Independent Advisory Panel on Deaths in Custody (IAP)

An initial review of the academic and operational literature regarding alternatives to the use of restraint in police custody

February 2018

About the Independent Advisory Panel on Deaths in Custody (IAP)

The Ministerial Council on Deaths in Custody formally commenced operation in April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

The IAP forms the second tier of the Ministerial Council. The ambit of the Council (and IAP) covers deaths which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAP, an arms-length body, is to provide independent advice and expertise to the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE was appointed Chair of the IAP in 2016. Further information on the IAP can be found on the website: http://iapdeathsincustody.independent.gov.uk/

For more information on this report – or on the IAP more generally - please contact:

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1. Context of this report

1.1 The Rt. Hon Theresa May MP commissioned Dame Elish Angiolini DBE QC to produce a report on Deaths and Serious Incidents in Police Custody. This report, and the Government response to it, was published on 30 October 2017[1]. The Government response states that the Home Secretary has asked the Ministerial Board on Deaths in Custody to take forward further work in two areas: healthcare in police custody and support for families. Following discussions at the Ministerial Board on 1 November 2017, Ministers agreed a work programme for the Board which covers the following themes:

- Healthcare in police custody - *Reduce the risk of a death in police custody occurring*
- Support for families - *If a death in custody occurs, ensure better support for families*
- Inquests and Legal Aid - *If a death in custody occurs, ensure families are supported through the inquest process*
- Accountability - *Ensure organisations are held to account*
- Investigations - *Ensure investigations and inquests are timely and effective*
- Levers to improve performance - *Ensure lessons are learnt and improve accountability*

1.2 The police's use of restraint techniques has been reviewed and considered by a number of bodies. In 2017, a Memorandum of Understanding developed by a group independently chaired by Lord Carlile of Berriew CBE QC sets a clear national position about when the police can be asked to attend mental health settings, for what reasons and what can be expected of them when they do attend.

1.3 The Government, and the Ministerial Board on Deaths in Custody, in their response to Dame Elish's report have been clear that further focus needs to be given to examining potential alternatives to the use of restraint by police officers when faced with situations in the community (without necessarily suggesting that any of the alternatives considered will be adopted).

1.4 Ministers subsequently approved researching alternatives to restraint as the first workstream in the 'Healthcare in police custody' theme. The IAP has agreed to take this work forward given the IAP's extensive previous work on the issue of restraint in custodial settings.[2] Dr Meng Aw-Yong is the lead panel member for this piece of work.

1.5 **The IAP's role in this report is to produce alternative <u>options</u> to physical restraint for consideration by the Ministerial Board on Deaths in Custody. The IAP's intention is to encourage debate and discussion of the possible options. The IAP does not necessarily support the use of**

[1] https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody
[2] http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/use-of-restraint/

the options outlined in this paper and the inclusion of a particular option does not imply any endorsement of it by the IAP.

2. An introduction to restraint and its risks

The Human Rights context

2.1 The United Nations Code of Conduct for Law Enforcement Officials was adopted by the General Assembly in its resolution 34/169 of 17 December 1979. Article 3 of the Code states that: *"Law enforcement officials may use force only when strictly necessary and to the extent required for the performance of their duty".*

2.2 The police Personal Safety Manual explains:

> *"The commentary of the article explains that the use of force should be exceptional; while it implies that law enforcement officials may be authorised to use force as is reasonably necessary under the circumstances for the prevention of crime or in effecting or assisting in the lawful arrest of offenders or suspected offenders, no force going beyond that may be used."*[3]

2.3 The Human Rights Act 1998 gives effect to the European Convention on Human Rights (ECHR). The ECHR contains articles relevant to the state's use of custody such as Article 2- the right to life, Article 3 - prohibition of torture, inhuman and degrading treatment or punishment, Article 8 – the right to respect for private and family life.

Considering the reason and location of restraint incidents

2.4 Police officers – and other custodial staff – are, at times, authorised to use force. However, resorting to restraint techniques is not an end in itself – it is applied where criminal conduct is involved, or the welfare of individuals is at risk. Such actions are lawful and often necessary – but they also always carry an element of risk. The Royal College of Emergency Medicine[4] makes clear that such use of force should always be:

> *" … kept to a minimum using a level of force that is justifiable, reasonable and proportional to the individual case…"*

2.5 Given the risk involved, it may be helpful to consider what objectives police officers are trying to achieve when they use restraint techniques. These aims can generally be summarised as:

- To detain/arrest a suspect
- To search a suspect
- To save life/prevent injury

2.6 The possible alternative options to restraint will vary depending on what the police are seeking to achieve, and this should be borne in mind when

[3] http://library.college.police.uk/docs/college-of-policing/PSM/PSM-MOD-03-USE-OF-FORCE.pdf
[4] RCEM - Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance (ABD), May 2016

considering different ways to approach the situation. The external situation also plays an important role. The police have to consider whether, and how, to use restraint in the three main locations they will come across it - police custody suites, hospital settings (acute and mental health), and in dynamic settings in the community. The location of the incident will be an important factor in considering whether which, if any, of these alternative options may be appropriate.

The risks of using restraint techniques

2.7 The research report[5] that accompanied Dame Elish's report said:

> *"Caring Solutions (UK)[6], 2011 reviewed the literature on restraint-related deaths, arguing that there are no entirely safe methods of restraint. Current approved professional practice[7] published by the College of Policing emphasises that restraint should only be used when absolutely necessary, and then only for the minimum amount of time as to return the detainee to a manageable state."*
>
> *Between 1998/99 and 2008/09, a quarter (87 of 333) of deaths in police custody involved restraint at some point before death. In the latest statistics for 2015/16, it was known that restraint was used at some point by police officers in 5 out of the 14 deaths in police custody, but this does not mean that there was a causal connection between the use of restraint and the death."*

2.8 Dame Elish's recent report quoted the College of Policing Authorised Professional Practice (APP) on Detention and Custody (Control, restraint and searches) which outlined the risks involved in the use of restraint:

> *"Prolonged restraint and struggling can result in exhaustion, reduced breathing leading to build up of toxic metabolites. This, with underlying medical conditions such as cardiac conditions, drugs use or use of certain antipsychotics, can result in sudden death with little warning."*

2.9 This risk is also emphasised within the Guidance on the Safer Detention & Handling of Persons in Police Custody (2006):

> *"Prolonged restraint and struggling can, particularly where the lungs are being squeezed while empty, result in exhaustion. This can be without the detainee being aware of it and can lead to sudden death."*[8]

2.10 The Guidance goes on to state that there are factors which can contribute to a death during restraint:

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[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655710/Deaths_in_police_custody_A_review_of_the_international_evidence.pdf

[6] A report commissioned by the IAP: http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Caring-Solutions-UK-Ltd-Review-of-Medical-Theories-of-Restraint-Deaths.pdf

[7] https://www.app.college.police.uk/app-content/detention-and-custody-2/control-restraint-and-searches/

[8] Guidance on the Safer Detention & Handling of Persons in Police Custody (2006)

- *"The body position of a person results in partial or complete obstruction of the airway and the subject is unable to escape from that position;*
- *Pressure is applied to the back of the neck, torso or abdomen of a person held in the prone position;*
- *Pressure is applied restricting the shoulder girdle or accessory muscles of respiration while the person is lying down in any position;*
- *The person is intoxicated through drink or drugs;*
- *The person is left in the prone position;*
- *The person is obese (particularly those with large stomachs and abdomens);*
- *The person has heightened levels of stress;*
- *The person may be suffering respiratory muscle failure related to earlier violent muscular activity (such as after a struggle);*
- *Bodyweight should not be used on the upper body to hold down the detainee."*[9]

2.11 These factors can be considered alongside the findings from Caring Solutions which, in its research of those restraint-related deaths, found[10] that certain methods of restraint present particular risks to specific groups of people for biophysical, interpersonal, situational or attitudinal factors. These groups include:

- Those under 20 years old
- Those from Black and Minority Ethnic communities
- Those with a high body mass index
- Those with serious mental illness or learning difficulties.

2.12 Bishop James Jones recently wrote to the co-chairs of the Ministerial Council on Deaths in Custody outlining lessons learned from his work and report[11] on the Hillsborough families' experiences regarding restraint asphyxia. Bishop Jones pointed to how the risks of restraint are heightened by the position of the individual in question:

> *"Positional or postural asphyxia refers to a situation where respiration is impeded by the position of a victim's body. This may have a variety of mechanisms including wedging of the body in a confined space preventing movement of the chest wall and diaphragm, or acute flexion of the neck occluding the upper airway."*[12]

[9] [9] Guidance on the Safer Detention & Handling of Persons in Police Custody (2006)

[10] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Caring-Solutions-UK-Ltd-Review-of-Medical-Theories-of-Restraint-Deaths.pdf

[11] The patronising disposition of unaccountable power – a report to ensure the pain and suffering of the Hillsborough families is not repeated.

[12] Byard, R, Wick, R and Gilbert J, Conditions and circumstances predisposing to death from positional asphyxia in adults, *Journal of Forensic and Legal Medicine* 15 (2008) 415–419

2.13 The dangers of restraining an individual in the prone position are well known. Research[13] also suggests that the supine position presents risks due to the detrimental impact this position can have on the body's ability to access and use oxygen.

> *"These positions* [semirecumbent and supine] *do not facilitate V/Q matching as in the upright and full side lying position due to the hindrance to expansion of the dependent lung by the diaphragm and chest wall. Even in healthy participants the PO2 is 0.7 kPa (5 mm Hg) lower in the supine position than in the upright position."*

2.14 This research goes on to note:

> *"Evidence from a number of cohort studies shows that oxygenation is reduced in the supine position, both in healthy participants and in acute illness but there are no controlled trials showing benefit from specific body positions (evidence level 4)*
>
> ***Recommendation***
> *Because oxygenation is reduced in the supine position, fully conscious hypoxaemic patients should ideally be allowed to maintain the most upright posture possible (or the most comfortable posture for the patient) unless there are good reasons to immobilise the patient (eg, skeletal or spinal trauma) (grade D)."*

2.15 The findings of this paper reinforce the inherent dangers of using force which will often lead to the individual being restrained in a prone or supine position.

The specific risk presented by those with Acute Behavioural Disturbance (ABD)

2.16 As shown by the earlier paragraphs in this section, all uses of restraint carry some risk of causing death. The cause of such deaths is typically multi-factorial depending on where the incident lies on the spectrum from short to long periods of restraint. Fundamentally, incidents involving restraint are unpredictable and the risks of death are higher when police physically intervene with mental health patients on anti-psychotic medication and long-term drug users.

2.17 Patients in the latter two categories may present to police in an agitated and unusual manner which was historically referred to as Excited Delirium and now is referred to as Acute Behavioural Disturbance (ABD). The Royal College of Emergency Medicine guidelines describe the physical symptoms and signs typical of ABD as:

- *"Extremely aggressive/violent behaviour"*
- *Excessive strength/continued struggle despite restraint*

[13] O'Driscoll BR, Howard LS, Earis J on behalf of the British Thoracic Society Emergency Oxygen Guideline Group, et al BTS guideline for oxygen use in adults in healthcare and emergency settings *Thorax* 2017;72:ii1-ii90

- *Insensitive to pain*
- *Acute psychosis with fear of impending doom*
- *Constant physical activity without fatigue*
- *Hot to touch/profusely sweating/inappropriate state of undress*
- *Hyperthermia*
- *Tachypnoena* [abnormally rapid breathing]
- *Tachycardia"* [abnormally rapid heartbeat].

2.18 The RCEM describe this condition as follows:

> *"Acute Behavioural Disturbance (ABD) is the accepted terminology adopted by the UK Police Forces, the Ambulance Services and the Faculty of Forensic and Legal Medicine[14]. It describes the sudden onset of aggressive and violent behaviour and autonomic dysfunction, typically in the setting of acute on chronic drug abuse or serious mental illness. However, there is not yet a common standardised definition and its incidence has not been clearly quantified. ABD, or as it is also known 'Excited Delirium,' is the presentation of features of "acute delirium" and hyper-adrenergic autonomic dysfunction and must be considered a medical emergency. Its presentation is associated with sudden death in approximately 10% of cases[15]. High profile deaths of individuals displaying features of ABD have occurred whilst they have been in police custody."[16]*

2.19 ABD is considered to be more common in summer months when the temperature is warmer. The causes are multi-factorial but the use of cocaine has often been mentioned as a causal variable, and ABD is less a specific diagnosis than a description of varied behaviour caused by multiple factors. The Faculty of Forensic and Legal Medicine state in their guidelines[17]:

> *"Ideally, individuals with acute behavioural disturbance should not be taken to a custody suite but directly to an emergency department."*

2.20 The risks presented by someone exhibiting symptoms of ABD mean that the priority for the police should be minimising the use, and length of restraint, and acting rapidly in concert with medical professionals to calm the individual concerned. In the case of mentally ill people suffering from psychosis, this requires the taking of antipsychotic medication. For those with drug-induced ABD the objective is to calm the individual through the use of a sedative, given that the condition is not caused by an underlying medical illness.

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[14] Faculty of Forensic and Legal Medicine. Acute behavioural disturbance: guidelines on management in police custody. January 2016

[15] American College of Emergency Physicians White Paper Report on Excited Delirium Syndrome September 2009

[16] RCEM - Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance (ABD), May 2016

[17] Acute behavioural disturbance: guidelines on management in police custody

2.21 ABD is dangerous because, if the police attempt to restrain the individual, the individual may have already expended a significant amount of energy in the physical exertions that have brought them to the police's attention. This – coupled with the compulsion to continue resisting and struggling while under restraint can put the body under stress by the release of toxic metabolites. It is the combination of restraint and the body being overwhelmed by toxic chemicals that can cause rapid deaths in some cases. In one recent death, the pathologist determined that death was caused by multiple hypoxic organ failure. This was manifested by muscle exhaustion, increased lactic acidosis, and heightened levels of potassium from extreme physical exertion which can cause potentially fatal abnormal heart rhythms.

The use of sedatives and tranquilisers

2.22 The upper steps of the escalation pyramid include the use of chemical sedatives/tranquilisers to calm a person and bring them under control. This will not be appropriate or necessary in many cases that the police deal with on a day-to-day basis. However, for those who fail to respond to the options available on the lower steps of the pyramid, sedation offers the opportunity to calm an individual (for example, someone suffering from ABD) to the extent that responsibility for them can pass from the police to medical services. The NICE guideline on violence states:

> *"The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user and to others.' The aim is not to induce sleep and the patient should be able to communicate verbally at all times."*

2.23 Currently, the use of such medication is only available to paramedics and doctors. Expanding this facility to forensic medical examiners and nurses (under a Patient Group Directive) in police custody suites could be a relatively straightforward way of making some of the alternatives in section 3 more immediately feasible when managing an individual in the custodial environment.

3. Alternatives to restraint – possible options

Systemic alternatives

3.1 As mentioned in chapter 2, it is useful to consider what end the police are seeking to achieve when they restrain an individual. Increasingly, the police are called to attend situations that are outside of their core remit, such as dealing with people with mental ill-health. Part of the reason for the police using restraint in such a situation may be because it is outside of their remit – and therefore skillset – and fundamentally is not something they should be managing.

3.2 If one accepts this premise, then a clear method of reducing instances of restraint would be to reduce the number of times the police end up responding to such situations. This leads to a number of interesting systemic alternative models of operation.

3.3 Improvement in community and secondary care mental health services would reduce these demands. Consistent and effective information sharing of, for example, mental health records systems, is vital here in allowing police early recognition and appropriate management of mental health illnesses.

3.4 Extending the premise of street triage to having medical staff co-located or travelling with police to serious incidents could ensure the right people are on the scene at any one time. However, it should be noted that – in some cases – the rollout of street triage services was in parallel to disinvestment in acute mental health services potentially resulting in increased calls to the police.

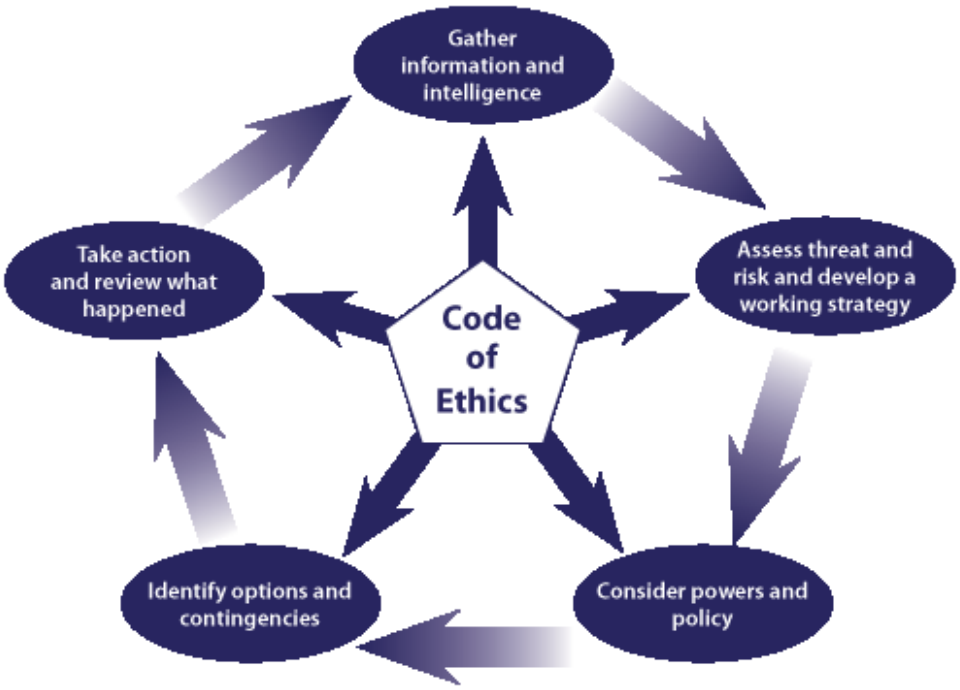
3.5 Furthermore, the call handling system on 999 telephone calls could be amended to try to ensure that, for example, where a case of ABD is suspected, police and ambulance staff are called together. This would negate the need for the police having to arrive first, and then calling for medical support – which could delay matters significantly.

3.6 A more radical option would be to acknowledge the premise above – that the police are currently responding to calls within social work and mental health remits – and respond by changing the service deployed to respond to them. In this scenario, a holistic public service could be created, made up of different service professionals such as police, social workers and healthcare staff, who could respond to each emergency call with the most appropriate staff depending on the nature of the situation. Adapting the services in this manner may mean a rebalancing of the number of emergency service staff, rather than adding to them but this would require considerable further analysis.

Introduction to operational alternatives

3.7 The police, when faced with an unpredictable situation, rely on the national decision model which sets out how the process by which a decision is

reached, and action undertaken. The police personal safety manual describes the model as *"… suitable for all decisions. It can be applied to spontaneous incidents or planned operations, by an individual or a team of people, and to both operational and non-operational situations."* The model can be simply represented as follows:



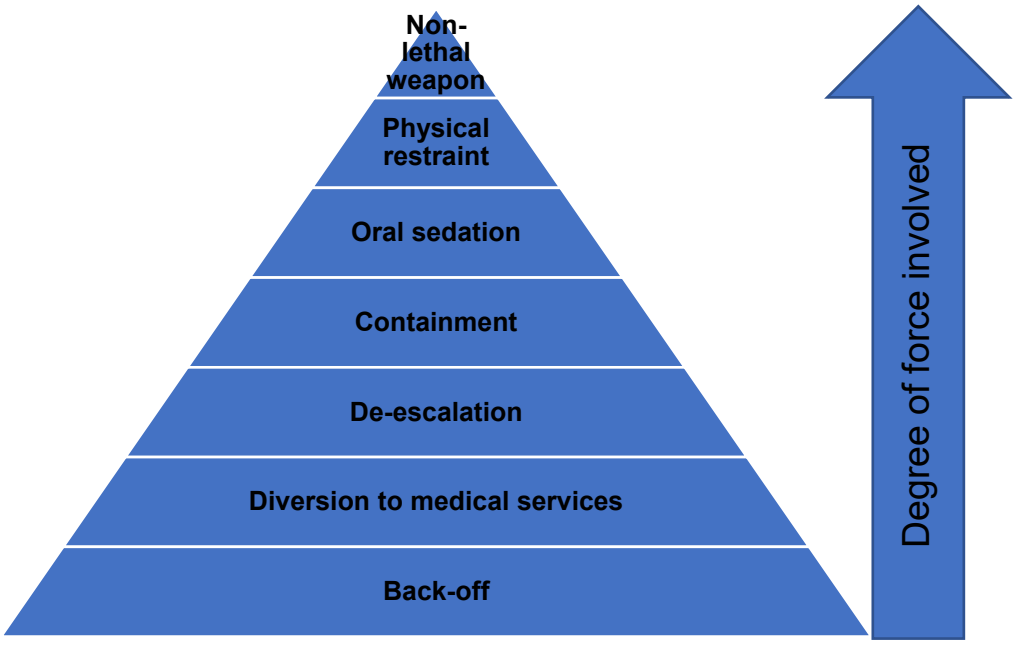
3.8 Faced with a violent or recalcitrant individual police officers may consider physical restraint as the method most likely to resolve the situation quickly and safely. Police, as noted in the national decision model, should consider any information they have regarding the nature and cause of the individual's behaviour:

> *"There may be an underlying medical reason for the behaviour such as a head injury, drug or alcohol misuse or a mental illness. If there is any suspicion that the violence stems from a medical condition, the person should be treated as a medical emergency. Whenever possible, the person should be contained rather than restrained until medical assistance can be obtained."*[18]

3.9 However, as described above, the use of physical restraint holds risks for staff and those being restrained. The following sections offer a potential alternative series of options for the Ministerial Board to consider via the model of an escalation pyramid. However, it should be noted that this pyramid should not be seen as a linear process by which police move up as the situation

[18] Guidance on the Safer Detention & Handling of Persons in Police Custody (2006)

becomes heightened. For example, in a community setting where lives are at imminent risk, attempting to de-escalate or contain the situation would risk more harm than an option 'higher' up the pyramid.



Back-off/withdrawal

3.10 One clear option for police to avoid using force is to back away from the incident and disengage with the individuals involved – although this may be unpalatable to the public. This will clearly be inappropriate when criminality or threats to life are present, but it is being highlighted here as an *option.* Given the earlier references to the police becoming involved in situations outside their remit, referencing this possibility may lead to discussions on where the boundaries of police involvement currently are, and where they could be. The option of immediately passing on responsibility for a situation to another public service leads on to the option in the following section.

Diversion to healthcare services

3.11 The police are often called to situations where the cause of the individual's actions is medical, and therefore may be more suitable for intervention by healthcare staff. People in such situations may be more appropriately treated by the healthcare services, but end up in police custody.[19]

3.12 There are a number of possible avenues to divert people away from police custody if their behaviour appears to be caused by medical issues. The successful use of these services could mean that police officers do not need to engage with individuals – which potentially could result in fewer uses of restraint by the police.

[19] It should be noted however that, although the actions may be due to a medical cause, the police may still be required to intervene if the resultant behaviours are a threat to anyone or are disorderly.

3.13 Street triage is described by NHS England[20] as:

> *"Street triage is an identification approach being piloted with adults in a number of areas in England. It takes the form of mental health professionals supporting police officers when responding to emergency calls to cases which involve a person who may be suffering from a mental illness. These members of the public often come into contact with the police despite not necessarily having committed an offence."*

3.14 Liaison and diversion services (L&D) identify those with mental health, learning disability, substance misuse or other vulnerabilities when they initially come into contact with the criminal justice system. This early contact means that people can be referred to healthcare services where necessary, and away from police custody.

De-escalation

3.15 De-escalation is a vital, and frequently used, option for the police when confronted with an individual who needs bringing under control. The Police Safety Manual explains that:

> *"When confronting aggressive behaviour, successful resolution may be achieved by calming the emotions and then building a rapport with the individual once they are back to thinking rationally."*[21]

3.16 The Faculty of Forensic and Legal Medicine state in their guidelines[22]:

> *"… a period of de-escalation (time-out) where the detainee may calm down (away from the arresting officers). The FP should avoid responding to aggression with aggression and adopt a reassuring and non-judgmental attitude. Only when de-escalation has failed to curb the disturbed behaviour should the FP consider giving medication."*

3.17 The NICE Guideline on Violence[23] advises that de-escalation techniques should be tried before sedation and makes the following recommendations:

> *"In a potentially violent or disturbed situation, 1 staff member should assume control. That person should then:*
> - *Manage the immediate environment—move to a safe space, remove unnecessary staff and other service users, give clear, concise instructions*

[20] https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/#q12

[21] http://www.npcc.police.uk/documents/FoI%20publication/Disclosure%20Logs/Uniformed%20Operations%20FOI/2013/003%2013%20Att%2007%20of%2015%20Police%20Officer%20Safety%20Manual%20Module%206.pdf

[22] Acute behavioural disturbance: guidelines on management in police custody

[23] National Institute for Health and Care Excellence. Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. CG25. London: National Institute for Health and Care Excellence, 2005.

- *Attempting to establish facts and encourage reasoning—try to establish a rapport, offer realistic options and avoid threats, use open questions to elicit the cause of the patient's aggression or anger, show concern and empathy, avoid being patronizing or dismissive of the patient's concerns.*
- *Avoid provocation and use non-threatening non-verbal communication—remain calm, controlled and confident, allow personal space, adopt non-threatening posture."*

3.18 This technique occupies an established position in the operational guidance for the police – and wider custodial staff – but it is an open question if sufficient training is provided on it. One possible explanation for the police using force when other alternatives could be preferable is a lack of confidence in using those techniques. If training, guidance and support for alternative options is not sufficiently promoted and embedded, police officers will default to those where they do feel more comfortable – which could be those involving force.

Involvement of external actors in the de-escalation process

One option the police could consider when considering the appropriate action to take is checking to see if there is anyone available who may be able to positively influence the individual in question. Bringing an external person to the scene requires time, and raises the possibility of increasing the chance of a negative outcome if it is this relationship which has caused the adverse behaviour. However, while this is possible, the arrival on the scene of a friend or family member could potentially reassure and stabilise the individual in question. Involving external actors may also be considered during the alternative option outlined in the next section *Containment.*

Containment

3.19 Police officers may have the option - where de-escalation tactics have failed, or as an alternative to them – to contain the individual as they wait for support from medical personnel. In the police custody suite the police has this option in the sense of placing someone in a police cell. However, this may present greater risk of harm if the individual engages in self-harming behaviour. Mental health establishments offer 'soft cells' which lower the risk of individuals harming themselves while in them and including some in the police estate is a potential option.

3.20 Containment is also possible outside of the custody suite and, in the right situation, could be deployed effectively in the community. In this context containment refers to the police boxing the individual into a position where, although they maintain freedom of movement, they are unable to inflict serious harm on other people.

3.21 However, it should be noted that this technique will often not be possible due to the physical environment or because the individual concerned is presenting

an imminent risk to his or other's lives and welfare. However, where this is not so, police officers could consider contacting emergency medical staff and containing the individual until they arrive. Once the medical crew are present the police can attempt to resolve the situation in the knowledge that, if restraint is used, it will be undertaken in the presence of medical professionals who can monitor the individual and provide treatment as required. Undertaking a tactic such as this requires the police to have effective protocols and agreements in place with local medical services. The actions subsequently taken by the police could be any of those higher up the escalation pyramid as explained in the following sections.

Oral sedation

3.22 When considering alternatives to restraint, less coercive methods can – in the right circumstances – be effective. One example of this is the option of persuading the individual concerned to voluntarily take an oral sedative. The Faculty of Forensic and Legal Medicine states that this option can be as effective as drugs administered via injections and describe the practicalities of this option further in their guidelines[24]:

> *"The proposed treatment should be explained to the disturbed patient, as most individuals will co-operate with an oral dosing regime with appropriate support from the doctor. In circumstances where the detainee lacks capacity to consent to the treatment, the forensic physician may still administer oral medication provided the doctor considers it to be in the person's best interests and the individual complies."*

3.23 This alternative to restraint may be combined well with the options of de-escalation or containment described earlier, but there are clearly limits to its effective implementation. Crucially, it requires medical professionals[25] to be present and able to administer the sedative. The typical medication provided should be benzodiazepines – especially if there is known intoxication. If the individual has a history of taking anti-psychotic medication the medical team may wish to consider administering a top-up of their normal medication[26].

Physical restraint with chemical sedation

3.24 This research report acknowledges that the physical restraint of an individual may be deemed necessary by the operational staff. However, this option need not be considered in isolation – it can be combined with the chemical sedation of the individual. The aim of this option is to physically restrain the individual for as short a time as possible – thereby minimising the risks presented by the use of force.

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[24] Acute behavioural disturbance: guidelines on management in police custody

[25] This might be a doctor or Advanced Paramedic Practitioner (APP).

[26] Johnson A, Cantle F and Aw-Yong M, *Sedation and Restraint in the ED,* Challenging Concepts in Emergency Medicine, OUP

3.25 Depending on the nature of the situation, the police may have the opportunity to make use of the options lower down the escalation pyramid. When considering physical restraint with chemical sedation, this is particularly useful as – even if they are unsuccessful – they offer time for the medical services to attend the scene. The IAP has been informed that the timing of medical response services varies enormously across the country. While this is outside the direct scope of this paper, the emergency services will need to be well coordinated for this approach to be practicable.

3.26 The Faculty of Forensic and Legal Medicine state in their guidelines[27]:

> *"The aims of rapid tranquillisation are threefold:*
>
> *a. to reduce further suffering for the patient: psychological and physical (through self-harm or accidents)*
> *b. to reduce the risk of harm to others*
> *c. to do no harm (by prescribing safe regimes and monitoring physical health)."*

3.27 If the sedative needs to be applied intra-muscularly, the medical team will typically choose between haloperidol, lorazepam and olanzapine – some services will also use ketamine. A review of the use of such drugs in psychiatric inpatient settings[28] found limited differences between the use of these drugs. However, due to the risk of dystonic reactions from haloperidol, NICE guidance[29] recommends that an antimuscarinic agent such as procyclidine should be immediately available. Furthermore, following tranquilisation, pulse, blood pressure and oxygen saturation levels should be monitored and recorded.

3.28 The use of sedatives instead of, or following, restraint requires the police and medical services to have carefully established procedures to ensure that the process is carried out legally and safely. Only an appropriately trained medical professional can administer the sedative, and the decision to do so lies with the medical staff, not the police. The London Ambulance Service and Metropolitan Police Service have established, in practice, procedures to resolve situations in this way and work is currently ongoing to establish it formally in a memorandum of understanding. Agreements at a senior level such as this are vital if this option is to work successfully.

Non-lethal weapon from distance (with chemical sedation)

3.29 Instead of physically engaging with the individual as outlined in the above section, another option that the police could choose is to temporarily immobilise them from distance either by a conducted energy device or

[27] Acute behavioural disturbance: guidelines on management in police custody
[28] Pratt JP, Chandler-Oatts J, Nelstrop L, *et al.* Establishing gold standard approaches to rapid tranquilisation: A review and discussion of the evidence of the safety and efficacy of medications currently used. *J of Psychiatry Intensive Care* (2008); 4:43–57.
[29] National Institute for Health and Care Excellence. Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. CG25. London: National Institute for Health and Care Excellence, 2005.

pelargonic acid vanillylamide (PAVA), a synthetic capsaicinoid (the active ingredient in pepper). Research indicates that the mere act of removing such weapons from their holsters can produce acquiescence – which can be an alternative to restraint in itself.

3.30 A conducted energy device (CED)[30] is described on Sussex Police's website as:

> *" … a single shot device designed to temporarily incapacitate a person through use of an electrical current which temporarily interferes with the body's neuromuscular system"*[31]

3.31 The use of a CED is a serious action and its use must be *"**proportionate**, **lawful**, **accountable** and absolutely **necessary** (PLAN)"*[32] – in a similar way to the police use of restraint as described earlier. Police use of a CED is collated by the Home Office, as part of the national annual data requirement (ADR) for all uses of force.

3.32 Despite the inherent risks of any use of force, the use of a CED may be deemed safer than restraining an individual by force due to a combination of the latent risks involved in the use of force, and the rapid immobilising effect such non-lethal weapons can induce. The loss of muscle control which can result in 'freezing' or curling up in a ball may allow time for an appropriate medical professional to administer an injected chemical sedative.

3.33 An internal government evidence briefing paper[33] described PAVA as:

> *"PAVA is the synthetic equivalent of capsaicin, the active ingredient in pepper. Its effect is therefore similar to that of pepper spray, also called OC spray. Pepper spray is used widely in the USA and some other jurisdictions as an alternative to physical or lethal force when police are confronted with aggressive or acutely disturbed individuals. PAVA is sprayed into the face in order to incapacitate an aggressive individual, making it easier to get them under control while avoiding the injuries that could be associated with other forms of force."*

3.34 Pepper spray has an intense effect on those sprayed. A recent study[34] describes the common reactions that generally wear off after 15-30 minutes as:

- Burning sensation on the skin and eyes
- Involuntary closing of the eyes
- Affected vision

[30] CEDs are commonly described as Tasers. Taser is a brand name and registered trade mark for a CED.
[31] https://sussex.police.uk/about-us/governance-and-processes/taser/
[32] College of Policing: https://www.app.college.police.uk/app-content/armed-policing/conducted-energy-devices-taser/
[33] First Look Evidence Summary: PAVA (Ministry of Justice)
[34] McGorrigan, J. & Payne-James, J. (201). *Incapacitant sprays: Clinical Effects and Mangement.* Faculty of Forensic and Legal Medicine.

- Discomfit in the nose
- Difficulty in breathing
- Disorientation and feelings of panic

3.35 The government evidence review mentioned above considered the academic literature concerning the effectiveness of pepper spray:

> *"In the majority of cases, ranging from 75% to 85% (Brandl and Shoshine, 2016; Kaminski and Edwards, 1999), pepper spray effectively leads to incapacitation and, according to police reports, makes arrest easier. However in about 10% of cases it appears to have no effect (also true of CS gas) (Rix and Kock, 1996) and in some cases (5-10% - varies somewhat across studies) people become more aggressive or resistant. … Adang et al. (2006) considered the effectiveness of pepper spray in terms of whether it increased police officers' perception of safety. This study found that the vast majority of officers were satisfied with the performance of pepper spray, particularly when the spray incapacitated people."*

3.36 Further analysis would need to be undertaken to consider whether – in the 10% of cases where pepper spray and CS gas is ineffective – this is particularly so for those people suffering from ABD or mental ill-health.

3.37 It is essential that the use of such non-lethal weapons should be administered in conjunction with medical professionals following established protocols to minimise the risk of miscommunication or delay.

4. Conclusion

4.1 As mentioned in the introduction, this paper is designed to present potential options as alternatives to the use of restraint – rather than make recommendations on how best the police should manage operational situations. Central to many of the options is the need for the police and other public services to work effectively. For many of the options outlined in section 3 of this paper, this co-operation could only be undertaken by the services developing clear protocols to ensure communication and delivery is undertaken effectively.

4.2 The IAP hopes that this report will provide helpful content for the Ministerial Board to note at their forthcoming Board meeting on 28 February 2018. The IAP encourages the Board to consider whether any alternative techniques have been left out, and actively seeks examples of situations and case studies where alternative options have been successfully used.

4.3 The Ministerial Board's work programme outlines the expectation that a workshop should be held to discuss the potential alternatives set out in this report further with a group of experts and interested parties. This will allow greater analysis and consideration of the options, based on the learning and experience of those involved. The IAP recommends such further discussion of the options presented in this paper, and encourages collaboration among all relevant partners in the shared effort to minimise the number of deaths involving the use of restraint.