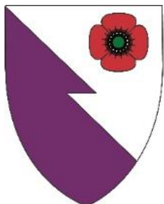
The Royal College of Emergency Medicine

Best Practice Guideline

Emergency Department Patients in Police Custody

June 2016 (revised)



Endorsed by the Faculty of Forensic & Legal Medicine of the Royal College of Physicians

Summary of recommendations

- Patients brought to the Emergency Department (ED) by the police service are entitled to the same level of care as all other members of the public.
- It is appropriate to assess the patient as a priority, within their triage category, by senior staff.
- It is essential to liaise with the healthcare professional (HCP) at the relevant police station if discharging a patient from the ED to a police station.
- Ensure that there is an easy and secure method to share information between ED clinical staff and the healthcare professionals (HCP) working with the police at the police station. If an HCP is unavailable, clear instructions should be provided to police personnel to ensure the well-being of the patient.
- It is not the role of the ED Staff to act as surrogate Forensic Medical Examiners.

Scope

This guideline has been developed to help medical and nursing staff within Emergency Departments (EDs) manage adult patients (18 or over) who attend whilst in the custody of the police. It includes recommendations on where to treat a patient, the timeliness of management and what information is required to be transferred with the patient if discharged.

The care of the patient attending the ED under the care of the Prison service is not included in this guideline. The College has produced specific guidance about patients with suspected internally concealed drugs.

Reason for development

Patients who are under arrest and in the custody of the police service may be referred to an ED for a wide variety of reasons. Some may cause disruption to the department and other patients. Therefore, there is a risk that they may be considered as an unnecessary, heavy burden. However, they are entitled to exactly the same standard of care as all other patients but may need dealing with differently to ensure all users of the service are not disadvantaged. The duties of consent and confidentiality are the same in the police setting, as in hospital and the community.

Introduction

All police services in the United Kingdom have access to healthcare professionals (HCP) who may be doctors (forensic physicians), nurses (forensic or custody nurse practitioners) and paramedics (custody paramedics). Currently this service is not part of the NHS and thus standards and processes are not comparable with the NHS.

The Police & Criminal Evidence Act 1984 laid down in its Codes of Practice (Code C), specific reasons why a police custody officer must call an HCP to assess a detainee. Specifically the Codes of Practice state at Para 9.5:

[A] custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practical if the person:

A) appears to be suffering from physical illness; or

B) is injured; or

C) appears to be suffering from a mental disorder

D) appears to need clinical attention

And 9.5A:

[this] Applies whether or not individual requests it and whether or not they've been treated elsewhere

Any detainee taken into police custody will have a detailed risk assessment questionnaire which may identify significant medical or mental health conditions. If the custody officer has no immediate access to an HCP, and they have concerns about that individuals well-being that may trigger a referral to hospital. In the absence of an HCP assessment there will be no letter of referral. See the publication 'Guidance on the Safer Detention and Handling of Persons in Police Custody – 2nd Edition' for further information [1].

http://www.homeoffice.gov.uk/publications/police/operational-policing/safer-detention-guidance-2012Most police stations do not have either a) the full-time presence of HCPs, or b) anything more than basic resuscitation facilities. In many cases the HCP works over a wide geographical area covering a number of police custody suites.

The experience and qualifications of HCPs may be very variable, ranging from very experienced forensic physicians who may hold the FFFLM or MFFLM qualification and custody nurses and custody paramedics with LFFLM or DLM, to those with very little specific training. Many of the HCPs may be specialists in not only forensic & legal medicine but other fields (e.g. ED, surgery, psychiatry, general practice) with backgrounds in a wide variety of medicine.

Healthcare Issues in Police Custody

Detainees are more likely to suffer drug and alcohol related problems and mental illness than the normal population. Chaotic lifestyles may also mean that conditions such as epilepsy, asthma, diabetes, hypertension and other chronic problems are poorly managed

Each year detainees in police custody die because of either lack of recognition or inappropriate treatment of some of these conditions. Sometimes such deaths in police custody occur after assessment in EDs. Preventable causes of death in detainees include substance intoxication, missed head injury, alcohol withdrawal and self-harm.

Reasons for Referral to Emergency Departments

The custody sergeant may request that the person to be brought to the ED if they feel a detainee needs immediate medical care or that they are unable to provide adequate care. Other individuals may be brought into the ED immediately after

arrest, by the arresting officers directly, if it is clear to them that there is a problem appropriate for the ED.

The referral may be from a HCP in the custody setting who will have clinically assessed in the individual and should be expected provide a clinical rationale for assessment or management in the ED. On some occasions the referral may appear inappropriate but no police station has the capability of providing safe clinical monitoring (e.g. head injury observations). Most custody officers or detention officers who are responsible for monitoring detainees in police cells, will have no more than Basic Life Support training. Pulse, blood pressure, neuro-observations (including Glasgow Coma Score), blood glucose and oxygen saturation cannot be monitored regularly in police stations. 30 minute rousing to speech is generally the most intensive monitoring that can be achieved. CCTV or close personal observation is generally used for those at risk of self-harm.

A significant number of patients will be referred to and/ or conveyed to the ED by ambulance service paramedics. Whilst these patients will have received a clinical assessment it is important to recognise that these patients may have presented in an environment in which a safe, comprehensive clinical assessment is not possible and may result in patients being referred to the ED from 'scene' for review.

Custodial medical services are not structured to provide the assessment and triage familiar to EDs, but are there to provide primary medical clinical care, depending on the level of expertise and training of the healthcare providers. Even the most experienced HCP will have a low threshold for referral to the ED (e.g. for chest pain or reducing conscious level)http://www.london.gov.uk/sites/default/files/13-10-12-submission%2520by%2520dr%2520jason%2520payne-james%2520and%2520dr%2520peter%2520green.pdf

Standards of referral to the Emergency Department

As with any referral to a specialty there is information that the clinician should send with the patient, where possible. Unfortunately this may not always be complete, due to the uncooperative nature of the patient, and drug or alcohol ingestion. A referral letter, appropriate for a referral to an ED from a custody suite, should include the information as below.

The following are pieces of information that should, ideally, be provided:

- Date of referral
- GP details
    1. GP name
    2. Practice name
    3. Address
    4. Telephone number
- Patient details
    1. Name

2. Sex
3. Date of birth
4. Address
5. Telephone number (daytime or mobile if possible)

- Medical history
- Current medication
- Significant history, including previous consultations for the same condition, name of consultant seen previously
- Active problems
- Clinical information
- Preliminary investigation and results
- Reason for referral
- Information regarding special/social circumstances. (Does patient have hearing, visual, mental health difficulties or mobility impairment? Is an interpreter needed?)
- The name and contact details for the referring HCP

Proformas can standardize the referral process and are encouraged. The police should provide all the information they know relevant to a patient's care. The referring HCP should always speak to the relevant professional within the ED to explain the referral. Most referrals will be transported by the local ambulance service. If there is significant delay the relevant custody HCP may have had to move locations to other patients and may not be aware of the patient's destination hospital. The HCPs contact details should be on the referral letter to ensure queries can be directly addressed if necessary.

Priority

Patients brought to the department by the police are entitled to the same standards of healthcare as all other patients. They must therefore be initially assessed in the same way as all other patients i.e. 'triage', or equivalent process. However, the patient may bring with them significant challenges, which must be considered; the patient may be aggressive, under the influence of drugs and/ or alcohol and generally disruptive. They may be accompanied by several police officers, whose presence can create concerns relating to space. There may also be individuals in the department who were involved in a previous altercation with the patient, who may become provoked.

Overall, for the safe running of a department it is important that these patients are seen as soon as possible. This should be done not only to ensure disruption is kept to a minimum but also to help free officers accompanying the patient to return to normal duties. To facilitate this, the patient may be given greater priority within the triage category to which they have been assigned. This prioritisation should not be seen as preferential treatment, but a pragmatic method of ensuring safety and smooth running of a department and supporting the police.

Staff

Some individuals brought to the ED by the police may be violent, exhibit challenging behaviour and appear to know a great deal about the healthcare system. There may also appear to be attempts be manipulate situations. In these situations, or if there is acute behavioral disturbance, the most senior doctor available should be involved in their care. The staff should have the capacity to make final decisions of care and not require time consuming or redundant investigations or referrals, in the process. This will not only help expedite care through the system, but also prevent unnecessary manipulation. Those skilled in dealing with the aggressive patient can also help to de-escalate any issues that may arise. Therefore all patients in police custody should be seen by a middle grade, or more senior, doctor. If this is not initially possible, most patients in this group must be discussed with a middle grade doctor or above.

Environment

Detainees should be risk-assessed prior to treatment to determine the most appropriate environment to prevent contact with the rest of the department, expedite care and accommodate the accompanying police officers. It should also be safe for both patients and staff. Whilst the police officer's role is to ensure the patient under arrest behaves and respects the environment, a department should do what it can to facilitate the smooth passage of patients in police custody through the area.

The clinical assessment area should be clear of excessive equipment and furniture that could be used as weapons or damaged during altercations. There are some areas of the department where a patient may be separated from the police, e.g. toilets. These areas can be used for self-harm, escape and for hiding of evidence. It is therefore sensible to assess the area to remove items such as ligature points and have ceilings sealed to prevent patients getting into the voids or concealing items. There is guidance on ED design available from the Department of Health [2].

Assessment Process

Detainees brought to the department will normally be accompanied by two or more police officers. The number will have been dictated by the assessment made by the police based on factors such as their cooperation, safety, need for restraint. At least one officer should know why the patient has been referred and provide the referral letter, if present. To help understand the situation better and assist in maintaining safety, it is useful to ask three initial 'non-clinical' questions:

1. Which station are you from and contact details?

2. Is the patient under arrest, held under Section 136 or simply being accompanied?

3. Has the patient been searched?

Police officers must remain with patients whilst in the department at all times. At least two should be present for the safety of staff and other patients. If the patient is restrained, officers with the ability to remove restraints must remain with the patient. They will only remove restraints if they deem it safe. In a health environment the supervising clinician must make the determination of the appropriateness of retaining or removing restraints in close collaboration with the police officers.

Patients in custody are entitled to the same level of confidentiality as other patients. If possible, the patient should be free to discuss medical matters with staff in confidence. This may be difficult if they are aggressive and restrained. It is may therefore be appropriate to ask police officers to turn off recording equipment (such as Body Worn Cameras). However, if possible, clinical staff can assess the patient whilst officers remain immediately outside the cubicle / room but within direct line of sight. The officers will advise if this is suitable or safe. Often when officers are absent, the patient may be more cooperative and open with their clinical history e.g. drug ingestion or self-harm and so this may be more appropriate. This assessment should ideally not be performed by members of staff working on their own and isolated from the rest of the ED.

If the police feel that the removal of handcuffs or restraint devices is unsafe, the advice must always be understood and the reasons clearly documented in the medical records. This may mean, for some patients, handcuffs can only be removed during life threatening emergencies such as administration of anaesthetics or defibrillation.

Assessment and treatment of the patient should be as close to that given to any other patient as is reasonably possible.

Patients discharged back to a police station must have adequate information shared with the police service. In general the documentation accompanying the patient, with history, reason for referral etc. will have a section for the ED Clinician to fill in. The basic requirement of diagnosis and treatment / medication is standard, but requirements for observation is also needed. This will help to prevent the unnecessary return of patients if the custody officer is clear as to what is expected. If in doubt liaise with the police HCP at the relevant custody suite to come to a consensus as to disposition. Some patients may refuse to allow information to be passed to the police in the custody suite. This confidentiality must be respected. In order to facilitate this it is appropriate to send information back to the custody suite solely for the clinical staff and not the police officers, in a separate envelope. Information provided to the police officers should be limited to that which is necessary to allow them to look after the patient whilst in custody unless the patient

has given consent to disclosure and this has been recorded in the medical notes. The information should be clear and comprehensive to a non-healthcare trained individual as there may be delay before review by a HCP at the police station.

If consent is not obtained, the clinical staff at the custody suite should be contacted prior to discharge to discuss the patient's care. Retain a copy of the document in the ED notes and document any conversations.

It is important to note that the documentation described here is solely intended for the purpose of clinical care for the patient. It is not for medico-legal purposes. Any requests for medico-legal statements are not needed immediately and can be arranged in a timely fashion via the ED administrative staff.

Documentation should be as thorough as that for any other patient but include relevant information relating to the fact the patient is in police custody. Most areas will also have a 'Discharge to Police Custody' form which should be familiar to all staff. This should be filled in as appropriate.

Treatment and Discharge

Clinical standards for patients in custody must be the same as for any other member of the public. Treatment necessary in the department should be undertaken in a timely manner. It should also be undertaken with the appropriate consent. If a patient refuses treatment that is not life or limb threatening, this should be respected, but an option of returning should be given. This should be documented in the ED notes and in the discharge form to the custody sergeant or police clinician.

Disclosure of information is discussed above. However there may be occasions when disclosure of information is necessary for the 'public interest'. If considering disclosure of this nature, then it must be in concordance with the General Medical Council guidance on Confidentiality (paragraphs 36-39)[3]. Examples might include those with serious communicable diseases whose behaviour is putting staff or police at risk, and this specifically covered in GMC guidance [5]. Any medication required for treatment, such as antibiotics, should be given to the patient along with written instructions. If this is not possible, it should be given to the officers.

As it should be assumed that patients returning to police custody will receive the minimum of clinical observation the custody sergeant may be unhappy to receive a patient back into the cells. The balance of risk associated with those who are deemed too aggressive for the ED as opposed to 'too drunk' for the cells may be difficult to clarify. It is therefore vital that knowledge of local police resources is known and that dialogue between the services is undertaken. Patients requiring observation following head injury will not receive the required level of care in a police cell. The level of risk for discharge should be the same as if returning a non-detained patient home.

Refusal of Treatment

It is common for a detainee to decline assessment and treatment in an ED having been either brought directly or referred from custody. It is essential to document that an assessment of capacity has been undertaken. The risks of non-assessment or treatment must be made clear to the patient and discussed with custody HCP so they can make decisions as to whether the person is fit to detain. It must be explained to the person that treatment is available at any time should they change their mind and this should be facilitated. There must be ongoing assessment of capacity by custody HCP and further discussion with ED staff as needed.

Medico-legal roles

It is important that a distinction is made between the pure therapeutic role of clinical staff in the ED compared with the dual role (therapeutic and forensic) of those clinicians working with police services. In particular there are important roles that should be undertaken relating to evidence documentation and collection.

It is important to discuss the need for maintaining the 'chain of evidence' in cases involving the police. In particular any clothing they may require should be set aside and placed in bags provided by the police. The police should make clear any requests they may have.

ED staff should not undertake roles that are specific to the police HCP. These include the taking of blood samples for toxicology levels, assessing and documenting injury for forensic purposes, undertaking sexual assault examinations or intimate body cavity searches, as explained in related Royal College Guidelines. Discussions between relevant professionals will ensure that the best practice is followed.

Summary

The care of police detainees is often a challenging one, most misconceptions about roles are caused by lack of communication between custody HCPs and ED practitioners and vice-versa. The roles of both can be made easier for the staff and safer for the detainee if appropriate healthcare information is communicated between named staff in both fields.

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First published in May 2015

Re-published following review by the FFLM June 2016

Acknowledgements

The Faculty of Forensic and Legal Medicine of the RCP

The Best Practice Sub-committee of the QEC, RCEM

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None declared.

Disclaimers

The College recognises that patients, their situations, EDs and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None specified, however the development of a standardised transfer of information form should be considered.

Audit standards

None specified, however an audit of the quality of transferred information, may be of benefit.

Key words for search

Police Custody, Emergency Department

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

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Registered Charity number 1122689

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