

Original communication

## Near miss incidents in police custody suites in London in 2003: A feasibility study <sup>☆</sup>

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### Abstract

**Introduction:** Potentially preventable deaths in police custody include those which involve illicit drugs, alcohol and deliberate self-harm. Near miss incidents (NMI) that did not result in death have a crucial role in understanding risk factors in custody. Such research has not previously been undertaken. A program of research has been developed to study NMI, in order to better identify those at risk in police custody. For the purposes of this research, NMI have been defined as 'an unplanned and unforeseeable or unforeseen event that could have resulted, but did not result, in human death or may have resulted in injury or other adverse outcomes'. It was intended that the definition although broad, would not include simple accidents (e.g. slipping on urine in a cell) or trivial injury.

**Aims and methods:** The two aims of the study are (a) to determine whether it is realistic to attempt to assess NMI with the intention of identifying information of use in enhancing detainee care and (b) to assess how frequently NMIs occur and whether there are specific patterns. Pilot interviews were conducted with three forensic physicians practising in London, UK to create a structured questionnaire for all forensic physicians working in London. The questionnaire provided the basis of a retrospective recall survey of all forensic physicians working in London as Forensic Medical Examiners. The questionnaire was designed to assess the numbers of NMI, patterns in occurrence and relevant learning points within the previous 6 months. A covering letter, background questionnaire (exploring the background of the medical practitioner), copies of the survey, and reply paid envelopes were sent to each Forensic Medical Examiner ( $n = 134$ ) in London, contracted to provide forensic medical services for the Metropolitan Police Service. Data about all incidents were anonymised.

**Results:** Ninety six (73%) Forensic Medical Examiners responded. Of these 18% were Principal grade, the remainder were Senior (24%), Standard (35%) and Assistant (23%). Thirty eight NMI were reported by 27 Forensic Medical Examiners (of all levels). The initial reason for police contact was recorded as alcohol ( $n = 8$ ), theft and robbery ( $n = 7$ ), warrants ( $n = 4$ ), violence ( $n = 3$ ), traffic violations ( $n = 2$ ) and single cases of drugs, murder and immigration offences. Of the main perceived cause of each NMI, illicit drugs were involved in 12/38, alcohol in 17/38, deliberate self-harm in 11/38, issues concerning searches, checks or rousing in 8/38, failure of inter-agency communications in 5/38, and possible resource issues in 4/38. In a number of cases more than one factor was involved.

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**Conclusions:** The information established about NMI is broadly consistent with documented patterns of deaths in police custody in England and Wales which supports the validity of the data. The next stage of this research will be a prospective six month study in which NMI will be analysed in order to learn lessons which may be utilised to attempt to prevent potentially avoidable deaths in police custody.

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**Keywords:** Custody; Deaths; Police near miss incidents; Drugs; Self-harm; Alcohol; Detainees

## 1. Introduction

The healthcare management of detainees held within police custody in England and Wales is generally undertaken by forensic physicians (FPs – formerly known as police surgeons). Such doctors are independent practitioners providing services to the police forces. The requirements for the attendance of a forensic physician or other healthcare professional in England and Wales is determined by Codes of Practice which are contained within the Police and Criminal Evidence Act 1984.<sup>1</sup> The spectrum of health problems within this setting embraces substantial amounts of drug and alcohol misuse, mental health problems and deliberate self-harm. The Police Complaints Authority (PCA – the body set up by statute to supervise police investigations into complaints alleging serious misconduct or incidents causing public concern and to review whether any police officer should have his or her conduct referred to a misconduct hearing) published annual reports, the last of which (the Authority was replaced by the Independent Police Complaints Commission in April 2004) showed that 50% of deaths in custody are related to drug and/or alcohol or self-harm. In 2002–2003 there were 30 deaths in police custody in England and Wales.<sup>2</sup>

The Metropolitan Police Service (MPS) has a responsibility for the healthcare of prisoners – and custody officers (police officers responsible for the care of prisoners in police custody) and forensic physicians are all required to undertake basic training in clinical forensic medicine prior to undertaking their respective roles. Forensic physicians providing forensic medical services for the MPS are known as Forensic Medical Examiners (FME). FMEs are divided into different grades, Principal FME, Senior FME, FME and Assistant FME. These grades are not directly related to expertise or training (with the exception of Assistant FMEs) but are titles related to management structure and length of service. Thus comparison of the different grades does not have a place when assessing different outcomes. Potentially serious incidents take place with no adverse outcome – these have been termed near miss incidents (NMI) – but had the situation or circumstances been different an adverse outcome, such as death, might have occurred. Care of detainees in

police custody, and deaths of detainees in police custody have come under particular scrutiny as a consequence of the Human Rights Act placing as it does increased emphasis on death investigations to contribute organisational learning to the police in an effort to ensure that, wherever possible, prevention lessons can be learned.<sup>3</sup>

The current study therefore has two aims: (a) to determine whether it is realistic to attempt to assess NMIs with the intention of identifying information of use in enhancing detainee care and (b) to assess how frequently NMIs occur and whether there are specific patterns.

## 2. Methods

As studies into NMIs have not previously been undertaken, this study was conducted in two parts: firstly, an initial set of pilot interviews with three FMEs working within the MPS was undertaken to assess the feasibility of this work and to generate appropriate research methods for the subsequent stages and, secondly, a retrospective study utilising a structured questionnaire was distributed to all FMEs working for the MPS to assess the prevalence of near misses, patterns in their occurrence and relevant learning points over the six months prior to the questionnaire.

### 2.1. Pilot study

Prior to the commencement of any data collection activities an NMI Project Working Group was established. The membership of this group was drawn from the Linguistics and Forensic Medical Services Branch of the MPS, The Association of Forensic Physicians, the PCA and a senior forensic physician. Initial questions were generated through a series of discussions between members of the project team and a small pilot study of FMEs was utilised to fine tune the retrospective study questionnaire and the definition of NMI. Three FMEs were selected to provide a range of experience and seniority. Each FME participated in a semi-structured interview of 1 h duration, and based on these detailed responses a questionnaire was devised.

## 2.2. Retrospective study

The questionnaire utilised in the pilot study was developed around the data collected during the pilot study in conjunction with information from the Project Working Group. Based on the pilot work, a definition of NMI was agreed for the purposes of this study for inclusion in the questionnaire, as:

*‘A near miss incident will be defined as an unplanned and unforeseeable or unforeseen event that could have resulted, but did not result, in human death or may have resulted in injury or other adverse outcomes’.*

It was intended that the definition although broad, would not include simple accidents (e.g. slipping on urine in a cell) or trivial injury. Clearly however this definition remains open to individual interpretation and thus may influence the reporting rate.

The survey period was the six-month period prior to receipt of the anonymised, structured questionnaire. To achieve this, the postal questionnaires and covering letters were prepared by the PCA but posted out by the MPS to each of the 134 FMEs working in London during the assessment period. Each pack contained a covering letter outlining the purpose of the survey along with completion instructions, a background questionnaire for each FME, four copies of the near miss survey, and a pre-paid return envelope. Having completed the questionnaires, FMEs were asked to include their MPS Reference Number to eliminate respondents from follow-up contacts whilst maintaining anonymity. In order to maximise the response rate, one month after the initial questionnaire was sent out, a second wave of questionnaires was sent to all FMEs who had either not replied or had not included their MPS Reference Number on their returned questionnaire. Finally, two months after the initial questionnaire was distributed, contacts were

made with each outstanding FME by e-mail, telephone or fax.

A copy of the questionnaire is available from the corresponding author.

## 3. Results

### 3.1. Pilot study

The three interviewees were (1) a Principal FME who works 39 h per week; (2) an FME for five years, and sees 70–80 detainees per week; (3) a Principal FME who works 16 h per week. At this stage a precise definition of NMI was not given to the interviewees. Instead they were asked to describe any incidents that had occurred in the last year whilst working in custody that could have resulted in the deaths of detainees had it not been for the intervention of custody officers, other police personnel or an FME, or some other chance factor. In total, 12 cases of potential NMI were identified and these are summarised in the Table 1.

Pilot interviewees also commented on the need for adequate and consistent quality of training to be provided to all custody staff and FMEs; the need to ensure adequate checks and rousing of detainees; the need for appropriate staffing to carry out the required checks; potential problems of information sharing with other agencies (e.g. court transport) and the ability of other agencies to provide appropriate care and manage risk in the custody situation.

Other issues that arose from the pilot interviews that needed to be incorporated into the questionnaire structure related to what lessons were learned from each incident (i.e. did policy or practice change and how were the lessons disseminated if at all).

Table 1  
Pilot interview examples of potential NMIs

FME	Reason for arrest	NMI issue	Possible learning point*
1	Drunk and disorderly	Alcohol and methadone overdose	Need to recognise overdose vs. intoxication
1	Disqualified driving	Ruptured spleen	Mistaken belief of faked injury
1	Impaired driving	Diabetic	Illness masked by alcohol
2	Breach of exclusion order	Intended self-harm	Search procedure; communication
2	Drunk and disorderly	Alcohol and ecstasy overdose	Appropriateness of being in custody; ambulance attendance times
2	Drunk and disorderly	Head injury	Head injury not identified because of alcohol
2	(Not known)	Broken needle in vein	Some drug users may be unsafe to be in custody
2	(Not known)	Alcohol and methadone Overdose	Overdose masked by alcohol
2	(Not known)	Self-harm attempt	Need for constant monitoring of known self-harm cases
2	(Not known)	Deliberate overdose	Risks associated with delay in booking in process
3	Robbery	Self-harm attempt	Need for constant monitoring of known self-harm cases
3	(Not known)	Self-harm attempt	Search procedure

\* It should be emphasised that as the FMEs were recalling events, these can only be subjective views as to (a) the key NMI issued and (b) whether the possible learning point is valid.

### 3.2. Retrospective survey questionnaire

Because of the retrospective recall nature of the study, some data were missing from survey responses. Results are given related to the numbers of responses for each question when data were present.

Ninety six of the 132 FMEs, responded (73%), reporting a total of 38 NMIs, these being reported by a total of 27 different FMEs. During the telephone stage of the survey, two FMEs reported that they were not willing to be involved, and two that they had not worked in that period. Of those who replied 18% described themselves as Principle FMEs, 24% as Senior FMEs, 35% as FMEs and 23% as Assistant FMEs. Twenty percent indicated that they were approved under Section 12 of the Mental Health Act 1983 (as having special experience in the diagnosis or treatment of mental disorder). Just under one quarter (24%) reported that they held the Diploma of Medical Jurisprudence (DMJ), whilst a further 26% reported that they were currently studying for it. The Diploma of Forensic Medicine (DFM) was held by 3% with the same number currently studying for it. A further 15% of the sample reported that they currently held other forensic qualifications. Respondents had been qualified in medicine for a mean of 27 years, and had worked as FMEs for a mean of 11 years. Respondents worked as FMEs for a mean of 22 h per week, with a mean of 31 detainee consultations during that time.

In 30/38 of NMIs reasons for police contact was provided. The most common reasons related to alcohol-specific issues (8/30), followed by thefts and robbery (7/30), individuals wanted on warrants or bail (4/30), incidents involving violence (3/30) and drink driving (2/30). Individual instances were recorded of deception, drug possession, arrested at a flight gate at an airport, a failure to return to jail, murder, and illegal immigrant status.

With regard to the individuals involved, due to the retrospective recall nature of the survey variable amounts of information were provided by the FMEs on the characteristics of the detainees. Thirty one detainees were described as male and five as female. The cases involved white detainees (27/34), with a further four of the remaining cases involving Asian detainees, two involving black detainees. There was one final case where ethnicity was not recalled.

Medical screening Form 57M (Form 57M being an MPS medical screening form completed by direct inquiry from detainees at booking in to the custody suite) were complete in 12/29 cases, and respondents were aware of relevant warning and/or information markers present on the Police National Computer (PNC) markers in 6/29 cases. Nine of 31 detainees were known to have had an alcohol problem, 11/35 to have had a mental health problem and 15/30 were known to have had a drug problem. Seventeen of 34 individuals are described

Table 2  
Possible risk factors associated with NMI (identified by recall)

Number (total = 38)	Possible risk factor
17	Alcohol
12	Illicit drugs
11	Deliberate self-harm
8	Police procedure (search, checks, rousing)
5	Inter-agency communication
4	Resources

as having been intoxicated at the time of the incident, while a further five are described as withdrawing at the time of the incident.

The mental health problems that were identified included depression, previous self-harm attempts, psychosis, obsessive compulsive disorder, and drug dependence. In 9 of 31 cases the individual was known to have had a history of self-harm and other vulnerabilities.

The incidents involved a number of risk factors and involved a wide array of circumstances. Those risk factors identified by the FMEs are listed in Table 2.

Although retrospective recall may limit interpretation across incidents a number of themes relating to alcohol arose. These included its role as a component of polydrug overdose; alcohol in relation to inter-agency working with ambulance services or reluctance of hospitals to take drinkers because of their abusive or aggressive behaviour; alcohol in incidents involving self-harm attempts; alcohol in conjunction with physical injuries (including a ruptured spleen and head injuries); alcohol in connection with long-term alcohol dependence problems, and alcohol and hypoglycemia.

Specific issues that arose related to illicit drugs were: overdose of drugs (accidental or deliberate) in nine of the cases (with a possible overdose in another case but insufficient evidence was provided to clarify this); drug swallowing. Drug concealment arose as a near miss risk in three cases, while another area of concern related to pharmaceutical drug consumption following theft by detainees of drugs from the FME. Specific issues that arose related to deliberate self-harm were: deliberate self-harm and the use of alcohol and/or illicit drugs; deliberate self-harm by concealed knife; deliberate self-harm by attempted choking or to hanging with clothes or papersuits and use of wire from a brassiere.

## 4. Discussion

It must be emphasised that the data generated from this study are retrospective and originate from FMEs alone. The views as to what were the causes of the NMI are subjective. There was no input from others (such as custody officers or gaolers) to the study process as it is designed to be reviewed from a medical standpoint. Although it would be desirable to utilise data from other sources, legal

issues prevented using non-medical personnel for data collection at the time of the study. Clearly this may introduce bias into the data collection. Additionally FMEs may choose to not include incidents for which they considered they might have responsibility. This is another potential source of data bias.

The numbers of NMIs was too low to allow appropriate comparison of sub-groups of respondents (e.g. those with different levels of experience, of different workloads), but clearly such factors may (amongst many others) be of considerable influence. The data from the retrospective survey suggest – if applied to all FMEs for 1 year – that there may be a total number of 107 NMI within the Metropolitan Police Service area each year. This should be set against a total of ~190,000 detainees seen within the MPS by FMEs annually (Kenneth Pratley, personal communication). However, a total of around 100 near miss incidents in London would suggest that there is a major learning opportunity to identify ‘at-risk’ individuals that may not be being monitored or audited adequately. It is interesting to note that if the experiences of the 3 pilot FMEs were extrapolated, the number of NMIs would be substantially higher. The time spent on the structured interview appears to result in better recall than that of simple recall used for completing a questionnaire. It may be that the small pilot study gives a better indication of the potential number of NMIs. Of those NMIs identified – all are broadly consistent in type with the overall characteristics of Category 3 deaths in police custody as reported by the PCA. The three dominant categories of incident – relating to illicit drugs (concealed or whose use results in overdose), alcohol (relating to self-harm, or concealing injury or illness) and self-harm itself, are indicative that the learning points from near misses are consistent with the broad areas of concern relating to police-related death.<sup>4,5</sup> These reflect the vulnerabilities of those in police custody in London, UK of which 15 alcohol misuse problems, 30% will be dependent on heroin and/or crack cocaine and 18% will have significant mental health issues.<sup>6</sup> Recently, a second edition of ‘Healthcare of Detainees in Police Custody’ has been published which draws attention to many concerns.<sup>7</sup>

However, the circumstances of the NMIs described in this study are sufficiently varied that they offer vital

opportunities for learning and for preventative changes to processes, training and structures. Furthermore, if nothing else because of their greater number, they offer insights into new risks not previously seen in PCA-supervised deaths. For example incidents involving the theft (and swallowing or concealing) of drugs from the FMEs offers a core learning point that requires urgent dissemination.

The two aims of the study, determining whether it is realistic to attempt to assess NMIs with the intention of identifying information of use in enhancing detainee care and to assess how frequently NMIs occur and whether there are specific patterns, have been, in part, achieved. However this can only act as the beginning of research into this complex and sensitive area. It is clear that it is now appropriate to proceed with a prospective study to review NMIs utilising the information obtained in this study. As data accumulate in this area it may become possible to identify what other (non-detainee) factors influence such events. It is equally clear that consideration must be given to ensure the best way of communicating the lessons learned to all agencies and individuals involved in the care of detainees in custody in order to continue to improve their care.

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