For Information	
Public/Non Public	Public
Report to:	Audit and Scrutiny Panel
Date of Meeting:	17th June 2014
Report of:	FORCE IMPROVEMENT ACTIVITY, LESSONS LEARNED MONITORING, IPCC LESSONS LEARNED REPORT
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Agenda Item:	6

IPCC LESSONS LEARNED FEEDBACK

1. Purpose of the Report

1.1 To inform the PCC in respect of force improvement activity, lessons learned monitoring, and the implementation of learning from the ipcc 'lessons learned' bulletins during the relevant period – October 2013 to March 2014.

2. Recommendations

2.1 That the Audit and Scrutiny Panel notes the report.

3. Reasons for Recommendations

3.1 To provide the PCC with relevant information and oversight in respect of how Nottinghamshire Police responds to lessons learned as a result of public Complaints and internal conduct matters.

4. Summary of Key Points

4.1 The DCI Head of Complaints and Misconduct Unit (CMU) is the Professional Standards Directorate (PSD) lead for organisational learning. Where PSD investigate a public complaint or conduct matter, or are asked to review a particular incident to determine whether it was appropriately dealt with, the investigation also considers whether there is any learning that can be used to improve future organisational responses. We capture that information on the Organisational Learning tab of our recording system which is called Centurion.

4.2 Following these investigations, if the learning is for an individual through management action, an action plan or additional training, this will be progressed following disclosure to the officer's or staff member's line management.

4.3 Where the learning is consider relevant to the wider organisation then this will be shared by PSD with the most appropriate lead department, such as

Learning & Development, Custody or Contact management, and will also be communicated on the PSD intranet site.

4.4 If there is any learning which requires fast-time action that will be progressed with the appropriate department and the recipient asked to reply back with any action taken by a given deadline. The requests and responses will also be attached to the Centurion record.

4.5 Where appropriate PSD will conduct reviews to ensure that any immediate or recommended changes have been effectively implemented.

4.6 In addition, the CMU DCI also reviews the 'Learning the Lessons' bulletins from the IPCC and circulates them to all Heads of Departments. Identifying and implementing best practice from the 'Learning the Lessons' bulletins helps to manage risk and maintain or improve the service we provide, thus impacting positively on the trust and confidence from those we protect and serve.

4.7 The effective implementation of all relevant learning is also monitored through the force 'Professional Standards and Integrity' board, chaired by the DCC. Membership of this board includes representation of the OPCC. The quarterly PSD newsletter 'Integrity Matters' and the PSD intranet site are also used to further communicate or refresh key messages regarding organisational learning for all staff and officers.

4.8 In the relevant reporting period, October 2013 to March 2014, there has been one recommendation from an IPCC investigation in relation to the way an officer dealt with an allegation of 'common assault' by a stranger which included;

a) Use of a 'Violent crime handover package'
b) Guidance for Real Time Intelligence Unit staff
c) Setting of time scales for investigations within officers PDRs
d) Devising a force policy on use of Blackberrys

These are all currently being progressed through the process as described above and will be monitored through the Standards and Integrity Board.

4.9 Other learning is included on the PSD intranet site along with a link to the IPCC 'Learning the Lessons' bulletins. The last bulletin was Bulletin 20 in January 2014 concerning 'General Policing issues' which has been circulated to all Heads of Departments.

4.10 The issues covered in the bulletin include;

- Contact Management- sharing information when conducting cross border activity- conducting welfare checks on vulnerable people
- Call handling-call grading' how we respond to mental health callers
- Child Abuse- dealing with historic reports
- Detaining young people in custody-overnight detention, strip searches

These are also being progressed through the process as described above and will be monitored through the Standards and Integrity Board.

5. Financial Implications and Budget Provision

5.1 No specific financial implications have been identified.

6. Human Resources Implications

6.1 No specific implications.

7. Equality Implications

7.1 No specific internal equality implications are identified. Learning around improving services to the vulnerable, the young and in respect of mental health services will enhance equality of service across the local communities.

8. Risk Management

8.1 The process as described ensures that learning is embedded in a way that reduces and mitigates against risk

9. Policy Implications and links to the Police and Crime Plan Priorities

9.1. Strategic Priority Theme 1: Protect, support and respond to victims, witnesses and vulnerable people

10. Changes in Legislation or other Legal Considerations

10.1 None

11. Details of outcome of consultation

11.1 None

12. Appendices

12.1 Appendix A IPCC BULLETIN 20

LEARNING THE LESSONS

www.ipcc.gov.uk/learning-the-lessons

Ask yourself: Could it happen here?

Bulletin 20: **General**

Learning the Lessons bulletins summarise investigations conducted by the Independent Police Complaints Commission (IPCC) or police forces where learning opportunities are identified. Police forces facing similar situations to those described can use the experience of other forces to improve their policies and practices. The bulletin challenges forces to ask "Could it happen here?".

Issues covered in this bulletin:

Arrest and dentention

Planning	1
PNC checks on mobile devices	2
Risk assessment	1
Sharing information with other forces	1

Call handling

Call grading	3, 4
Delays to deployment	3, 4
Dealing with a request for a welfare check	3
Mental health	4

Child abuse

Dealing with historic reports	5
Acting on information from CEOP	6
Recognising risk	5
Handovers	6

Custody

Dealing with young people	7
Searching medical coverings	8
Use of smocks	9
Bailing detainees	7

Find out more online

Learning reports available online include the recommendations made in each case, full details of action taken by each of the forces involved, and details of any criminal or misconduct outcomes.

Contacting us

Please email **learning@ipcc.gsi.gov.uk** with any queries or to join our mailing list.

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Case summaries:

Arrest and detention

1 Control of a detained person

While a man was waiting to stand trial for supplying class A drugs, officers uncovered information indicating that he had committed a further offence of conspiracy to import class A drugs. Officers began planning for the man's arrest.

As the arrest was due to take place in another force area, a control room operator was asked to notify the other force. The other force had no record of receiving this information.

Taking into consideration the intelligence they had about the man, including his conviction history, age, physical appearance and their recent contact with him, the officers assessed the risk the man posed to himself and the officers as low. They also did not consider that the risk had changed significantly since their last contact with him.

The officers did not check with the other force's intelligence bureau to check whether they had any useful intelligence to inform the risk assessment. Had they done so, they would have identified that the man had recently reported that he had been burgled and that keys to the cars they hoped to seize while at his property had been stolen.

Officers did not conduct a formal documented risk assessment on any of the people due to be arrested or their addresses. They also did not consider there to be an added risk connected to the change in offence for which the man was due to be arrested. As the man was on bail, for supplying class A drugs, and being monitored by an electronic tag, he was unlikely to be bailed following this arrest.

Early one morning, four officers attended the man's home to arrest the man and search his property. Two of the officers had dealt with the man when he was previously arrested and had some knowledge of his demeanour.

Officers took the man, who was alone in the house, into the kitchen area and arrested him.

Officers conducted a dynamic risk assessment of the situation, taking into consideration the man's physical build, the fact that he was barefoot, naked under his dressing gown, sitting at a table, compliant with all requests and had never acted in a violent or confrontational way. As a result, the officers felt that handcuffing him would be an unjustified use of force.

While officers searched the property, the man was allowed to move around the kitchen and make himself cups of tea as he had on previous occasions when the police dealt with him.

Nearly two hours into the search, the man stood up, unnoticed by the officer. When the officer looked up, he noticed that the man was holding a large kitchen knife in his hand. The man then swung the blade round towards his own body, before he used two hands to plunge the knife into his own chest. Despite receiving first aid at the scene, the man died of his injuries.

Key questions for policy makers/managers:

- **What steps has your force taken to ensure that all relevant information is shared with other forces during cross-border activity?**
- **Does your force's risk assessment process prompt officers to consider the psychological risk associated with an arrest?**
- **Does your force always advise officers attending search operations to deploy with the appropriate personal protective equipment?**

Key questions for police officers/staff:

- **If you are carrying out an arrest in another force area would you always ensure that you have access to any relevant information from the force working in that area to inform the risk assessment process?**
- **Do you always treat a suspect as an unknown risk no matter how many times they have been dealt with previously by the police?**
- **Do you always ensure that suspects are detained in the safest room of the house, to reduce the risk of harm to the officers and suspect?**
- **Do you always ensure that a suspect is not allowed to freely move around their home once detained to prevent them from being able to pick up concealed items such as weapons?**

Action taken by this police force:

- **The risk assessment in the record of search booklet has been amended to require the incident log, or equivalent incident reference numbers, from both forces, to be included for any cross-border enquiry. This is to prove that both parties have communicated.**
- **Learning from this case has been incorporated into a review of standard operating procedures, a new risk assessment toolkit and officer safety training.**
- **All officers involved in this case, and based in the same unit, have also been debriefed on the key learning.**

Click here for a link to the full learning report

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2 Conducting PNC checks by PDA

Police were called to a railway station to deal with a man suspected of travelling without a ticket.

After obtaining the man's name, one of the officers conducted a Police National Computer (PNC) check on his personal digital assistant (PDA). The PDA showed a "wanted/missing" marker against the man's name.

As the man was acting in an irate, awkward and evasive manner, the officers walked him freely without handcuffs to a nearby police van. They placed him in the back of the van before carrying out a further PNC check via radio. This further check showed that the "wanted/missing" marker displayed on the PDA was a "locate trace" marker added

to the PNC by another force who wanted to locate the man to issue him with a harassment warning.

On receiving this new information the man was released from the police van, and the PNC check was explained to him. As no offences had been committed he was allowed to leave.

The man later made a complaint against police alleging unlawful arrest and incivility.

Key questions for policy makers/managers:

- **If your force encourages officers to use PDAs to conduct PNC checks do you advise them to make a secondary check via radio, in sight of the person, where warning markers are shown, without detaining the person in a vehicle?**

Action taken by this force:

- **The force advised officers in similar circumstances to make the secondary PNC check via radio in sight of the person being checked rather than detain them in a vehicle, where possible.**
- **The force has asked its communications department to look at the use of PDAs to carry out PNC checks to see if a solution to this problem can be found.**
- **Officers were reminded that when they make a mistake they should be open and honest and offer an appropriate apology.**

[This case was investigated locally by the force]

Click here for a link to the full learning report

Call handling

3 Conducting a welfare check on a vulnerable man

Around 1pm, police received a request from social services to conduct a welfare check on an 83-year-old man who had not been seen by his carers for two days.

A Computer Aided Dispatch (CAD) message was generated and the call was graded as “significant”. It was downgraded by a supervisor, in breach of standard operating procedures, to “extended” (requiring a response within 48 hours). This was to enable her to make enquiries to identify additional information, such as details of any illnesses the man had, or information about any follow-up investigation already undertaken by social services. She planned to reassess the grading but was distracted and further enquiries were never made.

Shortly after the call was downgraded a police community support officer (PCSO) from the neighbourhood policing team was assigned to the call. After receiving no response from the intercom system, the PCSO used a fob key to enter the building through the communal doorway.

When the officer received no response from within the property or from neighbours, an appointment was scheduled for someone else to attend the address at 6pm. It was felt that if the man had been at a hospital appointment, for example, he would be back by this time.

When the CAD reappeared there was a delay in resourcing it as the officer initially assigned was assigned to deal with four other calls that were graded “immediate”. As the officers made an arrest in response to the fourth call they were then deassigned from the CAD relating to the welfare check.

Around 1.40am the next day, the supervisor scheduled an appointment for someone to attend the man’s property later that morning because he felt that, at that time of the morning, it might be a couple of hours before officers could attend, and it would be inappropriate to force entry given the time of day.

An officer arrived around 8.40am and tried to enter the building using the intercom. The officer was unaware that other officers had access to a fob key. The officer was unable to enter the building using the intercom.

An appointment was scheduled for that afternoon, however social services called and expressed concern that police had still not gained entry to the property. The officer who attended that morning was reassigned and after gaining entry to the block and speaking to neighbours, he forced entry and found the man had collapsed. The man was taken to hospital but died the next day.

Key questions for policy makers/managers:

- **How does your force ensure that these types of call do not get lost in the CAD system and are resourced in a timely manner?**
- **If a call gets lost in the CAD system or is left unresourced for a considerable period, does your CAD system send out automatic notifications to alert control room supervisors?**
- **Where specific teams have access to key fobs that allow entry through communal doorways in blocks of flats, are all officers aware of how to access them?**
- **What is in place in your force to make sure that once incidents like this are reported, they are searchable on computer systems, and supervisors can ensure they are properly resourced and handled effectively?**
- **Does your force have a memorandum of understanding with social services that sets out how welfare checks should be dealt with?**
- **In your area, when the expectation is that entry will be forced, do social services staff routinely attend immediately as part of a welfare check?**
- **Does your force provide officers with clear guidance on when entry should be forced where there is genuine fear for welfare?**

Key questions for police officers/staff:

- **If you need to gain access to blocks of flats, or housing for the elderly or vulnerable, do you check first to see if the care provider or relatives have a key to gain access?**
- **If you are unable to complete an assigned task due to other calls do you advise the control room and/or your supervisor so that the call can be reassigned?**

Action taken by this force:

- **The force has reminded all staff about the criteria for amending the grading of CADs.**

Outcomes for the officers/staff involved:

- **The supervisor who downgraded the call, resulting in the delay in conducting the welfare check, received a written warning.**
- **The officer who attended but did not gain entry through the communal door, received management action for his failure to make sufficient enquiries when carrying out the welfare check.**

Click here for a link to the full learning report

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4 Recognising the threat

One evening, a force received a call from a young pregnant woman who reported that she was being intimidated by a neighbour and she was worried that he might try to force entry to her property.

The call was graded as a '2' (priority response) meaning that officers should be deployed within ten minutes and attend within 30 minutes. The caller was also classified as vulnerable.

Thirty minutes later, police still had not responded and the woman called police again to report that the man had been calling her and threatening to harm her and her son. The woman was advised that police would attend when a unit was free.

Twenty minutes later, the man called police to make a complaint about the woman. The man was not making much sense and the intelligence system showed warning markers for mental disorder and firearms.

The ambulance service later called to say that they were at the woman's property, that the woman was vulnerable, and that police needed to attend.

Later that evening, the police received a second call from the man, who said he had uncovered a drugs ring.

Officers arrived at the man's property soon after. After talking to the man they also spoke with the woman. Shortly after, they reported that all was in order and that the man had mental health issues. The log was then closed. The man called again later to repeat the same allegations about uncovering a drugs ring, but the call was downgraded based on the officers' previous contact with the man.

Around ten minutes later, the man called the police to say that he had killed someone. He gave the woman's name but refused to give his address. The call handler terminated the call and then closed it noting that the man had mental health issues and had already been seen by police that day.

The man called back ten minutes later and repeated that he had killed someone. He repeated the woman's name but terminated the call before answering all of the call handler's questions.

The call handler then downgraded the call.

Despite the downgrading, a dispatcher sent officers to the man's address.

When officers finally gained entry to the property, they discovered the body of his partner.

Key questions for policy makers/managers:

- **What training do you give to call handlers to help them spot and respond to callers with mental health issues?**
- **How do you ensure that calls from people with mental health issues are dealt with appropriately?**
- **How do you ensure that supervisors are alerted when officers are not dispatched to deal with calls within the appropriate timescales?**
- **Does your force require supervisors to confirm in the incident log that they are aware of delays to deploying officers in response to calls?**
- **What steps does your force take to monitor the quality of calls, including those that have been closed?**

Key questions for police officers/staff:

- **If you were one of the officers who attended the man's property, what action would you have taken if you had found that the allegations he had made were not true and you suspected that he had mental health problems that could make him a danger to himself or others?**

Action taken by this force:

- **The force has developed a training package to improve the way that calls from people with perceived mental heath issues are handled.**
- **All controllers are now required to work through a series of workbooks, and to complete a mandatory e-learning package on NCALT.**
- **The force has taken steps to ensure that controllers are able to draw on all available resources to deal with calls requiring immediate attention.**
- **The force's quality assessment team regularly dip-sample certain categories of call and check whether the call was correctly closed.**

Outcomes for the officers/staff involved:

- **The controller who failed to deploy officers when the man admitted to killing the woman, and then graded the call as a '2', received management advice around assessing calls.**
- **The controller who closed the second call from the man when he admitted to killing the woman, instead of referring the matter to a supervisor, as is required by force policy when the matter includes a threat to life, received a 12-month written warning.**
- **The call handler who terminated the second call after the man said he had killed someone resigned from the force before the investigation could be completed.**
- **The controller who downgraded calls from the man and failed to deploy resources despite the man's admission of murder received a 12-month written warning.**

Click here for a link to the full learning report

Child abuse

5 Acting on a report of child abuse

A man called police to report that he had been sexually abused and raped between the ages of 10 and 15 and that he was reporting the matter now because he was

concerned that the man involved was now abusing another young person.

Officers raised a crime report in respect of the historic offences committed against the man, and a separate incident log was created to record the man's concerns about the young person.

Officers decided early on that the matter should be referred to social services but no referral was ever made.

Despite the concerns raised, no immediate action was taken to safeguard the wellbeing of the young person at risk and to prevent them from being subjected to further abuse. The man responsible for the abuse was not arrested until some 59 days after the matter was first brought to the attention of the police.

The supervisor responsible for the officer leading the investigation remained unaware that there was an ongoing risk to a young person. This was despite regular communication with the investigating officer, as he had not read the incident log that contained this information or properly performed his management and supervisory duties.

Force policy requires the duty detective inspector to be notified of all rape allegations within 48 hours and to review all undetected and/or no further action rape offences before finalisation (and in any case no later than 28 days after the initial reporting). The first review by a detective inspector in this case did not take place until nearly 12 weeks after the matter was initially reported to police.

Following his arrest, the man was granted street bail by the arresting officers and went on to have contact with the young person he had been abusing.

The man was subsequently charged with 19 charges of rape and sexual activity and the taking of indecent images of children. He pleaded guilty to all charges and received a 12-year prison sentence.

Key questions for policy makers/managers:

- **How does your force ensure that officers do not overlook current risks when dealing with historic reports of sexual abuse?**
- **How does your force ensure that supervisory officers are kept informed of all similar allegations and are able to discharge their supervisory responsibilities and ensure that appropriate action is taken to respond to them?**

Action taken by this force:

- **The force has recognised that there is a need for enhanced safeguarding training across the force and work has been carried out to define the minimum training requirements for the different roles that exist within the force.**

Outcomes for the officers/staff involved:

- **The investigating officer received a final written warning for her failure to make a referral regarding the young man to social services and for the overall breakdown in communication between her and her supervisor regarding the safeguarding concerns relating to the young man.**
- **The supervisor received management advice for his failure to read the crime report update that detailed the safeguarding concerns for the young man; for his failure to properly supervise the investigating officer; and for the overall breakdown in communication between him and the investigating officer in respect of the safeguarding concerns relating to the young man.**

6 Acting on information from CEOP

After carrying out research into a number of child abuse images, the Child Exploitation and Online Protection Centre (CEOP) passed intelligence to a force which included the name, address and contact number for one of the suspected offenders.

Social workers at CEOP graded the risk to the children in these images as 'critical'. This was because they had reasonable cause to believe that a child was suffering, or at risk of suffering, significant harm; and immediate intervention was required.

Over the next two weeks, the force attempted to work on the intelligence provided by CEOP, to confirm the identities of the children involved.

Although CEOP was confident it had provided enough information for officers to obtain a warrant for the address, confusion over the identity of the offender, and whether children were still at the property, meant that officers did not take immediate action to visit the property and identify whether any children were still at risk.

An officer checking a local computer system was eventually able to identify a man linked to the property as being one of the men in the images.

Despite this positive identification, a number of days passed before officers executed the warrant due to staffing levels.

CEOP staff remained concerned that the matter was not being dealt with quickly enough and continued to push the force and social services for updates.

As a result of staff leave and other commitments, responsibility for the case had been passed between a number of individuals within the force.

An intelligence pack was eventually handed over to the Criminal Investigation Department (CID) who obtained a section 8, Police and Criminal Evidence Act (PACE) warrant for the address.

The man identified in the photo was arrested and charged with ten offences against his stepchildren, including three offences against one of the children who was still resident at the property. The latest offence had taken place three to five days before the warrant was executed.

Key questions for policy makers/managers:

- **What steps does your force take to ensure that officers**

- **who are allocated investigations fully understand the nature and significance of any intelligence received?**
- **How does your force ensure that the handover of information between teams or departments is properly managed?**
- **What safeguards does your force have in place to ensure that similar information received from CEOP would be dealt with more effectively?**

Action taken by this force:

- **If either the CEOP designated point of contact in the force, or the contact at CEOP, considers intelligence to be time-critical, it will be sent to the duty detective superintendent for the serious crime division to be managed.**
- **All duty cover detective superintendents and Force Intelligence Bureau staff have been made aware that real-time or high-risk intelligence must be co-ordinated and responded to by the duty cover senior detective.**
- **Detective inspectors have also been made aware of the importance of having direct contact with the source of any intelligence to ensure that any handovers are effective.**

Click here for a link to the full learning report

Custody

7 Detaining a young man in custody

A 15-year-old young man was arrested for robbery late one evening and was held in custody overnight, pending interview the next day.

Around lunchtime the next day, the young man was interviewed in the presence of his mother and his solicitor. After the interview was completed, he was returned to his cell and the case was referred to the Crown Prosecution Service (CPS) for a charging decision.

Officers were aware that the young man suffered from attention deficit hyperactivity disorder (ADHD) and Asperger's syndrome, and that when he was arrested previously, he had been found carrying a penknife.

When officers observed the young man scratching at the cell floor and doors with an object they decided to enter the cell to remove it. As the man had learning difficulties, the officers felt it would be hard to communicate with him so decided to restrain him before carrying out a strip search to find the object.

Officers entered the cell, held his arms in a 'one-armed bar' (holding the wrist with one hand and lifting the arm up and away from the body, while placing the other hand on the shoulder), and also removed his trousers, assisted by a female detention officer. During restraint, the young man sustained an injury, and yelled out to officers in pain, before telling them where the item was.

The young man remained on the floor and continued to complain about the pain in his arm. One of the officers examined his arm but could not see any sign of an injury.

The officers then left the cell, and twenty minutes later, one returned to check on the young man. The injury to the young man's arm was now more apparent so an ambulance was called.

The young man was later diagnosed with a fracture to his elbow.

Key questions for policy makers/managers:

- **Are all your cells equipped with CCTV, which can be observed by officers and recorded?**
- **In a similar case, would you encourage your officers to bail the suspect, pending receipt of advice from the CPS, particularly where the detainee is young or vulnerable?**
- **Do you encourage officers to automatically bail detainees (where appropriate) if the CPS fails to meet the time limits agreed for providing advice?**
- **Have you provided your custody staff with training or guidance to help them understand the effects of ADHD, or Asperger's syndrome or other autism spectrum disorders on detainees, to help them communicate or act in an appropriate manner and minimise the stress to the detainee?**
- **Do you provide guidance to officers about strip searching, which includes who should be involved, how it should be carried out, and considerations to apply when strip searching young or vulnerable people?**

Outcomes for the officers involved:

- **The custody officer received management action for allowing the strip search to be conducted in front of a female detention officer, for his failure to complete the custody record correctly following the search, and for leaving the detainee in the cell after he had sustained an injury.**
- **The detention officer left the force before she could receive management action.**

Click here for a link to the full learning report

8 Medical coverings

A man wearing a plastic support boot on his right leg was brought into custody when he breached the conditions of his bail.

The man was uncooperative when he was brought into custody so the custody sergeant was only able to collect limited information during the risk assessment process.

There were 14 local intelligence warning markers on the custody handling system, relating to this man. The most recent marker related to the man secreting items in his underwear. The custody sergeant however, decided not to place the man on constant supervision or carry out a strip search as he did not want to risk injuring him or causing further problems for his health. The custody sergeant had viewed the intelligence markers in a format that displayed them in a random order and did not scroll down the entire list to view all the available information. He therefore did not see the most recent intelligence marker outlined above.

The man was examined by the force's healthcare provider and was deemed fit to be detained. The nurse

advised that he should be given plenty of water to keep him hydrated as he was intoxicated, but no action appeared to have been taken to address this.

Some time later, an officer carrying out a cell check spotted that the man was in need of medical assistance and an ambulance was called.

When the plastic support boot was removed from the man's leg, in the presence of paramedics, a quantity of tablets was discovered, including 13 empty blisters. It is now known that the tablets recovered were diazepam tablets. One of the empty boxes showed that the diazepam tablets were prescribed to the man from a local pharmacy. There was also one red/white capsule with PGN 300 marked on it.

The man was subsequently taken to hospital.

Around this time, the inspector took the decision to release the man from custody. There was some confusion which led to custody staff not releasing him from custody on the IT system and the custody record not being endorsed accordingly. This breakdown in communication had a knock-on effect when the officers, who took the man home, were incorrectly served with regulation notices.

As part of his treatment, he was given naloxone, which is often used where there is a suspicion of a methadone overdose, or to prevent or reverse the effects of opiates and opioids (for example heroin, methadone, and codeine). Naloxone is an opioid blocker and can lead to withdrawal symptoms (including stomach cramps, nausea or shivering) in an opiate/methadone addict, like this man. Repeat doses of naloxone are commonly required when the opioid involved is methadone, as the effect of the naloxone can stop before the methadone has cleared the body, leading to the potential for a relapse several hours later if a methadone overdose has been taken.

Despite being advised by doctors about the seriousness of his condition, the man decided to discharge himself from medical care.

Officers drove the man home, as they knew that there was someone there who could look after him.

Despite denying taking any substances while in custody, the man reportedly admitted to friends on leaving the hospital that he had done so.

Early the next morning, the ambulance service received a call to say that the man had been found dead at his home address.

Post mortem toxicology showed high levels of methadone in the man's system.

[This case was investigated locally by the force]

Key questions for policy makers/managers:

- **Has your force provided officers with similar guidance on how to deal with detainees who arrive in custody with medical coverings or other medical assistance aids?**
- **What other steps has your force taken to help minimise the risk associated with medical coverings or other medical assistance aids?**
- **What steps has your force taken to ensure that warning markers and significant information is clearly visible to officers using force IT systems?**
- **How do you ensure that your healthcare provider provides clear instructions to staff working in custody?**
- **If someone is released from hospital back into police custody after receiving treatment, would you place the responsibility on the detainee to provide details of any treatment or aftercare required to assist with the risk assessment process, or do you require officers to ask the hospital to provide any relevant information?**

Action taken by this force:

- **During the course of this investigation, the force made contact with the National Policing Improvement Agency (NPIA) to identify whether guidance had been issued about searching medical coverings. NPIA were able to ascertain that no such guidance existed, and as a result, developed new advice for forces on dealing with individuals with medical coverings and other medical assistance aids, which was then shared nationally.**

NPIA advice on dealing with individuals who present in custody with 'medical coverings' and other medical assistance aids

For the purpose of this advice, medical coverings are defined as:
- plaster casts;
- removable casts / support boots / air-cast pots;
- heavy bandages.

Other medical assistance aids could include:
- neck braces;
- wheelchairs;
- prosthetic limbs;
- crutches.

When any person comes into police custody it is highly important to ensure that a thorough, searching, intelligence led and properly recorded initial risk assessment is undertaken. If the risk assessment indicates that the detainee may be concealing an item which could potentially cause themselves or police officers or staff harm, then it will be appropriate to ensure that a search of the detainee and their belongings take place.

If the detainee presents in custody with some sort of medical covering or other medical assistance aid it may be appropriate for custody staff to question and probe during the initial risk assessment as to:

(a) whether the medical covering is genuine and/or if the assistance aid is required constantly; and
(b) whether the detainee may be secreting something which could cause harm or be of

significance to their arrest within the medical covering or other medical assistance aid.

Any such questioning/probing should be undertaken with reference to the initial risk assessment and any warning markers shown on the Police National Computer (PNC). In such cases it would be advisable to consult with a medical professional.

Through questioning it may be that the detainee offers to remove the covering (if applicable and it would be advisable to have a medical professional in attendance) or surrenders items that they should not have in their possession.

If concerns remain and no information or consent is forthcoming from the detainee, the custody officer should consider what a proportionate response to the risk identified is. Removal of a medical covering should be as a last resort and in any case a fixed cast should never be removed within a custody environment and removable cast only by a medical professional. Officers should also be aware of the impact of removing a medical assistance aid upon a detainee – for example removal of a wheelchair or crutches could prevent the detainee being able to use the cell toilet independently.

In a case where a custody officer considers that there is a significant risk to the individual due to the concealment of an item which could cause them harm, it would be advisable for the detainee to be held under constant observation/supervision.

More information about this case is available in the learning report for this case which is available on our website at **www.ipcc.gov.uk/learning-the-lessons**

Click here for a link to the full learning report

9 Use of smocks

In the early hours of the morning, a man called police to report that his ex-partner had smashed a window at his home.

Police attended, and described the woman as uncooperative, aggressive, unsteady on her feet, and behaving in a way that was likely to affect local residents or passers-by. As a consequence, the officers decided to put her in the back of their police vehicle to try and find out what had happened.

Despite there being grounds to suspect that the woman had been involved in committing an offence, she was not immediately arrested and cautioned.

When the woman's behaviour deteriorated, to the point that the officers felt it was likely to cause offence, alarm or distress to people walking past the vehicle, they decided to arrest her for a Section 5 Public Order Act offence.

When officers moved to handcuff the woman she reportedly kicked one of the officers in the face. Officers then handcuffed her and pulled her from the vehicle.

The woman continued to be aggressive and uncooperative when she was brought into custody, and the custody sergeant was unable to complete the risk assessment process. Officers suspected that she was under the influence of alcohol. Before she was taken to a cell the sergeant gave the instruction for the woman to be stripped and placed in a smock as he had concerns that she may try to harm herself if left with her clothing.

During the time the woman was in custody, five of the 13 detainees had also been placed in smocks. Records showed that each of these detainees had previously attempted to self harm. A previous death of a man in the custody suite was felt to have contributed to the over-use of smocks.

When officers tried to remove the woman's clothes she continued to struggle and be abusive. Officers restrained her to prevent her from kicking out. One officer used a hammer-fist strike when the woman attempted to bite her, but this was not recorded in the custody record.

Eventually the woman's clothing was removed, in the presence of male officers and the woman was left naked in the cell. While the woman was naked, officers (including male officers) checked the cell every 30 minutes. However, the investigation found that the custody record did not always record the name of the person who physically checked the cell.

Eventually, the woman was provided with paper knickers, sanitary items and a smock.

The woman was subsequently taken to hospital for treatment for the injuries she had sustained to her eye after being hit by the officer.

When the woman was returned to the station, she was charged with assaulting a police officer and a Section 5 Public Order Act offence.

Key questions for police officers/staff:

- **How would you have ensured that the woman's dignity could be safeguarded whilst she was naked in the cell and observations were being carried out?**

Key questions for policy makers/managers:

- **Does your force provide staff with guidance on how and when to use smocks or custody safety suits, and does your force take other steps to ensure that they are not overused?**
- **Does your force routinely record the use of force by custody staff?**
- **Does your force insist that the individuals who carry out cell checks are responsible for updating the custody record?**

Action taken by this force:

- **The force has reminded all staff of their responsibilities in relation to recording use of force.**
- **The force custody inspector has circulated guidance**

on the use of safety smocks.

- **The force has undertaken a detailed audit looking at the reasons and rationale for the use of smocks and custody safety suits.**

Outcomes for the officers/staff involved:

- **The custody sergeant who booked the woman in custody received management action for failing to conduct a risk assessment, for not informing the woman of her rights and for not providing her with the reason for her detention.**

Click here for a link to the full learning report

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