to themselves”. FMEs confirmed that items such as shoe laces, belts, drawstrings and jewellery were removed from those detainees who were identified as being at risk of self-harm at

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11 PACE Code C, paragraph 4.2.
Case Study One

An FME was called to assess the mental health status of a man who had been held overnight prior to his court appearance. The man reported to the FME that while in his cell he had cut his wrist. He revealed a large incision wound which was cut deep enough to expose the tendons and, if left, could have led to sufficient blood loss to cause collapse or even death. This had been done using a can of drink which had been given to him in his cell.

Case Study One underlines the need for awareness in the provision of items to a detainee. In this case, the man had had his shoes removed, but was then left with a metal can when he could have been provided with the drink in a plastic cup.

Six of the incidents involved individuals cutting themselves with plastic cutlery despite MPS custody procedures emphasising that all food utensils and containers should be removed from cells and detention rooms as soon as possible (MPS, 2005). Some FMEs asked for the provision of rubber cutlery which is designed to avoid such incidents. However, a trial of this type of cutlery in the MPS faced health and safety issues concerning the handling and cleaning of the utensils. This led to the trial not being extended across the MPS. Furthermore, it is unlikely that totally safe cutlery can be designed; for example, utensils that cannot be used to cut may be flexible enough to be used to choke on. With safe alternatives not available, we believe that the emphasis should be on adherence to the custody policy and the removal of cutlery from detainees as soon as practicable.

Not providing blankets to people who are seen to be at risk of self-harm raises a number of issues. Although blankets may be used by detainees to harm themselves, for example as methods of strangulation or choking, FMEs noted that people who are unwell, or are withdrawing from drugs or alcohol, need to be able to keep warm. One FME advised that instead of not providing blankets to such individuals, the type of blanket material should be reassessed and safer options should be sought, which should be available in all custody suites. MPS custody policy states that blankets should be checked to ensure that they are not damaged or soiled, but it does not touch on whether or not to issue a blanket. Furthermore, it is unclear how consistent Custody Officers’ considerations are about the risks of issuing blankets. More generally the view of officers responsible for setting custody policy was that no blanket could guarantee safety from self-harm. However, a large amount of work has been done on creating ‘safer blankets’ for use in prisons. No blanket will be completely safe but some blankets may be safer than others, and the latter may be appropriate for police custody.

**Safer Custody**

There was general agreement that cell design had improved in recent years with the reduction of possible ligature points. Over the study period, none of the incidents involved a detainee using cell structure or furniture in an attempted hanging. However, this should not lead to complacency as the dangers of self-strangulation are very real. Between 2003/04 and 2005/06, four of the eleven apparent suicides which occurred in police cells were the result of self-strangulation (Home Office, 2004; Teers and Bucke, 2005; Teers and Menin, 2006). In this study, eight people were sent to hospital following incidents of self-strangulation; two of these individuals required resuscitation. In one incident, the likelihood of a man dying after tying a ligature around his neck was seen as ‘very likely’ if the attending officer had not had immediate access to a safety knife which allowed him to quickly remove the ligature.

MPS custody policy emphasises the need to check cells when they are vacated and the need to remove items from cells such as food utensils (MPS, 2005). Despite this, in a number of the reported cutting incidents, an object was used which had been left in a cell by the previous occupant. We believe that such incidents raise questions about the extent to which these procedures are being followed. Furthermore, leaving potentially dangerous items in cells undermines efforts by officers to reduce any risk of self-harm by removing possessions from a detainee prior to him or her being placed in a cell.
Communication with detainees

Of particular concern are those individuals who self-harm without exhibiting any signs or signals which could alert staff to their potential risk. Indeed, many acts of self-harm are a spontaneous and an immediate reaction to current circumstances which would be very difficult for others, or even in some cases the person involved, to predict. An example of this is presented in Case Study Two, in which the act of self-harm was viewed to be an impulsive response to what was interpreted as unfair treatment by police staff. The incident may have been avoided if there had been better communication between the member of staff and the detainee, underlining the importance of the quality of relationships between the two.

Case Study Two

A man, who had been detained in a cell for two days without incident, cut his wrists after having a telephone call terminated by a member of police staff. According to reports given by another member of staff to the FME, the call was terminated with no explanation to the detainee. On arrival back in his cell, the detainee, who reportedly had no prior history of self-harm, cut his wrist and then tied his jumper around his neck. He received treatment in hospital.

In a number of the cases reported in this study, the motivation for an act of self-harm was described as “attention seeking”; for example, self-harming in the hope that it would “lead to early release from custody”. Certainly, the description of self-harm as a manipulative act is relatively common and while there may indeed be an instrumental element to some individuals’ behaviour, it is unclear how useful applying this label is in understanding, or indeed preventing future incidents. In one incident, a Local Duty Social Worker refused to arrange a mental health assessment “on the grounds of the detainee’s past history of Borderline Personality Disorder and attention seeking behaviour”. The woman later attempted to strangle herself with her ‘disposable suit’. The use of terms such as these may serve to legitimise an indifferent or hostile response to individuals which may then have implications for their treatment (Snow et al, 2002).

Drugs

Findings from a national survey of drug use among arrestees in England and Wales in 2003/04 concluded that 57% of arrestees reported having taken one or more drugs in the last month (Boreham et al, 2006). A survey of arrestees carried out in 16 police custody suites in 1999/00 and 2001/02 found that 65% of the 3,064 individuals surveyed provided a positive urine test for one or more illicit drugs at the time of arrest (Holloway et al, 2004). FMEs generally agreed that dealing with people who had consumed drugs accounted for a large proportion of their time. A survey of individuals detained in police custody suites in London in 2003 found that just under a third of detainees seen by FMEs were dependent on heroin or crack cocaine (Payne-James et al, 2005). This was nearly a threefold increase in the number of individuals reporting drug dependence during the previous decade.

The Sample

FMEs reported that drug use was in some way related to a third (41) of the reported near miss incidents. In 40 of the incidents, drug use was seen as central to the incident and in one case this was secondary to an act of self-harm. Of these 40 cases:

- 17 incidents involved individuals swallowing drugs during or following arrest in an apparent impulsive act to conceal them from officers;
- 13 were the result of intentional ingestion; for example, heroin or cocaine use prior to arrest;
- six incidents involved apparent accidental overdose; and
• in four cases a person was in possession of, or attempted to take drugs, but was stopped by police staff or an FME.

FMEs were asked to report what drug(s) the detainees had consumed. A number were found to have taken more than one drug, with FMEs reporting that:
• 18 were known to have taken heroin or other opiates;
• 16 had used cocaine or crack cocaine;
• 16 had consumed prescribed or non-prescribed medications, most commonly anti-depressants or opiate substitutes such as methadone; and
• eight detainees had used other drugs such as cannabis or ecstasy.

In 19 incidents information that an individual had consumed drugs came from the detainee himself/herself. In 17 incidents an officer or other member of staff reported the drug use and 13 FMEs reported that the information came from their own checks or observations.

Eighteen of the 40 incidents were reported as ‘very likely’ or ‘fairly likely’ to have resulted in a fatality had there been no intervention. Twenty-eight (70%) of the 40 individuals were sent to hospital and five required resuscitative measures in the custody suite. Four of those who required resuscitation had apparently swallowed cocaine and/or heroin on arrest or in custody and one person had overdosed on heroin and cocaine prior to their arrest.

‘Contact Precipitated Concealers’, also known as ‘Drug Swallowers’
Dealing with people who have swallowed drugs in an attempt to conceal them from officers was described by FMEs as particularly challenging since the type and quantity of the drug was often unknown or excessive, and absorption into the bloodstream could be rapid. PACE reflects these concerns by stating that individuals suspected of swallowing drugs should be roused every hour, have their condition assessed and clinical treatment arranged, if appropriate. MPS custody policy goes further by stating that a detainee suspected of swallowing drugs must be treated as having taken an overdose and an ambulance called (MPS, 2005). The latter instructions were generally followed in the incidents in our sample, with 16 of the 17 individuals who apparently swallowed drugs to conceal being sent to hospital as a result of their consumption. Four detainees had required resuscitation while in the custody suite and ten were known to have been detained in hospital for observation or treatment.

If swallowed in a wrapping, the effects of the drug can be unpredictable, making early detection more difficult. Initially, a wrapping can delay absorption into the bloodstream. If the wrapping then disintegrates or bursts, the effects of the drug can be sudden. As illustrated in Case Study Three below, a person who had swallowed wrapped drugs had been in custody for a day and a half before the effects of the substance became evident.

Case Study Three
An FME was called by a Custody Officer to assess whether a man was fit to be interviewed. He had spent the night in custody and in the morning was described by the officer as “a bit dopey”. When the FME arrived the individual was found unconscious. The FME decided that the unconscious state was likely to have resulted from a heroin overdose and administered an opiate antidote, a drug which could be potentially dangerous if consumed in conjunction with cocaine. When the ambulance arrived the man was still only semi-conscious. He was taken to hospital where he was detained for 35 hours after it was discovered that he had swallowed a wrap of heroin and cocaine on arrest. The effects of the drug had only become evident when they began to leak from the wrapping they had been swallowed in. When the sergeant looked back through the arresting officer’s notes, he found a comment that officers had suspected that the person had swallowed drugs on arrest, information which had not been passed to the Custody Officer or to the FME.

Case Study Three could have been averted if arresting officers had responded to this observation and, in accordance with force policy, taken him directly to hospital rather than to

12 PACE Code C, paragraph 9.3.

the custody suite. FMEs noted that this message needs to be reinforced to all arresting officers. Anybody who has swallowed drugs, or is suspected of having swallowed drugs, is a medical emergency and should be taken directly to hospital. If this occurs in the custody suite, they require vigilant observation while awaiting transfer to hospital.

**Treatment and Care**
FMEs did not refer all detainees who had recently consumed drugs to hospital. However, there was a general consensus that all such individuals must be seen and assessed by one of their colleagues. If the individual appeared physically well, the FME was satisfied with their condition and there were no other concerns, then they could be detained and observed in custody.

**Case Study Four**
A known user of opiates, crack cocaine and alcohol was seen by an FME and declared fit to be detained. Due to his drug dependency, the Custody Officer was advised to have the detainee reassessed by an FME later that evening if he was to be held overnight. This was recorded in his custody record. However, the FME reported that the instruction was not acted upon and an assessment was not made until the following morning, when the detainee was given substitute medication. Several hours later an FME was called as a matter of urgency as the man had started to vomit and fit in his cell. On his arrival, the FME suspected that he was suffering from a drug withdrawal fit. An ambulance was called and he was taken to hospital.

Case Study Four concerns the failure to follow an FME’s recommendation that a detainee should be assessed before staying overnight in custody. The FME in this case stated that Custody Officers should know that drug-dependent detainees should be assessed prior to an overnight stay given the risks related to withdrawal. Such cases suggest that there are training issues for some Custody Officers around the care of drug users. Some FMEs believed that existing training on the care of drug-dependent detainees could be delivered more consistently and be provided to staff who support Custody Officers such as Designated Detention Officers (DDOs). Other studies have emphasised the need for all custody staff to be provided with guidance on how to care for this vulnerable group of detainees (Stark and Gregory, 2005). This includes information about the possible risks associated with drug dependency, overdose and withdrawal, such as seizures, chest conditions and heart failure. Certainly, we believe that custody staff should be aware that these detainees require frequent checks, at least every half hour, and if they are to be detained for long periods they need to be assessed by medical staff for possible withdrawal and appropriate medication. People withdrawing from drugs are also at an increased risk of self-harm. For example, opiate withdrawal can result in anxiety, known as dysphoria, which can lead to suicidal feelings (Handelsman et al, 1992).

The incidents in this study also raise concerns about the management of detainees once drug use had been identified in terms of staff’s understanding of withdrawal and overdose and appropriate care. FMEs felt that drug and alcohol misuse can be a signal of deeper concern, and staff should guard against the assumption that the condition of those who arrive under the influence of drugs or alcohol will improve with time.

**FME Practice**
Another issue raised by interviewees concerned the physical allocation or handling of medication by FMEs. In three incidents, detainees snatched or illicitly took medication from an FME during a consultation. This practice was also reported in the feasibility study which identified that three of the 38 reported incidents involved detainees taking and consuming drugs from an FME’s property (Best et al, 2006). In our study, on one occasion, a man managed to swallow several dozen valium from a bottle on an FME’s consulting table. This was not recognised until the man lost consciousness several hours later. Following another similar incident, the FME expressed concern that the restricted size of the examination room prevented him from maintaining the necessary distance between his medication and the detainee to safeguard against such incidents occurring. When operating in conditions such as this,
FMEs need to be especially vigilant in their dealings with detained persons.

**Identification**

A study of 277 deaths which occurred in police custody between 1990 and 1997 found that symptoms of drug abuse were often mistaken for drunkenness. It reported that nearly half of those dying from drug misuse were arrested for being drunk, despite most of them not having consumed alcohol. The authors warned that officers’ assumptions that a detainee is drunk without any further investigation could lead them to potentially miss more serious drug abuse (Leigh et al, 1998).

In this study the difficulty for Custody Officers in assessing risk was not overlooked by FMEs. They recognised that many detainees are reluctant to report drug use, not only because of its illegality, but also because admitting to drug use may be viewed as adding corroboratory evidence to a criminal allegation. However, the introduction of drug testing for those arrested or charged for specific trigger offences has made identification easier. It is not surprising though that FMEs reported that they were sometimes more likely to extract more accurate verbal information on self-reported drug use from a detainee than officers. FMEs were also alert to the fact that drug-dependent detainees often denied to medical staff that they had recently used drugs in an attempt to increase the likelihood of being prescribed detoxification medication. The provision of inconsistent information by detainees “to acquire some perceived secondary gain” was highlighted as an issue by Gregory (2006) in his study of the medical management of drug misusers in police custody.

FMEs reported that most experienced Custody Officers were fairly competent at identifying people who had taken drugs or who were intoxicated with alcohol. However they did urge that officers draw on all available sources of information in their assessment of a detainee, and that despite concerns about inaccurate self-reporting, they highlighted the importance of talking to the detainee. Assessment of apparent physical condition alone may often fail to indicate more serious problems.

**Medical Condition**

PACE states that if a detainee is believed to have a medical condition, other than a minor ailment, advice must be sought from a healthcare professional. More than half of detainees seen by forensic physicians while detained in police custody present a broad spectrum of chronic medical conditions, which include pathologies such as asthma, diabetes, epilepsy, hepatitis and heart conditions. Studies suggest that almost 30% of detainees will not be registered with a primary care physician and so may not have access to regular medical or healthcare advice and may not have access to, or be taking appropriate medication (Payne-James, 2005 and Payne-James et al, forthcoming). The poor level of health among many detainees means that without proper medical care and assessment there is a high risk that individuals will enter custody with a serious untreated or poorly managed medical condition which takes a turn for the worse.

**The Sample**

Twenty reported incidents related to an existing medical condition; in 17 of these cases the medical condition was central to the near miss incident. Eight of these 17 cases were related to diabetes and four to chest pain or other heart problems. The remaining five cases involved incidents relating to epilepsy, seizures, high blood pressure, pneumonia or pregnancy. Fourteen of the 17 incidents were reported by the FME as ‘very likely’ or ‘fairly likely’ to have resulted in a fatality had there been no intervention.

**Diabetes**

The management of insulin-dependent diabetics in police cells is recognised as posing particular difficulties. There is the possibility for deliberate overdosing and a lack of facilities and trained staff to monitor blood sugar levels when required. Additionally, there are generally poor arrangements for specified diets (British Medical Association, 2004). The British Medical Association advises that doctors are quickly alerted to the presence of diabetic detainees in order for them to assess the potential difficulties of managing such cases against the need for continued detention.

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15 PACE Code C, paragraph 17.

16 PACE Code C, paragraphs 9.7 and 9C.
Six of the eight incidents which centred on diabetes were described by FMEs as ‘very likely’ or ‘fairly likely’ to have resulted in a fatality had there been no intervention. In four of the incidents, alcohol was viewed as contributory to the severity of the case. Low blood glucose, known as hypoglycaemia, may exacerbate or mimic alcohol intoxication (Wheeler et al, 2004). This makes the identification of diabetic-related conditions particularly difficult because the symptoms can be very similar to those associated with alcohol intoxication, as illustrated in Case Study Six described later in this chapter.

According to PACE, “if a detainee … claims to need medication relating to … diabetes … the advice of the appropriate health care professional must be obtained”.

Stressful situations, such as being in police custody, can escalate the condition which can result in seizures, laboured breathing and/or brain damage. Excessive sweating and ‘stroppy’ behaviour observed in a diabetic are of particular note as they may indicate a sharp drop in blood sugar levels which could lead to convulsions, coma or death.

FMEs warned that they should supervise insulin-dependent diabetics, who should also be closely monitored by custody staff. Insulin dosage should be measured in line with volume of food intake. Custody staff should monitor the food intake of any reporting diabetics and this must be communicated to FMEs. It is particularly important for diabetics that all dietary requirements can be catered for in the custody suite at all times.

**Case Study Five**

A 52-year-old insulin-dependent diabetic man was seen by an FME eight hours after his arrival in custody. Before administering insulin, the FME asked the Custody Officer to check what the detainee had eaten since his arrival. This revealed that the man, who was a vegan, had not consumed anything. It is unclear whether this was because there was no vegan food available or whether he had declined the food offered to him. If insulin had been administered without this knowledge, it could have resulted in lack of consciousness or even death.

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Chest Pain

Four of the reported incidents related to chest pain or other heart-related conditions. A number of FMEs felt that Custody Officers were not fully aware that complaints of chest pain from detainees may be a warning sign of a serious problem. One FME gave an example of a detainee who was in obvious need of medical attention; he “was overweight, hypertensive and said that he had been banging on the cell door for ‘some time’ complaining of chest pain. I saw him after another prisoner … custody staff were not aware of the significance of chest pain in this sort of patient.” Clearly if FMEs are seeing a number of detainees in one custody suite they need to ask for information and prioritise the more serious cases. However, FMEs recommended that, if chest pain was severe, or was reported in combination with other warning factors, such as being on medication, overweight, intoxicated, drug dependent or any other medical conditions, then medical assistance should be sought.

Alcohol

Alcohol consumption is a major health concern in the UK, not least because of the risk it poses in terms of increased mortality. The number of deaths in the UK relating to alcohol has increased sharply in recent years, nearly doubling from 4,144 deaths in 1991 to 8,221 in 2004. This equates to an increase in the alcohol-related death rate from 6 per 100,000 of the population in 1991 to 12 in 2004 (Office for National Statistics, 2006).

Alcohol use is common within the detainee population. Findings from a national survey of substance use among arrestees in England and Wales in 2003/04 reported that 57% of the arrestees were “harmful or dependent drinkers” (Boreham et al, 2006). This is considerably higher than levels of alcohol use among the general population. A national survey of the general population in England reported that in 2002, 27% of men drank more than the recommended weekly benchmark of 21 units. This proportion has remained largely unchanged since 1992. Levels of heavy drinking among young women appear to have peaked in 2005 following a concerning upward trend in female drinking between 1998 and 2002 (Office for National Statistics, 2005).
In a study of two city centre custody suites, three-quarters of the 169 arrestees were found to have consumed alcohol prior to arrest and 59% were considered to be intoxicated (Deehan et al, 2002). A study of FME practice concluded that up to 80% of FMEs’ work has some connection with alcohol use or misuse (Hunt, 1996). These detainees pose specific risks in the custody environment; for example, they may be unable to take part in appropriate risk assessment and their intoxication may mask other conditions. They may also be at elevated risk of serious illness or injury. Each year between a quarter and a third of all deaths during or following police custody, where the cause of death is known, result from drug or alcohol use (Teers and Menin, 2006).

The Sample
Nearly half (59) of the 121 incidents reported in the survey stage of the study involved detainees who were known to have recently consumed or be intoxicated with drugs or alcohol. In around two-thirds of these cases this information came from either the FME’s own examination or from information from officers. Twenty-six individuals directly reported to the FME that they were intoxicated with drugs or alcohol.

Alcohol use was reported to be relevant to 27 (22%) of the incidents. Loss of consciousness, or a diminishing state of consciousness, was reported in ten of these incidents raising concerns about the associated effects on respiratory depression and vomit inhalation. Alcohol intoxication or withdrawal was the central factor in eight of the reported near miss incidents. In all eight of these cases, the individual was sent to hospital and in five instances they were detained there for observation or treatment. In four of the eight cases, the incident was described by the FME as ‘very likely’ or ‘fairly likely’ to have resulted in a fatality had there been no intervention. Despite accounting for only 7% of the overall cases, alcohol-related incidents resulted in four of the 12 individuals in the study who required resuscitation.

‘Masking’
FMEs were concerned that intoxication could mask other medical conditions or injuries. Medically, it is well recognised that the symptoms of some injuries or illnesses such as head injuries or diabetes are very similar to those displayed by someone intoxicated with alcohol. Detainees intoxicated with alcohol may also be less likely to report other conditions, as alcohol can impair their awareness of the severity of their condition.

Case Study Six
A person was arrested for drink driving as officers presumed from his manner and behaviour that he was intoxicated. On examination by the FME, the man reported that he was diabetic. It is unclear whether custody staff were already aware of this. The FME tested his blood glucose level and found it to be very low. Hypoglycaemia can result in a number of complications including death if undetected or untreated.

Ensuring that Custody Officers are aware of these dangers, and that they question whether someone who on first contact appears to be intoxicated could actually be suffering from other medical issues, was highlighted as an important aspect of any medical or forensic awareness training provided to custody staff.

Vigilance
Custody staff routinely deal with intoxicated individuals who are then released without incident. However, FMEs warned that staff should be careful that this common experience did not lead them to become complacent in their treatment of such individuals and guarded against the view that intoxicated detainees could be safely left to ‘sleep it off’. They warned that ‘complacency’ was of particular concern when staff dealt with someone who was known to them; for example, a known alcoholic who had passed through custody on a regular basis without complications. Staff should consider the circumstances of each detention independently of previous experience, and remain vigilant in their assessment and care of all intoxicated individuals.

Treatment and Care
Custody Officers have to make a decision about how best to deal with a detainee apparently intoxicated with alcohol. This is complicated by the fact that intoxicated detainees are often
more unpredictable and less compliant than other detainees, and may be unwilling, or unable, to participate in a risk assessment. FMEs reported that responses to detainees varied among Custody Officers depending on the condition of the detainee, and also on the experience and expertise of the Custody Sergeant on duty. For example, experienced Custody Sergeants were more likely than newer ones to monitor a mildly intoxicated detainee in their cell rather than call for an FME. However, FMEs did recognise the difficulty Custody Officers face in distinguishing between those who were mildly intoxicated, and those who posed a greater risk, and were keen that if officers were concerned, they exercised vigilance and erred on the side of caution.

Hospital Referral

MPS custody procedures state that if a “person cannot walk unaided or talk coherently, on entering the custody suite or at any time during their detention, they must be treated as a medical emergency and be taken to hospital by ambulance” (MPS, 2005). However, FMEs reported reluctance on the part of hospitals to receive a detainee who was intoxicated. In one reported instance, officers called the London Ambulance Service (LAS) on three occasions due to their concerns about the condition of an “incoherent and very intoxicated” individual. On the third occasion, an FME was also in attendance and persuaded the LAS to take the individual to hospital where he was detained for observation.

Alcohol Withdrawal

Acute alcohol withdrawal can, if untreated, result in death. Indeed in September 2005, a known alcohol misuser was found collapsed in her cell by police staff. She did not regain consciousness and died shortly afterwards. A Home Office pathologist recorded the cause of death as “acute alcohol withdrawal”. An IPCC investigation into her death recommended that the “possible fatal consequences of ... (alcohol withdrawal) ... should be highlighted to those in direct contact with vulnerable people ... and ... rather than the visual checks which currently occur for people with low levels of alcohol, these checks should be rousal ...” (Independent Police Complaints Commission, 2006).

FMEs asserted that staff need to be aware of the signs of alcohol withdrawal, such as hallucinations, excessive sweating, shaking and paranoia, and of its potential severity. They were keen to stress that if staff suspect that a person is suffering from alcohol withdrawal then they should be treated as a potential medical emergency, requiring an urgent medical response and close supervision. However, there was recognition that awareness of alcohol withdrawal was also lacking among some hospital staff.

Symptoms of alcohol withdrawal can be confused with those of a mental health disorder. In one incident, staff surmised that a person described as extremely confused and behaving ‘bizarrely’ was suffering from a mental health illness. An FME was called who identified that in addition to the above noted symptoms, the person was sweating excessively and shaking, and diagnosed that he was probably suffering from alcohol withdrawal. An ambulance was called and the individual was taken to hospital where he was treated for acute alcohol withdrawal.

Guidance

Our findings suggest that there is a need to ensure that Custody Officers are aware of the potential health risks a detainee intoxicated with alcohol can pose. It is important that all intoxicated detainees are risk assessed, regardless of whether or not they display any immediate signs of concern and, as stated in PACE, that they are visited and roused at least every half hour. FMEs suggested that Custody Officers should be provided with additional instructions which would assist them in deciding on the appropriate level of care required; for example, the level of monitoring and supervision while in custody, and whether or not medical attention is necessary. Staff should also be rigorous in ensuring that individuals are roused in accordance with force policy.

Mental Health

FMEs raised concern about the number of detainees with mental health needs who are detained in police custody, questioning whether the custody environment was an appropriate place for the care of such individuals. Of the 105
near miss incidents reported in this study where the medical history of the detainee was known, 32 (30%) had a known history of mental illness and seven people were described as having a personality disorder.

Previous research suggests that people with mental health needs are at particular risk of death or near death during their detention. A study published by the Police Complaints Authority found that just over 50% of the individuals who died in police custody between April 1998 and March 2003, for whom information was available, had a prior indication of mental health problems (Best et al, 2004). FMEs in our study singled out schizophrenics as a particular high-risk group requiring close supervision due to their unpredictable behaviour, which may lead to spontaneous self-harm. Although not directly transferable to police custody, prison studies emphasise the link between mental health and self-harm. Singleton et al (1998) found a strong relationship between ‘mental disorders’ and prisoners who had thought about or attempted suicide. Prisoners with psychotic or neurotic disorders were particularly at risk, with 41% of prisoners who had attempted suicide in the past week having a psychotic disorder, nearly 23 times the percentage of those who had never attempted suicide (Singleton et al, 1998).

A person’s mental health status is an important element in any assessment of a detainee’s vulnerability. The spectrum of mental health issues is broad, ranging from those who are stable, and have their condition controlled with medication, to the chaotic individual whose condition may be amplified by the use of drugs and/or alcohol. FMEs warned that even if an individual is stabilised on medication, it is important that staff are aware that the possible side-effects of that medication, such as drowsiness, can increase a person’s medical vulnerability. A review of deaths in police custody occurring between 1998 and 2002 revealed that 42% of those who died had a combination of mental health and substance use problems. The authors warned of the increased risks associated with this and the need to improve awareness of the extent of the problem and its likely impact on detainee vulnerability (Best et al, 2004).

As part of their assessment of a detainee, an FME will consider whether or not an individual with mental health issues can be safely detained in police custody. If not, they can decide to refer the person to a local mental health unit or to a mental health specialist in order for them to make a full assessment. Mental health in-reach varies significantly between custody suites. In some areas, Community Liaison Nurses are available who can find out about a person’s past medical history and liaise with the various support services. More commonly, it was reported that Custody Officers had to wait several hours before an appropriately trained individual could attend, and even longer to find a place in a specialised unit. Due to the potential volatility of a person who is seriously mentally ill, FMEs believed it was important that the process of gaining access to a mental health assessor or psychiatrist was reviewed, with the intention of accelerating this access.

Having examined the main types of near miss incident, Chapter 4 looks at the context in which these events occurred with a specific focus on those areas of custody procedure which seek to protect the physical safety of detainees.
4. Near Miss Incidents and the Custody Environment
Police custody suites are heavily regulated environments. The police have a duty of care to those they take into custody and one aim of this regulation is to protect the health of detainees. This chapter examines the context in which near misses occur and looks at a number of procedures which seek to reduce harm occurring to those in custody. The chapter firstly addresses how detainees are risk assessed and then discusses the searching and observation of detainees. It then goes on to discuss custody staff in terms of experience, training and communication with FMEs. Finally, the chapter discusses issues concerning detainees who require hospital treatment.

### Assessment of Risk

The standard way in which police forces seek to reduce the chance of harm occurring to detainees is to identify any risks when an individual enters custody. This assessment is usually done as part of the ‘booking in’ process and is conducted by the Custody Officer in the main public area of the custody suite. The Custody Officer may be looking for information on areas such as: potential ill health, such as health problems; a history of self-harm or suicide attempts; drug or alcohol intoxication; and a history of violence to others. Such information may come from police records, through the detainee answering a series of questions, or as a result of the detainee being searched. The following sections look at these areas.

### Suicide/Self-harm Warning Markers on the Police National Computer

MPS custody policy states that a detainee’s details must be checked on the PNC at the earliest opportunity following his or her arrival at the police station (MPS, 2005). Any warning signals held on the computer must be noted, and acted upon, as part of a risk assessment. The Custody Officer is also responsible for ensuring that any new risks identified are updated on the PNC.

In our study some FMEs expressed concern that the ‘markers’ on the PNC which identify a risk with regard to suicide and self-harm may be out of date and therefore of limited value. However, findings from this study suggest that these markers do offer some value. Of the 121 individuals in our sample, 27 were known to have a suicide or self-harm marker and 19 of these went on to self-harm. This suggests that while such markers cannot be expected to provide a definitive indication of a person’s likelihood of self-harming, and should not be relied on in isolation, they do offer a supplementary tool to Custody Officers in their assessment of an individual’s risk. In general, FMEs saw their main purpose as providing a useful alert, which enabled them to probe a detainee and possibly elicit information which may not otherwise have been volunteered. However, they warned against labelling an individual inappropriately, and assuming that the mental or physical status of a person who had posed no concern during previous arrests had remained static.

FMEs do not have direct access to the PNC and are therefore reliant on having this information passed to them by Custody Officers. Some FMEs did raise concerns about this, stating that communication of such markers was usually done verbally, in response to their own questioning rather than through any formal mechanism. In 35 of the 121 reported incidents, the FME had not had access to this information.

### Risk Assessment Form

The ‘57M’ form is the risk assessment tool used by Custody Officers in the MPS to elicit information about whether a detainee is likely to present any specific risks to staff or to themselves. This includes consideration of a person’s current or past mental or medical history. Home Office Circular 32/2000 sets out minimum standards for risk assessment procedures to be applied to all detainees coming into custody (Home Office Circular, 32/2000). Custody Officers should ensure that the results of the assessment are incorporated into the detainee’s custody record, briefing colleagues about any identified risks and necessary action. The assessment should also assist staff in deciding whether or not a detainee requires medical attention. However, the difficulty in identifying problems should not be underestimated.

In the main, the MPS risk assessment was viewed as useful by FMEs. It provided another source of information which assisted custody and medical staff in developing a profile of a detainee’s risk status. The recent revision to the FME’s assessment sheet, known as the ‘Book 83’, to include a check box requiring them to tick whether or not they had seen the risk assessment form, gained support from FMEs as they reported that they were now more likely to have routine access to the information contained in the form. However there was recognition that the information contained in the form would generally be identified by FMEs when they undertook their own examination.

FMEs expressed some reservations with the form, most notably that it is dependent on information provided by the detainee. In PACE Code C, paragraph 3.8.
some instances the detainee may be unable, or unwilling, to provide a comprehensive and accurate response. There are a number of factors which could impact on this, not least the environment in which the assessment is undertaken. In many custody suites, detainees are required to respond to personal questions at the front desk, where they can be overheard by other detainees and staff. Some FMEs suggested that more accurate information might be collected if detainees were assessed in their cell, or in an interview room. MPS officers responsible for custody policy raised concerns about this suggestion in terms of the safety of Custody Officers and the resource implications involved in conducting private risk assessments. With current practice unlikely to change, FMEs stated that the non-private context and custodial environment in which the information for risk assessments was provided should always be taken into account when assessing its accuracy.

There were concerns voiced by FMEs that risk assessments were not always undertaken when appropriate. MPS custody policy states that if information relating to a risk assessment cannot be obtained initially then it must be sought as soon as practicable (MPS, 2005). In our study an assessment had not been completed for 26 of the 121 cases we report on. This may have been because the incident occurred very soon after the person had been brought in to custody and so there had not been an opportunity to conduct one. However, according to FMEs, it was also likely that this was because the person was suspected or known to have mental health needs, or that Custody Officers viewed them as being too intoxicated to participate. MPS custody policy has been strengthened in this area since our fieldwork period. It now states that an inability to obtain information from the detainee “should flag up an immediate concern and the reason for the delay must be noted on the custody record” (MPS, 2007). It goes on to state that a full risk assessment must be completed as soon as the detainee is suitably fit for the process to be conducted, even if this is through the ‘wicket’ (the window in the cell door). If a risk assessment remains incomplete then, as the policy states, consideration should be given to placing the detainee on constant watch.

Eighteen of the 26 individuals who had not been assessed prior to the incident were described as being intoxicated. Although some FMEs felt that this may be a valid reason for a minority of detainees, there was a concern that intoxicated detainees were overlooked too readily. Some FMEs felt that it was important in these cases for Custody Officers to record their personal observations of the detainee; for example, noting low mood, pressured speech or ‘bizarre’ behaviour.

In those cases where intoxicated detainees were not able to participate, FMEs warned that the very fact that a person is unable to respond to questioning should be noted by Custody Officers as a warning, and staff should consider contacting an FME or calling for other medical assistance. It was also suggested that new attempts should be made to assess the individual as soon as possible after an hour and if they were still not able to participate then the situation should be reassessed.

One FME suggested that the only valid reason for not carrying out a risk assessment or seeking medical assistance would be if the detainee was too violent. As PACE states: “Risk assessment is an ongoing process and assessments must always be subject to review if circumstances change.”21 One FME reinforced this point by stating that:

“The status of the detainee may change during time and I think that’s one thing that people need to bear in mind, any state of mind is a variable state. People have to stop thinking in a fixed manner – things can change.”

4. Near Miss Incidents and the Custody Environment

Searching

In 19 (16%) of the 121 reported incidents, FMEs noted that inadequate searching had an impact on the incident or outcome of the case. In the majority of these cases (14), custody staff had failed to find drugs which the detainee went on to consume. In one incident a man who had been arrested for assault, and had been in police custody for over 24 hours, was found by the court escort team to have nine wraps of heroin in his pocket. These had not been discovered by police staff despite him having gone to hospital and returned, which should have led to an additional search. This case not only reinforces the need for consistent searching, but also suggests that follow-up procedures may be necessary for some detainees.

Searches should be conducted on any detainee whose “behaviour or offence makes an inventory appropriate”.22 If there are reasonable grounds for believing a person may have concealed Class A drugs, then they may be subjected to an intimate search.23 FMEs reinforced that searches must be thorough and officers need to be vigilant during the searching process. In a number of reported incidents, the detainee swallowed the substance during the search. It was also recommended that food items, such as packets of crisps or drink cans, should not be left with detainees as these could be used to smuggle in drugs.

21 PACE Code C, paragraph 3A.
22 PACE Code C, paragraph 4A.
23 PACE Code C, Annex A.
Case Study Seven

During a routine body search, a man was seen by custody staff to take a urine specimen bottle from somewhere on his person, remove the lid, and consume the contents. He refused to tell staff what it had contained, but a small amount of white residue was found in the container. An FME who was in attendance at the station on another call examined the detainee and, although he was not exhibiting any physical effects from the substance, advised that he was sent to hospital for observation.

The FME who reported Case Study Seven was concerned that an individual was able to take out, undo and consume the contents of a closed container while being searched by officers. This case should alert police staff to the speed with which an incident can occur and the vigilance which is required during search procedures.

Observation and Monitoring

In twelve (10%) of the near miss incidents, FMEs reported concerns regarding the observation or rousing of a detainee. Of these incidents, three related to inadequate observation when a detainee was on ‘Constant Supervision’, six to concerns around CCTV observation, two centred on inadequate rousing and one person self-harmed when 15-minute watches were not undertaken as advised.

The PACE Codes of Practice state that “The Custody Officer is responsible for implementing the response to any specific risk assessment (...) increasing levels of monitoring or observation.”

They “should always seek to clarify directions that the detainee requires constant observation or supervision and should ask the appropriate health care professional to explain precisely what action needs to be taken to implement such directions.”

If somebody is considered to be at high risk of self-harm, or is mentally ill, or there are concerns regarding their levels of consciousness, then they may be placed on Constant Observation or Constant Supervision.

Constant Observation and Constant Supervision

If a risk assessment indicates that a detainee may self-harm they should be placed on Constant Observation. This may involve the constant monitoring of the detainee via CCTV and regular physical checks. However, in their review of police custody deaths, Best and Kefas (2004) found that individuals on Constant Observation were in fact checked only slightly more often than those on 30-minute checks. They described this checking as tending to be ‘opportunistic’ and stated that FMEs, having given an instruction about the need for Constant Observation, could not rely on it being followed. Some FMEs in our study reported reluctance among police staff to conduct this level of observation as it is very resource intensive. We believe that FMEs should not be influenced by this reluctance and should request the level of observation which they see necessary. Failure to provide Constant Observation if instructed to by a medical professional is not acceptable.

Constant Supervision is used for those detainees at greatest risk. It goes beyond simply observing via CCTV and usually involves an officer being physically present with the detainee. The officer is responsible for monitoring the detainee’s behaviour and condition, assisting them and preventing any attempts to self-harm. Constant Supervision is also known as ‘Constant Watch’ or ‘Close Proximity’. In this study, five individuals, including one pregnant woman, were on Constant Supervision at the time the near miss incident occurred. Four out of the five were placed on this level of monitoring due to concern regarding their suicide risk and all four of these individuals went on to self-harm. In two of these instances, the person was not being fully observed at the time of the incident. In the first incident an officer had left to deal with another detainee, and in the second the detainee had been left alone in the toilet area. In the other two incidents officers were present. In the first of these a detainee covered himself with a blanket and tied his trousers around his neck, while the second involved a detainee self-harming by banging his head against the cell wall.

15- and 30-Minute Checks

FMEs varied in their opinions of the validity of 15-minute checks. Many said that they thought they were simply not feasible in a busy custody suite without extra staff and, even when recommended by an FME, were not being undertaken. Some argued that if there was enough concern to prompt a 15-minute check, then the person should be referred to hospital or placed under Constant Observation. However, some FMEs did believe that 15-minute checks were worth recommending as long as they could be confident that they were undertaken, reporting that hospitals use 15-minute checks to monitor patients they are concerned about.

More generally, FMEs recommended that any checks should be
carried out at irregular intervals, so that detainees at risk of self-harm are less able to predict when the next visit will be made. Some FMEs also expressed concern that 15- or 30-minute checks were made through the wicket, recommending that they should be made by opening the cell door.

CCTV

Approximately half of all cells in MPS custody suites have CCTV. FMEs highlighted the potential benefits of CCTV as a tool for monitoring vulnerable detainees, but raised concerns about its true benefits, since they believed that the screens were only used sporadically when a detainee was at risk. MPS guidance also highlights the limitations of CCTV by emphasising that it “must not be used in isolation to conduct constant supervision” of a detainee. There is some support in our findings for FMEs’ views about the monitoring of CCTV screens. In six incidents, FMEs reported that people who had been placed in CCTV cells due to concerns over their ‘at risk’ status then harmed themselves while images provided by cameras went unobserved.

CCTV was deemed as appropriate by some FMEs as long as certain conditions were met. For example, CCTV monitoring can only be effective if the process of observing it can be incorporated into the custody environment. CCTV monitors need to be in a position where they can be easily observed, such as in the eye line of Custody Officers when they are at their main work position. Placing of the monitor on the Custody Sergeant’s desk, where it could easily be obscured by papers, was not seen to be appropriate. It was suggested that a rota should be set up so that an assigned person was responsible for monitoring CCTV over a specified time period.

FMEs also warned that CCTV is only appropriate for monitoring certain individuals; for example, people at risk of self-harm. If a person needs to be monitored because they are intoxicated or there are other concerns about their consciousness then it is imperative that these checks are carried out in person, with verbal rousing when appropriate. And even for those at risk of self-harm, CCTV should not replace physical checks entirely; it should be viewed as a supplementary surveillance mechanism of use in a busy custody environment. Vulnerable people are likely to be reassured by having some verbal contact with another person during their detention, and therefore they should still be subject to routine visits.

A number of other concerns regarding CCTV were voiced by FMEs in their discussion of near miss incidents. For example, there were concerns about:

- the layout of some cells which prevented the camera from capturing complete coverage and therefore allowed the detainee to move out of sight;
- detainees using blankets or other materials to block the lens of the camera; and
- systems which display a number of cells minimised on a single monitor and which require officers to press a button to focus in on a cell. It was reported that staff tended to leave the monitor on the multiple cell setting which made it difficult to view a single cell in the necessary detail.

Rousing

FMEs were generally positive about the formal policy on rousing although there were concerns that some Custody Officers were still unclear about what was meant by the term ‘to rouse’. PACE states that “a record must be made in the custody record of (…) the responses received when attempting to rouse a person using the (…) [rousability, response to questions, and response to command] (…) procedure”. Recording a person’s responses when attempting to rouse them enables any change in the individual’s consciousness level to be noted, and clinical treatment arranged if appropriate.

In one incident, an FME requested officers rouse an intoxicated detainee at specified intervals. The detainee was found sometime later unconscious in his cell. A review of the incident revealed that officers had conducted 15-minute visual checks through the wicket, rather than verbally rousing the individual. It was reported that the individual was snoring and it appears that officers had interpreted this as a sign that the detainee was conscious and stable. In fact, as became clear in this case, snoring was a sign of respiratory difficulty which eventually led to a lapse of consciousness requiring resuscitation and hospital attendance. FMEs warned that snoring should always be viewed as a warning sign until proved to the contrary.

Good Practice

Effective observation or rousing was identified as a positive factor in 44 (36%) of the 121 cases, with staff identifying potentially critical incidents, and through their action, possibly preventing a more serious outcome. In a number of these incidents FMEs praised the diligence of custody staff in their


27 PACE Code C, paragraph 9.15 and Annex H.
Custody Staff

In 11 incidents, FMEs reported that inadequate staffing levels may have contributed to the severity of the incident. They cited examples of detainees not being thoroughly assessed or recommended actions not being followed through due to constraints on time and resources. In one incident, insufficient staffing levels meant that there was no-one available to escort a detainee back to his cell following a consultation with an FME. The detainee was left in the corridor where lack of monitoring enabled him to return to the medical room and consume tablets from the FME’s bag. The detainee was left in the corridor where lack of monitoring enabled him to return to the medical room and consume tablets from the FME’s bag.

Certainly, many of the FMEs interviewed expressed concern about inadequate staffing levels during busy periods, with vulnerable detainees being placed at a possible risk due to the competing priorities placed on already busy staff. FMEs urged Custody Officers to refuse to take new arrestees when their cells were full. One FME voiced concern that at busy times arrestees were regularly brought in and detained, often for several hours, in the ‘caged’ waiting area of the custody suite before being appropriately processed or assessed.

There was recognition among FMEs of the difficulties facing Custody Officers who are required to make pivotal decisions about the treatment of detainees, often under a degree of pressure and without necessarily being provided with the appropriate support. Taking into account these considerations, FMEs were generally positive about the competency of staff, with a number commending DDOs, in particular, for their exercise of diligence and commitment in their role. In one incident, a DDO overruled advice from an FME that a detainee with a suspected heart condition was fit to be detained, and asked for further medical assistance. On arrival of the second FME, the man collapsed and required resuscitation before being taken to hospital by ambulance. The FME remarked that...

“... due to the prompt action of the DDO in recognising this was serious, and that (s/he) was not happy with the advice given by the previous FME, appropriate measures were taken.”

Had the DDO not reacted in this way, the FME reported that it was ‘fairly likely’ that the incident would have resulted in a fatality.

As with all working environments, FMEs reported that the competency of staff was variable. In identifying ‘good’ custody staff, FMEs referred to the importance of training and ‘experience’, which allowed staff to make decisions about the appropriate care of a detainee with confidence. While it is recognised that ‘experience’ in itself cannot be taught to new staff, a commitment to ensuring that all staff have adequate training and guidance would enable staff to have greater confidence in the decisions they make, in the knowledge that they had done all that could be expected of them under their duty of care.

Training and Guidance

Custody Officers receive first aid training both in their general training as police officers and more particularly for their work with detainees. However, there was a consensus among FMEs that this might need to be more specific, with custody staff being trained in identifying potentially dangerous symptoms and risk factors, specifically concerning drugs, alcohol and certain medical conditions. This raises questions about roles of custody staff and FMEs, and the extent to which the former could or should take on competencies which may be viewed as medical. Certainly, FMEs generally agreed that staff should be able to provide basic first aid and resuscitation, as they are currently trained to do. But they also recognised the above issue and believed that training should be provided with the intention of enabling custody staff to deal with a detainee while awaiting the arrival of emergency medical professionals, rather than being an alternative source of medical provision.

The issue of training was examined by Man et al (2002), who found that when asked about alcohol-related detainees just under three-quarters of officers stated that they need more instruction. Just over a quarter of the officers thought that they were not adequately trained to manage ‘drunken offenders’ and only a third said that they could recall receiving any formal training. However, there was a consensus among FMEs that this might need to be more specific, with custody staff being trained in identifying potentially dangerous symptoms and risk factors, specifically concerning drugs, alcohol and certain medical conditions. This raises questions about roles of custody staff and FMEs, and the extent to which the former could or should take on competencies which may be viewed as medical. Certainly, FMEs generally agreed that staff should be able to provide basic first aid and resuscitation, as they are currently trained to do. But they also recognised the above issue and believed that training should be provided with the intention of enabling custody staff to deal with a detainee while awaiting the arrival of emergency medical professionals, rather than being an alternative source of medical provision.

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training to help them deal with drunken or alcohol-dependent detainees. Furthermore, Custody Officers were found to assume too readily that a detainee’s ill health was due to alcohol consumption, while underestimating the real dangers associated with alcohol intoxication.

Our study also raised questions about the guidance given to arresting officers about whether to bring a detainee into custody rather than seek medical attention. For example, PACE provides some clear messages about detainees whose level of consciousness is a matter of concern and this is reinforced in MPS custody policy. However, as Case Study Eight highlights, while Custody Officers may follow this, it still remains an issue with other officers.

Case Study Eight
Officers responding to a road traffic incident arrested the driver on suspicion of being under the influence of alcohol. The man collapsed and lost consciousness and officers had to carry him into the police vehicle. He was then driven past the hospital and the arresting officer presented him for detention while he was still unconscious. The Custody Officer refused to take him and an ambulance was called.

Contact with Hospitals and Ambulance Staff

In a number of cases officers may decide that a person they have just arrested needs to go to hospital rather than a custody suite. After treatment the person may be well enough to be taken to a police station. Once at the police station the MPS custody policy states that an FME should be called, told why the detainee was taken to hospital, and be given any other relevant information about treatment there (MPS, 2005). If an FME has referred a detainee to hospital then they should be sent with a letter or form to be updated by hospital staff, documenting the treatment or medication the detainee has received. In the MPS, this document is known as the Form 170. However it was clear from the interviews that the form is not consistently used by FMEs or by hospital staff. FMEs reported that they were often reliant on detainees to provide them with information regarding any hospital treatment they had received. It was recommended that a form like the Form 170 should be developed for national use in connection with the PACE Codes of Practice, and that escorting officers should be instructed to refuse to take the person until it has been provided by the hospital. This is especially important if people have been given medication while in hospital as, without this knowledge, there is the potential for FMEs to prescribe similar medication which could result in an overdose. Equally, FMEs should have a duty to provide appropriate information when referring people to hospital.

Interpreters
The availability of interpreters was also raised as an issue. In one incident, staff were concerned about a non-English speaking person’s physical health. Attempts to find an interpreter failed and eventually the man was taken to hospital after his condition sharply deteriorated. It was later established that he was suffering from acute alcohol withdrawal.
MPS custody policy states that ambulance service regulations place an obligation on ambulance crews to refrain from ‘on street’ diagnosis and that they are required to take a person to hospital unless medical aid is positively refused and the person is in a fit state of mind to make such a decision (MPS, 2005). Furthermore, if there is a disagreement between Custody Officers and ambulance staff about a detainee’s need to go to hospital an on-call clinical advisor can be called for a decision. However, FMEs described the difficulty arresting officers face if they disagreed with the decisions made by healthcare professionals. Some FMEs expressed concern that the refusal of ambulance crews to take individuals to hospital may lead officers to take people into custody when it may not always be the most appropriate place for them. The near miss described in Case Study Nine suggests that ‘on street’ diagnosis by ambulance crews may still occur and highlights the dangers when this goes wrong. The FME who reported Case Study Nine urged Custody Officers not to be afraid to question or challenge advice given by healthcare professionals.

**Case Study Nine**

A man told police officers that he had overdosed on ‘over-the-counter’ medication. Paramedics attended the scene and decided that the number of tablets he had reportedly consumed did not constitute an overdose and so refused to take him to the hospital. The man was taken to the custody suite where, within minutes of arrival, he collapsed and lost consciousness. An ambulance was called and he was taken to hospital where it emerged that he had taken a large quantity of a number of different medications. He was detained in hospital for three days.

The next chapter summarises the findings of this study and makes a series of recommendations.
5 Conclusion and Recommendations
This study aimed to provide a better understanding of near miss incidents in police custody. It also sought to identify areas of learning in order to help reduce the risk of such incidents occurring in the future. In this sense the study has been a demonstration project which seeks to show that near miss incidents are an important source of learning and that there are benefits in having a formal way of collecting information on these incidents. The study involved FMEs reporting on incidents occurring in the MPS, but we believe that the main points of learning from this study are generalisable to all police forces across the country. We have included a copy of the form used by FMEs at the end of this report and would encourage those responsible for the management of custody policy and practice to consider adapting it for use by custody staff. They are in a much better position to encourage custody staff to report these incidents and respond to the issues.

One aim of our study was to produce an estimate for the number of near misses that occurred over the 12-month period that FMEs reported these incidents. When the rate of incidents is generalised across the total number of FMEs working in the MPS, it suggests that around 179 near miss incidents occur annually in the MPS. It is worth noting here that the MPS is only one, albeit the largest, of 43 police forces in England and Wales, and that the number of near miss incidents occurring nationally will be considerably greater. In 2005/06, six people died in or following police custody in the MPS (Teers and Menin, 2006). This figure suggests that for every person who dies, there are around 30 near miss incidents in the MPS and 900 across police forces in England and Wales each year. Support is given to this estimate by separate calculations which estimate a similar figure – around 1,000 near misses across forces in England and Wales. If we take a stricter definition and look at just those incidents in which FMEs thought death was ‘very likely’ or ‘fairly likely’, then we estimate approximately 400 of these very serious cases occur each year. For reasons discussed in earlier chapters this is likely to be an underestimate.

Despite the large amount of existing regulations, guidance and policies, our study identified a number of areas where improvements can be made in terms of avoiding near misses and fatalities. These all touch on issues concerning:

- the training given to custody staff so that they are sufficiently aware of and are able to identify certain risks and conduct appropriate assessments; and
- the need to reinforce to custody staff the importance of following procedures and training centring on the care of vulnerable detainees.

We believe that it would be unwise to assume that the above issues relate only to the MPS. Instead these are likely to be general issues for those managing and working in custody suites across England and Wales. As a result we have outlined a series of recommendations which are written for all police forces. We outline below the key areas from our study where we believe improvements could be made.

**Alcohol, Drugs and Medical Conditions**

The danger of not identifying risks among detainees is emphasised in various documents produced by the Home Office, the NCPE and the MPS. However, our research highlights that this still occurs in practice. In some cases incorrect assumptions were made about the behaviour of detainees. For example, in a number of near miss incidents, serious medical conditions, such as hypoglycaemia, were confused with alcohol intoxication. In other cases, serious head injuries led to symptoms which Custody Officers thought were due to intoxication. In these instances, detainees experienced a delay in receiving the medical attention they required and the risk of fatality increased.

Our study also highlights cases where known risks were not addressed. Examples here include cases where detainees were known to have swallowed drugs on arrest. Despite PACE Code C emphasising the dangers in these circumstances and the need for medical assistance, initially this was not called for in these cases. In other cases, the risks associated with individuals correctly identified as severely drunk were not initially addressed. The condition of the detainees was then found to have deteriorated and FMEs were finally called. As stated above the need to correctly identify risks and respond to them is reflected in a number of official documents. The challenge is to ensure that these messages are regularly and consistently reinforced among custody staff.

**Recommendation 1:** for those responsible for custody policy in police forces to consider whether custody staff are fully aware, or need to be reminded via guidance and training about the appropriate responses to drug swallowing and severe intoxication. Likewise the message needs to be reinforced that apparent symptoms of intoxication may in fact be the result of an injury or medical condition, and that intoxication may mask or be found in conjunction with serious health needs.
Risk Assessment

One of the most serious issues emerging from incidents in this study concerns detainees who cannot be properly risk assessed on entry to custody. In the vast majority of these cases alcohol intoxication was the main reason why an assessment could not be conducted, with a smaller proportion of cases relating to mental health needs. FMEs felt that intoxicated detainees were overlooked too readily and that the danger in such cases was to place the detainee in a cell and conduct a risk assessment when they were in a fitter state. However, the fact that a person is unable to respond to questioning should be viewed by Custody Officers as an important warning, and staff should consider contacting an FME or calling for other medical assistance. FMEs also suggested that new attempts should be made to assess the individual as soon as possible after an hour, and if they were still not able to participate then the situation should be reassessed.

Recommendation 2: for police forces to consider whether Custody Officers have been provided with sufficient guidance on the management of those detainees who are either unwilling or not able to participate in a risk assessment.

In a number of incidents inadequate communication undermined risk assessments. This could be between arresting officers and Custody Officers, or between Custody Officers and FMEs. The result here was that some detainees were not dealt with in accordance with custody policy, or medical advice was not followed. However, of more specific concern was a lack of effective communication between hospital medical staff and Custody Officers. The MPS has a specific form which hospital staff should use to record treatment and medications received by detainees who are sent for their care. The inconsistent use of this form meant that detainees could re-enter police custody without Custody Officers and FMEs knowing what, if any, medical treatment the detainee had received.

Recommendation 3: for police forces and health service providers to ensure that Custody Officers and FMEs are provided with a record of treatment for detainees returning from hospital. This may require discussion between the two organisations about the best way to communicate any treatment information, and if a method exists already, to ensure that hospital staff are aware of their role in this practice.

Observation and Searching of Detainees

Several of the incidents in our study occurred after detainees had been placed in cells still in possession of drugs. This underlines the importance of effective searching, with the consideration that certain individuals, such as known drug dependants, may require especially thorough searching and may attempt to swallow substances during the search.

Nearly half of the near misses in this study involved self-harm or a suicide attempt. The incidents involved a wide range of items, but in some instances these included food containers and implements left in cells by previous occupants. This raises the importance of checking and clearing cells between occupancies, as well as being clear what detainees should be allowed to take into cells. While PACE allows Custody Officers to withhold clothing and personal effects if they think they will be used to cause harm, some of the FMEs in our study felt that identifying risk among detainees was difficult. This led them to suggest that the removal of shoe laces and belts from all detainees would greatly reduce opportunities to self-harm. Officers responsible for custody policy in the MPS thought that this would be difficult to defend legally in terms of the rights of detainees. However, ensuring that safety knives are readily accessible to custody staff to help removal of ligatures was seen by FMEs as a way of reducing levels of risk.

Recommendation 4: for police forces to ensure that Custody Officers are aware of the importance of checking cells when they are vacated and the need to remove items which could be used to self-harm by later occupants.

Recommendation 5: for police forces to ensure that Custody Officers have ready access to ligature knives.

Our study raised a number of issues about the observation and checking of detainees. Past studies have raised questions about Constant Observation and we found reticence among Custody Officers to follow FME recommendations that this should occur in high-risk cases. While these cases were small in number, they still included instances where the detainee had managed to harm themselves sufficiently for an FME to be called. In some cases this occurred when the detainee had been left alone even though they were under ‘Constant Watch’ and this underlines the need to emphasise that ‘Constant Watch’ should be just that.
5. Conclusion and Recommendations

**Recommendation 6:** for police forces to ensure that Custody Officers are aware of the requirements for the monitoring and observation of detainees as outlined in PACE Code C and national guidance on ‘The Safer Detention & Handling of Persons in Police Custody’.

CCTV was viewed positively by FMEs in terms of monitoring those at risk of self-harm. However, they emphasised the need for cameras to have complete coverage of the cell, the monitors to be in a location which allows them to be viewed properly, and custody staff to have a rota for watching at-risk detainees. Finally, several incidents highlighted issues around the rousing of individuals which suggested that instructions in PACE were not being followed. In particular, instructions about the need to rouse a detainee viewed as a risk tended to be translated into regular observation of that detainee. FMEs in these cases stated that observation alone was not adequate and that an instruction that an individual requires rousing should mean rouse to speech. Failed attempts to rouse a detainee to speech should mean immediate transfer to hospital.

**Recommendation 7:** for police forces to ensure that Custody Officers are clear that ‘rousing’, as outlined in PACE Code C, means eliciting a verbal or physical response from the detainee.

Issues concerning observation also extend to the responsibilities of FMEs during their interactions with detainees. We were surprised to find three near misses in our sample where detainees had snatched and consumed drugs in the possession of an FME. Such cases reflect the level of honesty of some FMEs in reporting near misses in which they are involved. Furthermore, such incidents were also reported in the pilot project for this study. This suggests to us that these cases are more than simply rare aberrations.

**Recommendation 8:** for FMEs to be aware of the danger of detainees stealing medication during consultations and to take precautions to avoid this occurring.

**Recommendation 9:** for those responsible for managing custody suites to consider whether the flow of detainees at peak times compromises custody staff’s ability to follow PACE Code C and to plan appropriately for such occasions.

Custody Officers are likely to receive first aid instruction and other associated tuition both as part of their general training as police officers as well as for their current post. FMEs were clear that they did not expect custody staff to act as quasi-paramedics. However, FMEs expressed concern about the content of this training and how consistently it had been delivered. More specifically, FMEs felt that greater awareness of issues around, for example, substance misuse, suicide and self-harm, and common medical conditions would lead to more prompt action which may aver future incidents. In addition, refresher training was viewed as necessary in ensuring both a consistent set of abilities and understanding. At the very least this would ensure that staff could apply basic first aid techniques, such as resuscitation, while awaiting the arrival of medical assistance.

**Recommendation 10:** for police forces to ensure that Custody Officers, as part of their training, gain sufficient awareness of the symptoms of key conditions, involving substance misuse and health conditions, to be able to conduct robust risk assessments.

**Near miss reporting**

The active monitoring of near miss incidents in police custody suites offers a valuable opportunity for learning and prevention. While some police forces do have procedures which seek to capture information on near misses, many of these lack a clear definition of a near miss. Others have a broader remit to capture incidents across a range of areas as well as police custody. All tend to be vulnerable to under-reporting for fear of the repercussions for the custody staff concerned.

For near misses in police custody to be effectively identified, there needs to be a clear definition of which incidents should and should not be reported on and the related form should be...
easy to complete and accessible. The system needs strong management support and staff need to feel comfortable that it is not a blame-apportioning exercise. This may mean consideration of an anonymised reporting system. Importantly, staff also need to see evidence that the information provided is being acted upon.

It is hoped that this study can provide an illustration of how information on near miss incidents can be usefully and effectively captured. It can offer a framework for forces, who can adapt and develop the reporting system to meet their own requirements. Indeed, the IPCC is already aware of some forces that have drawn on the questionnaire used in the study in developing work around safer detention. We therefore attach a copy of the near miss form to this report and encourage police forces to consider using it.

Police forces may also wish to consider ways of identifying near misses through existing methods. One suggestion put to us during this study was that custody records may be a useful source of information since they should identify the occasions when detainees have had to attend hospital for treatment. Not all hospital visits by detainees will be related to a near miss but the more serious near miss cases should be among this number. The issue for forces would be how to identify detentions involving hospital visits since this may be only recorded on paper. With thousands of detainees passing through custody only electronic records would allow an efficient method of identifying these cases.

Recommendation 11: for police forces to consider developing ways in which near misses in custody can be reported to those with responsibility for managing custody policy and procedures.

Deaths and near misses

A comparison of the near miss incidents in our study and deaths suggests some strong differences. Firstly, our sample contained a far greater proportion of attempted suicides and cases of self-harm compared to instances of suicide contained in the national figures on deaths. Secondly, there were proportionately more near misses related to drugs and alcohol compared to deaths due to these substances. Thirdly, when compared to fatalities, there were far fewer near misses related to health matters such as medical conditions, organ failure or injuries. As discussed earlier, these differences may reflect that the incidents in this study were reported by FMEs, and the large amount of self-harm and substance misuse among detainees.

Our study also examined the factors that lead to incidents remaining as near misses rather than becoming fatalities. At the start of this study we thought that serendipity may play a part, but an alternative explanation emerges which has important implications for the prevention of future deaths. In many of the high profile deaths in police custody a similar pattern emerges which involves a series of flawed decisions being made about the care of a detainee. A case may involve, for example, an unconscious man being brought into the custody suite of a police station. The Custody Officer decides to accept the person into detention, an FME is not called to assess the person, the detainee is placed in a cell and the appropriate checks or rousing are not fully carried out. Serious concerns are eventually raised. Paramedics are called, but it is too late to save the man’s life.

In contrast, the cases in our study are characterised by a decision being made by the Custody Officer which halts the chain of events progressing any further towards a possible fatality. In some instances the incident is in its very early stages. In others the incident had progressed some way and, arguably, some flawed decisions had been made. Overall, there is little evidence that serendipity played a key role here in the cases in our study. Instead the following of procedures, such as checking and rousing, tended to identify a risk which was responded to through medical assistance. A key message here is that adherence by Custody Officers to PACE and associated policies saves lives. But since in a notable number of cases this was not what happened in practice, this message needs to be reinforced to custody staff. This message is supported by the fact that many of the issues identified in this study have been addressed by MPS custody policies. Again, the issue is about seeing this reflected in custody practice.

In 2006 the NCPE produced guidance on ‘The Safer Detention & Handling of Persons in Police Custody’ on behalf of the Association of Chief Police Officers and the Home Office. This was developed to help police forces ensure that they have in place “strategic and operational policies to help raise the standards of custodial care for those that come into contact with the police” (NCPE, 2006). The guidance aims to help staff to identify warning signs and carry out effective risk assessment in an effort to minimise deaths and reduce the number of adverse incidents occurring in police custody. The findings of

30 The only exception here involves those instances where an FME was already in the custody suite attending to another detainee.
this study lend support to a number of key areas addressed in the NCPE guidance; for example, the need to provide guidance on the assessment, management and care of detainees with substance misuse, mental health and medical needs. The challenge for police forces, medical professionals and wider policy makers is to consider how this learning can be incorporated effectively into the development of custody policies and protocols, and to ensure that the related messages to custody personnel are reinforced and reflected in practice. Only by addressing the issues reflected in this report and in the NCPE guidance will an impact be made on the near misses and deaths that occur in police custody.
References


References


Appendix:
FME Survey Questionnaire
### THIS FORM SHOULD BE USED TO RECORD ANY INCIDENTS WHICH RESULTED IN, OR COULD HAVE RESULTED IN, THE SERIOUS ILLNESS, INJURY OR SELF-HARM OF A DETAINEE.

**GUIDANCE IS PROVIDED ON THE REVERSE OF THE FORM**

#### Incident Details

| 1. Incident time (24 hr clock) |  |
| 2. Time FME requested |  |
| 3. Start time of contact with detainee (if applicable) |  |
| 4. Incident day |  |

#### Detainee Details

| 5. Age in years |  |
| 6. Gender of detainee | Male | Female | Other |  |
| 7. Self-Reported Ethnicity of Detainee | White | Chinese or other | Black | Mixed |  |

#### Prior to Incident

| 9. Time arrested (24 hr clock) |  |
| 10. Time arrived at station |  |

#### Incident Type (continued)

17. If Incident involved **DRUG INGESTION** please answer Q17a to Q17c

| 17a. IF DRUG INGESTION | (Please tick one only) |  |
| Apparent Swallowed to Conceal |  |
| Apparent Accidental e.g. opiate intolerance |  |
| Apparent Stuffed / Packer |  |
| Apparent Intentional i.e. self-harm / suicide |  |

17b. IF DRUG INGESTION | (Please tick all that apply) |  |
| Cocaine / Crack Cocaine |  |
| Opiates (Please specify below) |  |
| Prescribed medication (Please specify below) |  |
| Non prescribed medication (Please specify below) |  |
| Other drug/s (Please specify below) |  |

NAME OF DRUG/S INGESTED:  

| 17c. IF DRUG INGESTION | (Please tick where this information came from. Tick all that apply) |  |
| Medical check / observation (own/other’s) |  |
| Information from Officer / Other Staff |  |
| Told by the Detainee |  |
| Other (Please specify) |  |

18. If Incident involved **APPARENT SELF HARM / SUICIDE** please tick the applicable method and then provide any further relevant information e.g. ligature type

| 18a. IF APPARENT SELF HARM / SUICIDE | (Please tick one only) |  |
| Hanging/Self-Strangulation |  |
| Cutting/Scratching/Wound Aggravation |  |
| Head banging with intent to harm self |  |
| Other method of Self-Harm | (Please describe e.g. burnt self) |  |

#### Mental Health / Drug History

| 20. Was the individual known to have any of the following? | (Please tick all that apply) |  |
| Mental illness |  |
| Drug Dependence |  |
| Alcohol Dependency |  |
| Self Harm History |  |
| Other relevant (Please specify) |  |

#### Outcome & Recommendations

| 21. Were any resuscitative measures required? | Yes | No | Don’t know |  |
| 22. Was an ambulance called? | Yes | No | Don’t know |  |
| 23. Did the individual go to hospital? | Yes | No | Don’t know |  |

25. In your opinion what factors, if any, had a **POSITIVE** impact on this incident?  
(Tick all that apply)  

| Checking / Rousing |  |
| Searching |  |
| Speed of FME request |  |
| Custody Staffing Levels |  |
| Other (Describe below) |  |

#### Incident Description

| 15. Nature of Incident: | (Tick all that apply and then complete all relevant Qs in next section (Q16-Q19)) |  |
| Alcohol related |  |
| Drug Ingestion |  |
| Self-harm / Attempted Suicide |  |
| Injuries Sustained During Arrest / Restraint |  |
| Medical Condition / Other Injury |  |
| Not known / Other (Please describe) |  |

| 16. If ALCOHOL-RELATED | (Please tick all that apply) |  |
| Fitting |  |
| Choking |  |
| Changing levels of consciousness |  |
| Vomiting |  |
| Other (Please specify) |  |

#### Incident Type

20. Was the individual known to have any of the following?  
(When you are reviewing the incident, consider different factors and their impact. When completing this section, you may find it useful to consider: the relationship of the individual to the staff members; the impact of any use of force; factors which could have been modified to prevent the incident, etc.)  

| 20a. If incident related to **MEDICAL CONDITION / INJURY** | (Please tick as applicable) |  |
| Diabetes Related |  |
| Asthma Related |  |
| Epilepsy Related |  |
| Head Injury |  |
| Heart Related |  |
| Other (Please specify) |  |

#### Other

Please Return the Questionnaire in the Envelope Provided

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*Thank you very much for your time*
**NEAR MISSES IN POLICE CUSTODY**

**Appendix: FME Survey Questionnaire**

### IPCC Near Miss Research Study

**QUESTIONNAIRE GUIDANCE**

The circumstances in which a questionnaire should be completed are included at the top of the form. However, if you are in any doubt about whether or not an incident is relevant, please complete a questionnaire adding as much detail as possible. The researchers will then use this information to make a decision as to whether or not the incident is relevant to the project. Alternatively seek advice from the IPCC on the contact details provided below.

### Incident Details

| Q1: | Enter the time, in the 24 hr clock when staff first decided that the nature of the incident / condition of the detainee required medical assistance. |
| Q2: | Enter time you were first requested. |
| Q3: | Enter the start time of your consultation with the detainee. This refers to when you saw the detainee regarding the relevant incident. |
| Q4: | Insert the day of the week only. We do not want to know the exact date as this may breach confidentiality. |

### Detainee Details

| Q5: | Enter D.O.B. or age in yrs. If unknown then please estimate, specifying that it is an estimate. |
| Q6: | Code sex of respondent. |
| Q7: | These ethnicity codes correspond to the 16+1 self-report groupings used by the Police. |
| Q8: | Please code the main reason for arrest (information available on the custody record). |

### Prior to Incident

| Q9, Q10, Q11, Q12, Q13: | The information required to answer this set of questions should be available on the individual’s Custody Record Sheet. |
| Q14: | This refers to the detainee’s state at the time of the incident. Please code why you think the detainee was intoxicated e.g. your own observation, an officer/the detainee told you etc. |

### Incident Description

| Q15: | This relates to the nature of the incident. All the relevant factors should be ticked. You must then complete all the relevant follow-up questions (Q16 to Q19). |

**Alcohol-related:** This should be ticked if you think that alcohol was a relevant factor in this incident.

**Drug Ingestion:** Includes illicit and prescribed medication and both ‘accidental’ or ‘intentional’ ingestion.

**Self-harm / Attempted Suicide:** Includes any harm which appears to be caused intentionally by the action of the individual with the aim of causing self injury.

**Injuries sustained during arrest / restraint:** Includes any injuries which were sustained through contact with police staff during arrest or in custody.

**Medical condition / Injury:** Any harm related to an existing medical condition or an injury not covered above. This should only be ticked if it is relevant to this incident.

**Other:** If the incident cannot be coded into one of the above, then the ‘Other’ box should be ticked and a note should be added outlining the circumstances. |

### Incident Type

| Q16: | If the incident was alcohol related, please identify from the list which of these alcohol related factors were relevant. |
| Q17: | You should only answer Q17a to Q17c if you believe that an individual’s drug ingestion was directly relevant to this incident i.e. if a detainee thought to have swallowed drugs loses consciousness. If an intoxicated person is involved in an incident e.g. cut self, but their drug ingestion is not directly relevant to the nature of their illness or injury then this Q is not relevant. |
| Q18: | This should only be answered if the individual’s illness/ injury is thought to result from intentional self-injury other than drug overdose which will have been described in Q17 above. |

### Mental Health / Drug History

| Q19: | This question should only be answered if you believe that this incident is related to a medical condition or that it results from any injury not covered in Q18. Relevant examples would be accidental injuries and exacerbation of pre-existing conditions e.g. a diabetic who loses consciousness. |
| Q20: | This question should be completed for all incidents. All applicable factors should be coded in order to provide as much information as possible about the person’s history of mental health and/or substance misuse. |

### Outcome & Recommendations

| Q21, Q22, Q23, Q24: | These Qs relate to the treatment / management of the incident. |
| Q25: | This question asks you to identify any operational / environmental factors which you feel had a positive impact on this incident e.g. appropriate checks led to timely intervention. |
| Q26: | This question asks you to identify any operational / environmental factors which you feel had a negative impact on this incident e.g. a delay in contacting you led to an escalation in the seriousness of the incident. |
| Q27: | This question will be used as a proxy to gauge the perceived lethality of the incident. Please circle the number which corresponds to the statement which you believe is most applicable. |

### Continuation Space

Please use this space to provide any additional relevant information, or to expand on any of the information you have provided overleaf.

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**The information provided on the form is confidential. However, if contact details are provided, as with other such documents, it is potentially disclosable in the event of investigative proceedings.**

If you have any queries please contact Rebecca Teers at the IPCC on:

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