Detention and custody risk assessment

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When an officer makes an arrest, they are personally responsible for the risk assessment and welfare of the detained person. This responsibility continues until the suspect is handed over to the custody officer for a decision regarding detention.

Risk assessment means assessing the risk and potential risk that each detainee presents to themselves, staff, other detainees and other people coming into the custody suite. The dynamic nature of the incident and the process of arrest may have a bearing on the assessment which, by its very nature, is likely to be continuous and needs to respond to changing situational requirements. It may be impractical for this assessment to be written, but it must be documented at the earliest opportunity.

Officers must be aware that they have a continuing responsibility and duty of care to the detained person and must assess their environment and the impact of their actions.

Assessment and monitoring

Assessment must be ongoing and must be reviewed throughout the period of detention.

The risk that a detainee may pose to themselves and others may alter when a detainee is charged, refused bail or released on bail. The custody officer must, therefore, review the risk assessment at these stages and prior to release or transfer.

Escalation and de-escalation of the **level of observation** appropriate for each detainee (for example, level 1 general observation up to level 4 close proximity) must be based on a current risk assessment that has been appropriately and thoroughly reviewed. Officers must record all risk assessments in the custody record.

Risk assessment should be as objective as possible and officers should never make assumptions when assessing risk. Police custody is stressful for most detainees and for some it is particularly traumatic. Simply being placed in a police cell may raise the category of risk immediately for a detainee.

Recording information

Officers and staff must record all information regarding risks to the detainee in the custody record. The custody officer must be informed of identified risks or changing circumstances that may lead to additional risk and ensure that those risks are documented and managed.

Content of risk assessments

Officers and staff must record identified risks and control measures in the custody record, as covered by the **Police and Criminal Evidence Act 1984** (PACE) **Code C, paragraph 3.8**.

Paragraph 3.8A requires officers to comply with the principles of the **Data Protection Act 1998**. However, they should not withhold information from any person acting on the detainee's behalf, for example an appropriate adult, solicitor or interpreter, if to do so might put that person at risk.

Advice is available for distribution to third parties required to enter the custody area. See **Home Office (034/2007) Safety of Solicitors and Accredited and Probationary Representatives Working in Custody Suites at Police Stations** and, where persons are arrested under section 41 of the Terrorism Act 2000, **APP Counter terrorism – OFFICIAL SENSITIVE** (this link is only available via College Learn).

Responsibility for risk management

The arresting or escorting officer should monitor the welfare of the detainee that they are responsible for until such time as they bring them before the custody officer. The custody officer is responsible for documenting and recording the risk assessment for every detainee in the custody record, in accordance with **paragraphs 3.6 to 3.10** of PACE Code C.

The custody officer must ensure that all those responsible for the detainee's custody are briefed about the risks. They should ensure their responses to risk are dynamic, reviewed and communicated to all people involved in the care of the detainee, including relevant healthcare staff.

The arresting or escorting officer should make checks with any immediately available sources of information relevant to the welfare of the arrested person. This may include:

- the detainee
- the detainee's friends or relatives
- witnesses
- all staff involved in the person's arrest and detention
- Police National Computer, Police National Database and other local IT systems
- healthcare professionals (HCPs), including GPs
- legal representatives
- an appropriate adult
- other detainees
- other relevant bodies and organisations, eg, youth offending team

Checklist: assessing detainees

Custody officers must ensure that the detainee is asked the following questions.

- Is this your first time in police custody?
- How are you feeling in yourself now?
- Do you have any illness or injury?
- Are you experiencing any mental ill health or depression?
- Would you like to speak to the doctor/nurse/paramedic (as appropriate)?
- Have you seen a doctor or been to a hospital for this illness or injury?
- Are you taking or supposed to be taking any tablets or medication? If yes, what are they and what are they for?
- Are you in contact with any medical or support service? If yes, what is the name of your contact or support worker there?
- Do you have a card that tells you who to contact in a crisis?
- Have you ever tried to harm yourself? If yes, how often, how long ago, how did you harm yourself, have you sought help?

If the detainee answers yes to any of the above, they should be asked the following.

- What is the name of your GP and GP's surgery?
- Do you have a family member who is aware of your health problems?

- Is there anything I can do to help?

When detainees are questioned they should, as far as possible, be asked probing, open questions in a manner that encourages and elicits information.

There is no standard risk assessment model for the British police service but risk assessment should be guided by the **National Decision Model (NDM)**.

Information sources

A person escort record form (PER form) is used to ensure that all staff transporting and receiving detainees are provided with all the information they need. This includes details of any risks or vulnerabilities that the detainee may present. Forces must ensure that custody officers are trained and competent in completing the PER form. Forces should establish procedures to audit and assess completed forms.

For further information, see **APP on Information management**.

Police National Computer (PNC)

The PNC should be considered the primary reference for recording and accessing risk information. Custody staff should have direct access to the PNC at all times.

Police National Database (PND)

Custody staff must check the PND when a person comes into custody and is known to live or have lived in other police areas. If this is not done, the reasons should be noted on the custody record. Information on local systems should be added to PNC or PND as soon as possible.

Where no information is available, officers and staff should contact other relevant forces directly for warnings and any other pertinent information that might be recorded on their local systems.

Violent offender and sex offender register

Custody officers should be aware of ViSOR (VS), which may hold relevant information regarding detainees who present a high risk. Access is restricted to those with licenses, usually in public

protection units.

A detainee with a ViSOR entry should have a corresponding VS marker on their PNC record. If this flag is present, custody staff should contact the public protection unit or other staff with ViSOR access for further information. They should bring any relevant information to the attention of healthcare staff.

Foreign nationals

Forces may also obtain information from the Home Office **Immigration Enforcement Command and Control Unit** in the case of foreign nationals. This would also assist in identifying risk.

Person escort record form

The PER form provides staff transporting and receiving detainees with all necessary information. This includes any risks or vulnerabilities that the person may present.

Officers must complete a PER form whenever a detainee is escorted from a police station to another location. This includes movement or transfer between separate custody suites (police stations) and other custody accommodation (courts, prisons and immigration detention facilities) and from custody to hospital. If the prisoner escort and custody services (PECS) contractor are transporting the detainee, officers must use the digital PER (dPER).

Officers must complete the dPER prior to handover to PECS. There are four main sections which require input and supporting narrative: the sections on **risk, offence, health and property.** Where there is nil to add in a section this should be clearly stated for example, ‘no health issues or medication needs identified’. No sections should be left blank.

Identifying a risk of suicide or self-harm is one of the prime purposes of the form. Staff must indicate both a current risk and any known past risks.

PER/dPER form requirements

Where the detainee is to be transferred from a police station, the responsibility for the PER/dPER form lies with the first custody officer who becomes aware of the transfer.

The form may be completed by a trained and competent custody detention officer, but responsibility for the form content and sign-off remains with the custody officer. This reduces the risk of important information being lost during any subsequent handovers between custody officers.

It is the responsibility of the custody officer who transfers the detainee from the police station to the escort to ensure that the PER/dPER is up to date and contains details of any additional post-charge or other care requirements.

Custody officers must provide supporting information when ticking a warning marker box.

Officers should attach copies of risk assessment forms and medical examination records that are not confidential to the PER/dPER. They should also enter relevant information onto the PER/dPER in case any of the attached information is lost. Confidential medical information must be attached in a sealed envelope. Information relating to self-harm or suicide cannot be deemed confidential and should always be on the PER/dPER form.

The PECS electronic booking system is a standalone system and does not interface with any other police system. Therefore officers must input any new or existing information about a detainee onto the dPER. This is especially important in relation to risk information and warning markers.

Staff should add a direct contact telephone number for the custody suite to the PER/dPER so that escort, court, probation or prison staff can make prompt contact with the custody officer should they need to clarify any information.

The escorting staff are responsible for maintaining a record of the detainee's movements and any occurrences during transit.

Managing an 'at-risk' detainee from a prison or young offender institution

While the detainee is in police custody, officers and staff should:

- maintain the assessment, care in custody and teamwork (ACCT) plan (this can provide important information for staff at the prison/young offender institution (YOI) that the detainee is returned to)
- document relevant conversations, observations, significant events, changes in mood, behaviour or circumstances on the PER/dPER form and on the ongoing record

The minimum frequency suggested by the prison/YOI for making such records is indicated in the ‘required frequency of conversations and observations’ box on the front cover. Officers and staff should continue to follow policies for receiving and caring for an at-risk detainee.

They should remember to:

- talk to the detainee
- send the ACCT plan with the escort staff to the prison/YOI that the detainee is being returned to, and note this on the PER/dPER form
- keep a copy of the ACCT plan with the custody record

Receiving an at-risk detainee

There are occasions when the police take people into custody who are already serving a prison sentence. They could be on a care or support plan, having been identified as being at risk of suicide or self-harm. Some examples are when a prisoner is:

- lodged overnight in police cells because of the distance of the court from a prison, and they are due back in court the following morning
- released to police custody (sometimes referred to as a police presentation) because of outstanding elements of an investigation or new charges
- arrested on release from prison (known as a re-arrest or gate arrest)

It is, therefore, possible that police custody staff have an at-risk prisoner temporarily in their custody, but have no information on how to maintain the care/support plan that is already in place for them. To assist police custody staff in these circumstances, the following information details the current systems used in prisons and YOIs and the signals that police custody staff need to look for.

At-risk status

When taking over responsibility for prisoners, officers and staff should always make an immediate check for at-risk status.

All public and private prisons use the ACCT system to identify and care for prisoners thought to be at risk of suicide or self-harm. It is an assessment and care planning tool.

There are two reasons for providing the police with the ACCT plan:

- custody staff are made aware of the risk and of what can be done to support the detainee and keep them safe
- when the detainee is returned, staff at the prison/YOI have information about any important events that occurred while in police custody, thereby aiding them to continue to care for the detainee

If the ACCT plan is not returned to the prison/YOI, the second aspect is lost.

ACCT plan

Officers and staff should check the information on both the front and inside front cover of the ACCT plan if the detainee is on an open ACCT plan. In particular, they should look at the:

- ‘required frequency of conversations and observations’ box on the front cover
- triggers/warning signs box on the inside front cover as this may contain particular behaviours or events to be aware of
- ‘concern and keep safe form’ (page three of the ACCT form) to learn why the ACCT plan was opened

Officers and staff should look at the current CAREMAP (pages 13 and 14 of the form) to see what action is required to keep the detainee safe.

Occasionally, where the ACCT plan has only just been opened, there may not be anything written on the CAREMAP. In this case, staff should look at the immediate action plan (page four of the form) to see what action to take.

They should also look at the Ongoing Record (pages 21 and 22 of the form) to see what has recently happened.

They should check the PER/dPER for any further information and, if anything is unclear, ask the staff handing over the detainee for more information.

Condition of the detainee

Officers should seek advice from an appropriate HCP if they have concern that a detainee has an injury, medical condition or a mental illness, appears to be experiencing mental ill health or

otherwise requires medical attention. This does not apply to minor injuries or ailments, but officers should still note those in the custody record. If unsure of the nature of a condition, officers should call an HCP. See **PACE Code C paragraph 9.5** and **Notes for Guidance, Note 9C**.

The need for medical attention may reoccur following earlier medical assessment if the detainee's condition subsequently deteriorates.

Wherever possible, officers must ask detainees about any current or recent mental health or medical conditions. They should also ask detainees about any medication they are currently taking. Items in a detainee's possession should also be checked as they may indicate a medical condition, for example insulin syringes, inhalers or other medication. The presence of a health condition and its severity affects decisions about how and where a person should be treated.

For further information, see **Independent Office for Police Conduct: Learning the Lessons**.

Vulnerable detainees

An appropriate HCP may provide advice to a custody officer as to the needs and requirements of any suspect who they believe may be vulnerable. The decision to request an appropriate adult is, though, for the custody officer.

'Do not resuscitate' (DNR) orders (otherwise known as 'Do not attempt resuscitation (DNAR) or 'Do not attempt cardio-pulmonary resuscitation (DNACPR))

DNACPRs (previously known as DNRs or DNARs) may be presented by people with terminal illnesses to police and custody officers. A custody officer should carefully consider the necessity to detain someone in these circumstances and in all cases they should seek the advice of a medical practitioner. The prevailing responsibility of the police officers and staff is to keep the detainee alive and safe while in custody. A DNACPR only applies to the provision of CPR. If there is any doubt as to the existence or validity of a DNACPR then CPR should be administered.

For further information, see Faculty of Forensic and Legal Medicine (FFLM) **Management of DNR/DNAR/DNACPR decisions in police custody**.

Detainees requiring urgent medical attention

Such detainees should not be taken to a police station. Detainees suspected of swallowing unknown quantities of drugs should be taken to hospital immediately.

Detailed guidance on National Police Chiefs' Council (NPCC) approved first-aid procedures and practices in response to a wide range of medical conditions can be found in the **ACPO Police First Aid Learning Programme** (available on College Learn to registered users only).

The **NPIA (2011) Template Protocol for the Management of Detainees who Require Hospital Treatment** provides forces with a template for drawing up agreements with local healthcare providers.

Symptoms or behaviours

If a detainee exhibits any of the following symptoms or behaviours, the officer responsible for the care of the detainee should consider immediate transfer of the detainee to hospital. As a minimum the detainee should be examined by an HCP.

These include:

- unconsciousness or lack of full consciousness (for example, problems keeping their eyes open)
- any confusion (not knowing where they are, getting things muddled up)
- any apparent drowsiness or sleepiness which goes on for more than one hour when the detainee would normally be wide awake
- difficulty waking
- any problems understanding or speaking
- any loss of balance or problems walking
- any weakness in one or more arms or legs
- any problems with vision
- very painful headache that does not go away
- any vomiting (unexplained)
- any fits (collapsing or losing consciousness suddenly)
- clear fluid coming out of their ear or nose
- bleeding from one or both ears
- new deafness in one or both ears
- abnormal breathing

- chest pain

Risk of suicide and self-harm

Custody officers need to be aware of the enhanced risk of suicide and self-harm during periods of detention. Detainees who are deemed to be a high risk of suicide or self-harm must be seen by an HCP and kept under close proximity supervision. This allows officers and staff to engage with the detainee and intervene if required.

In all cases, the HCP should provide a care plan that will specifically identify their assessment of the risk and any mitigating measures in all cases of suicidal ideation and self-harm. If the person has disclosed to them issues of self-harm or suicide, these will be mentioned in the care plan.

This care plan should also give the custody officer adequate information on which to base an exit risk assessment from custody and should be included in any PER documentation.

Factors which may indicate an increased risk include:

- mental ill health including depression, personality disorder, anorexia and schizophrenia
- it is the first time the person has been arrested and detained
- drug, alcohol or substance abuse or withdrawal
- breakdown of social support and isolation (military service veterans, students, prisoners, homeless people, immigrants, older people and refugees are at particular risk)
- being unemployed
- previous episodes of deliberate self-harm, especially if occurring in a custodial environment
- people in certain professions who have easy access to a means of suicide, for example poisons, drugs or guns, have higher rates of suicide than the general population
- chronic disabling pain or illness
- family history of suicide and/or mental ill health
- recent loss such as bereavement, divorce, separation, redundancy
- adverse childhood experiences
- people arrested in relation to violent or sexual offences, especially where they involve children, a close friend or family

Young people may be more at risk of suicide or self-harm when the following factors are present:

- impaired parent-child relationships (including poor family communication styles and extremes of high and low parental expectations and control)
- parental separation or divorce
- mental ill health in parents (for example depression)
- history of parental substance use disorders and antisocial behaviour

Self-harm

Increased vulnerability to self-harm may arise:

- after interview
- on being charged with an offence
- after arrest for further offences
- following a visit by family, friends or others who have taken an interest in their welfare
- after refusal of bail
- while on bail

For further information, see **NICE (2004) Guidance on self-harm and immediate treatment guidelines**.

Potentially violent individuals

Chief officers must establish local protocols with social services, local authorities and health trusts for dealing with potentially violent individuals, in line with local service availability.

HCPs may refuse to transport or care for an individual who is violent. Forces and healthcare agencies should agree protocols to establish respective responsibilities for dealing with such occurrences.

For further information, see the following.

- **Home Office Circular (17/2004) General principles to inform local protocols between the police and health services on handling potentially violent individuals**
- **NICE Guideline NG10 (2015) Violence and aggression: short-term management in mental health, health and community settings**

Acute behavioural disturbance

People who are violent and agitated may have an underlying medical reason for their behaviour. If there is any suspicion that the violence stems from a medical condition, the person must be treated as a medical emergency. Whenever possible, the person should be contained rather than restrained until medical assistance can be obtained.

The following medical conditions may cause violent, aggressive or changing behaviour and confusion:

- diabetes
- head injury
- epilepsy
- stroke
- infections
- angina and other heart problems
- dehydration (and salt imbalance)
- sickle-cell anaemia
- acute mental illness such as paranoia, hearing voices
- neurological diseases such as dementia and brain injury
- learning difficulties

There is an increased risk that symptoms of serious illness or injury may go unnoticed where an individual is well known or familiar to police officers and staff. In particular, when dealing with regular detainees who are known substance abusers and/or known to experience mental illness, it should not be assumed that physical or behavioural signs are due to their being under the influence of a substance/mental illness. They may also be caused by substance withdrawal or other medical reasons, any of which can have serious implications for detainee welfare.

The symptoms of acute behavioural disturbance (ABD) include:

- a state of high mental and physiological arousal – perceiving others as frightening and dangerous, ‘fight or flight’ reaction
- breathing problems
- agitation
- high body temperature and/or sweating – so may try to undress
- violence, aggression and hostility

- insensitivity to pain and incapacitant sprays

For further information, see the following.

- FFLM **guidance on managing acute behavioural disturbance**
- **The Royal College of Emergency Medicine best practice guideline for the management of Excited Delirium and Acute Behavioural Disturbance May 2016**

Restraining a person with ABD

People who appear to have this condition should be restrained only in an emergency. They must be taken by ambulance to hospital as soon as the condition is suspected. If no ambulance is immediately available, the person should be transported to hospital in a suitable police vehicle.

It is important that people experiencing ABD have their physical health needs assessed prior to any further mental health assessment.

Pre-existing medical conditions

These might include diabetes, epilepsy, asthma and heart conditions such as angina. Custody officers should consider all of these as part of the booking-in assessment process. On each occasion, they should seek individual advice from an HCP. This includes considering whether detainees should be left in possession of medication, such as inhalers. Each case should be considered on individual merits in line with local protocols, medical opinion and the risk posed to the individual.

Claustrophobia

This is the extreme or irrational fear of confined places and can lead to intense anxiety accompanied by:

- panic attacks
- shaking
- rapid heartbeat
- intense sweating
- difficulty breathing
- feeling sick (nausea)

- dizziness
- chest pain

In extreme cases, symptoms may be accompanied by the fear of:

- losing control
- fainting
- dying

Dealing with claustrophobia is difficult in the custody environment. There are generally no suitable areas in a custody suite to keep detainees who suffer from claustrophobia. Each detainee must be risk assessed and then a decision made on where they should be detained. It may be necessary to:

- keep them in a holding cell visible to the custody officer from the main desk, or
- place them in a cell on constant observation (level 3) or within close proximity (level 4), with a member of staff at the open door. See detainee care.

Dealing with claustrophobia

Staff should:

- stay calm
- reassure the detainee
- take them to a cool, quiet place
- encourage them to breathe more slowly
- stay with them until they have recovered
- call an HCP
- be aware that opening a cell hatch to alleviate any symptoms presents the risk of a ligature point

Head injuries

Detainees who have suffered a head injury should be immediately transported to hospital for medical assessment and monitoring.

For the purpose of this APP, head injury is defined as any trauma (external force) to the head, other than superficial injuries to the face.

Traumatic brain injury may be defined as a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force. It may be indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:

- any period of loss of or a decreased level of consciousness
- any loss of memory for events immediately before or after the injury
- any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking)
- neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia) that may or may not be a transient intracranial lesion

A blow to the head can result in bruising or bleeding inside the skull or inside the brain. Not all head injuries are visible and complications may occur at any time after the event. Staff must be aware of the risks associated with head injuries, particularly when dealing with detainees who may have been involved in a fight or a road traffic collision.

Staff should also be aware that symptoms of a serious injury to the head can display as the common signs of drunkenness (for example slurred speech, drowsiness and vomiting).

A head injury may result in a rapid deterioration in the health of the detainee.

Responsibilities of custody officers

Custody officers and staff should be guided by the **FFLM (2019) Head injury warning: Advice to custody officers, gaolers and detention officers** when dealing with a detainee who is exhibiting symptoms of a head injury. This may be necessary even where there is no obvious sign of injury, or when/if the detainee denies that any injury has occurred.

Infectious and communicable diseases

Officers should seek advice from an HCP whenever a detainee is known or suspected to have an infection or communicable disease. Some detainees give information readily about a disease or infection, others do not. Information may be available on the PNC, the PND or local force systems. There may be visible signs, such as discolouration of the skin or weeping sores. Officers should record information on the risk assessment and the detainee’s medical forms. If information is written on a whiteboard, it should not be visible to anyone other than custody staff.

All people who appear to have suffered a human bite should be taken to Accident and Emergency.

Procedures needed to manage potential risk

Forces must have procedures to manage the potential risk of communicable diseases. **PACE Code C paragraph 9.7** allows a detainee and their property to be kept in isolation at the discretion of the custody officer until medical directions have been obtained.

For further information, see **FFLM (2018) Managing blood-borne virus exposures in custody**

Cleaning cells

Every cell must be adequately cleaned between detainees, following **NHS cleaning standards**, to prevent the spread of infection and/or communicable disease. In the event of any significant infection risk such as bleeding, body fluids or concern identified by the HCP, the cell may need to be taken out of use and deep cleaning arranged.

Relevant information about communicable diseases must be included on the detainee's PER form.

Common communicable diseases

For up-to-date information on infectious diseases, see **NHS Choices** (or **NHS Direct Wales**) and **Public Health England**.

Release from custody

When making the decision to release or transfer a detainee, it is essential that custody officers are familiar with the **NDM** and can carry out and justify their decision making.

The custody officer should complete a pre-release risk assessment. They should not leave this until the point of release. Instead, it should be an ongoing process throughout detention and be concluded at the point of release. Custody officers should refer to all existing risk assessment information for the detainee. They should also personally speak to all detainees prior to release and consider the risk of exploitation and/or victimisation of the detainee. The custody officer then needs to decide what action, if any, is appropriate to support vulnerable detainees upon release.

In some circumstances it may be appropriate to simply offer an individual appropriate advice and options to support their welfare on release. The options open to the police for onward referral of a detainee vary according to local provision of services in:

- social care

- healthcare
- hostels/refuges
- charity support organisations (for example the Royal British Legion)
- other agencies

The force should ensure custody officers have access to available referral agencies and written material which may help a detainee self-refer to agencies if they choose to do so at a later point.

It is the responsibility of force custody leads to make strategic links with partners to ensure that appropriate local service options are available.

The custody officer should also ensure that any risk posed by the detainee to other persons has been considered as part of the pre-release process, and, when appropriate, bail conditions are put in place to address any risk identified. They should be mindful of the need to ensure that affected individuals are notified prior to release so that mitigating measures can be put in place where required. This includes liaising with any other officer responsible for a related risk assessment. In cases where a detainee is bailed in one force but transferred to the jurisdiction of another police force, clear lines of communication need to be established to ensure that the victim can be notified when the detainee is finally released. For full information on the Code of Practice for Victims of Crime, see **keeping the victim informed.**

There is no requirement to ask every detainee if they intend to self-harm upon release. However, custody officers should be aware that there is no evidence that asking a person about thoughts of suicide increases the risk of this occurring.

It is important that victims and suspects are kept updated regarding the progress of any criminal investigation, including where a person has been released under investigation or bailed. It is the responsibility of the investigating officer to keep relevant parties updated and notified. This includes if no further action is to be taken against the suspect. See **NPCC Operational Guidance for Pre-Charge Bail and Released under Investigation**.

Risk of self-harm and suicide after release

There are occasions when it becomes apparent through pre-release risk assessment that a detainee is extremely vulnerable and that there is a real and credible risk to that individual on release (including the risk of suicide). This risk may not always be apparent during the early stages

of detention, leaving the custody officer very little time to make an urgent referral.

An adult detainee charged with an offence can be refused bail and kept in custody under **section 38(1)(a)(vi)** of PACE if the custody officer has reasonable grounds to believe detention is necessary for his/her own protection. Other grounds for keeping a person in custody may also apply.

The custody officer has no explicit powers to detain a high-risk detainee before/without charge once their detention can no longer be authorised, in accordance with Part 4 of PACE or any other lawful power. They may consider using section 135 or 136 of the Mental Health Act 1983 (if the legislative criteria is met at point of release). Where section 136 is applied in the case of children, this relates specifically to the powers of a police protection order, while section 136A specifies that children may not be taken or kept in police stations as a place of safety. Section 43 of The Children Act 1989 also confers emergency police protection powers to remove or keep children in safe accommodation.

The custody officer responsible for the duty of care for that detainee has to make a decision on the best course of action for the detainee on release and, under exceptional circumstances, the safest course of action to protect the life of that individual.

Custody officers should take into consideration the duty of a police officer to preserve life. Under **section 6** of the Human Rights Act 1998, the police service is prohibited from acting in a manner incompatible with the **European Convention on Human Rights** (ECHR). One of the obligations under the ECHR is to take feasible operational steps (within the lawful power of the officer) to avert any real or immediate risk of death of which the officer is aware or should have been aware. As such, it may be appropriate in some circumstances to extend the detention period of the detainee for a minimal and limited period.

Similarly, a person may be detained if they are in need of mental health assessment and thus detention in custody after the criminal matter has been dealt with. The relevant case law includes:

- **Webley v St George's Hospital NHS Trust & MPS** [2014] EWHC 299 (QB)
- **MS v UK** (2012) 55 EHRR 23

The reasons for not releasing someone are:

- police have a common law duty of care to the detainee
- police have a duty to release into a safe environment

Forces should have clear escalation procedures up to the rank of superintendent where a custody officer has retained a person beyond the expiry of the provisions of PACE.

A person may also be kept for a minimal and limited period to allow for the transfer of care to other appropriate care services, for example transfer into social services or local hospital care facilities.

It is unlikely that a referral will be legally permitted without the explicit consent of the detainee unless there is a legal obligation to inform others. Where there is a legal requirement to make a referral but the referral has been made without the consent of the individual, officers should record the reason and justifications for this in the custody record.

For further information, see **Suicide prevention and risk management for perpetrators of child sexual exploitation and indecent images of children (IIOC)**.

Transfer of detention

Responsibility for the welfare of a detainee being transferred to court by prisoner escort and custody services (PECS) lies with PECS staff.

Restraining a detainee

Officers may restrain a detainee during transfer if there are reasonable grounds to believe that they may otherwise use violence against escorts or bystanders, or attempt to escape from custody. Where restraint is to be applied, it is important to communicate to the detainee what is happening and why. When the detainee is passed to another agency or service, responsibility for restraint no longer rests with the police.

Multiple detainees

Transporting multiple detainees may increase risk and should be subject to a joint risk assessment prior to transfer.

Checklist: transfer of detention

Prior to transferring the detainee, the custody officer must:

- review the risk assessment, custody record and attachments

- review medical notes
- complete a PER/dPER form (which should be accompanied as a minimum by the detainee medical assessment form (450), and the detainee medication form (450a), under confidential cover, if the detainee is being transferred to hospital)
- prepare the detainee
- check the detainee's property and consider authorising an additional search where necessary
- ensure the detainee has appropriate clothing
- check that the detainee has access to sufficient medication for their transfer
- consider whether restraint is necessary and the appropriate level of restraint
- consider the number of detainees being transferred

Tags

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