REGULATION 28 REPORT RESPONSE TO MR C DORRIES OBE, HM CORONER FOR SOUTH YORKSHIRE (WEST)

This response is provided to the Regulation 28 Report to Prevent Future Deaths which was prepared following the Inquest touching upon the death of Mr Neil Budziszewski. The report contained 29 matters of concern which were set out in section 5 of the report. The response to each of those concerns, on behalf of the Chief Constable of South Yorkshire Police, is set out below:-

1. *When Mr Budziszewski was first presented to the Ecclesfield afternoon shift custody sergeant he accepted custody without opening a custody record or completing a risk assessment. Whilst it is accepted that Mr Budziszewski was in drink at the time and un-cooperative there appears to have been no thought given to a risk assessment.*

   It is a basic requirement that anyone entering a custody suite should be assigned a custody record and a risk assessment should be completed. This should be done even where the detainee is un-cooperative. This is something which is covered by PACE Code C which is covered in the training provided to custody officers. Having spoken to a sample of custody sergeants during April 2015 an uncooperative detainee under the influence of alcohol is a regular occurrence in custody and a custody record is still routinely opened and a risk assessment completed on the information available and updated in due course. In the future this point will be highlighted in the training and all current staff will be reminded of this requirement by the end of May 2015 by way of briefing document from the Inspectors and rotational training commencing 21 May 2015.

2. *The afternoon custody sergeant failed to complete a Prison Escort Form for a transfer to Bridge Street (for LiveScan identification) in breach of guidance. Similarly, whilst the receiving custody sergeant at Bridge Street commenced a custody record and completed a risk assessment, he also failed to complete a Prison Escort Form for the transfer back.*

   It would appear that this was a commonly misunderstood form across South Yorkshire Police with custody staff believing that the PER form was only required where a detainee was being transferred to the custody of another agency and not internally. Following the outcome of the inquest touching upon the death of Mr Neil Budziszewski the policy has been reviewed and all custody staff have been informed of the requirement for this form to be completed when transferring a prisoner between custody suites or police stations as well as when transferring to an external agency. This will be followed up with a written notification to all custody staff explaining the need for this form to be completed whenever a detainee is moved from custody regardless of the agency transferring the detainee. That notification was circulated following the Inspectors meeting on 15 April 2015 and will be further circulated to all staff by 31 May 2015.

3. *The risk assessment completion at Bridge Street did not include asking Mr Budziszewski if he wanted to see a doctor, if he was on medication or if he was in contact with a medical service. Nor did it document that Mr Budziszewski should be checked every 30 minutes.*

When a detainee has a risk assessment completed, they are not asked whether they want to see a doctor, rather they are asked questions about their current health, welfare and medical needs which would inform the decision about whether or not custody staff believe a doctor is necessary. This is because it is often the case that a detainee does not believe there is a requirement to see a doctor however the custody officer may believe it is necessary.

It is also the case that the risk assessment, once the detainee arrived at Bridge Street, did not refer to the requirement for 30 minute checks because he was never taken to a cell at Bridge Street and was therefore under constant supervision. It is right that if he had been taken to a cell then he record would have been updated with the appropriate check times required.

4. *The Custody Sergeant at Bridge Street gave evidence that he was unable to conduct a full risk assessment because of Mr Budziszewski's lack of compliance. However, no arrangement was made for the risk assessment to be reconsidered at a time when Mr Budziszewski was more compliant (which happened quite shortly thereafter). This officer recognised that an alcoholic who was approaching sobriety is someone who needs to be seen by a health care professional.*

   Whilst Mr Budziszewski was at Bridge Street custody he was not cooperative with the risk assessment process. In any event this should have been reviewed upon his return to Ecclesfield. Custody staff are aware of the importance of the risk assessment and the requirement to regularly review where information is missing and therefore this failure on this occasion is down to officer error and not due to an issue with the training and practices. Appendix A refers to the new risk assessment which has been in force since October 2014.

   In relation to the requirement to call a doctor for alcohol related matters in custody, there are five criteria where a healthcare professional must be consulted, three of those relate to alcohol issues:-

   a. **Registers 150 micrograms on evidence breath test (only applies for OPL detainees)**
   b. Risk Assessment suggests that constant observations level 3 or close proximity level 4 is required;
   c. An epileptic fit occurs
   d. **Particular concerns such as visible head injuries**
   e. **Shows symptoms of alcohol withdrawal, especially delirium tremors.**

   Whilst at Bridge Street custody Mr Budziwzewski was not displaying any of these symptoms.

5. *When Mr Budziszewski was returned to Ecclesfield Police Station, the afternoon Custody Sergeant failed to complete his own risk assessment or query issues arising from the risk assessment undertaken at Bridge Street. It is likely that the escorting officers should have added a great deal of knowledge for the Custody Sergeant about what had been said by Mr Budziszewski at Bridge Street.*

   This relates to point 2. It is accepted that relevant documentation should have been completed for the transport and also that the escorting officers may well have had

relevant information to handover. A new process will be created including a briefing on issues to consider and observe when transporting a detainee and a de-briefing on the detainees return to the custody sergeant. This will be in place by 17 May 2015.

6. *The afternoon Custody Sergeant at Ecclesfield failed to place Mr Budziszewski on 30 minute rousing checks in breach of PACE Code C (paragraph 9.3). Indeed, there was no annotation on the custody record of the level of checks required.*

   It is accepted that Mr Budziszewski should have been on 30 minute rousing checks and that this should have been annotated on the custody record when the checks were undertaken. South Yorkshire police have now moved to fully digital custody records and each check will have to be placed onto the electronic custody record. This system has been in place since 17 February 2015 and it is mandated that the checks have to be carried out. The appropriate checks are preselected in a drop down menu on the electronic system and therefore clearly defined according to the appropriate guidance.

7. *The afternoon Custody Sergeant recognised guidance that a doctor would normally be asked to attend for an alcoholic detainee, but failed to record on the custody record or risk assessment that Mr Budziszewski should be considered for an assessment later on.*

   The new digital custody system will prompt staff to include comments on observations and prescribe the further assessments and checks to be carried out. This is now in place and should negate the risk of similar issues in the future. Training will be provided in relation to the electronic custody system which was brought in on 17 February 2015.

8. *The afternoon civilian Detention Officer believed that Mr Budziszewski had been taken off rousing checks by 8pm because he had been in custody some five hours and rousing 'was no longer necessary'. This seems to be a commonly made informal decision with no record made.*

   This is contrary to training which has been provided. All staff have now been reminded that all decisions regarding checks of detainees must be recorded on the custody record and that if the decision is not recorded then the decision has not been made. This was dealt with with custody Inspectors on 15 April 2015 and other staff will be reminded of this requirement in a briefing document by the end of May 2015.

9. *This Detention Officer felt that he had not been trained on the risks for alcoholics when they are sobering but was aware that they were susceptible to fits and sickness etc., because he had been told by one of the MEDACS nurses some time before. He recognises that this is important information that he had not been trained on.*

   The training programme which has been provided, both the initial training and the annual refresher, make specific reference to the risks of alcohol. South Yorkshire Police Training department have now been asked to incorporate the risks of alcohol withdrawal and acute alcohol withdrawal symptoms into the training and specifically the impact that has on the risk assessment in custody. The training which is provided is based on the Home Office training programme and therefore a limited number of health issues are included within the training. It would be difficult to incorporate all health conditions into this training as time is limited. This will be part of the general guidance which will go out from Inspectors by 31 May 2015 and will be included in the next round of First Aid training provided to custody staff.

10. *There was no consideration given at the time to calling a health care professional, notwithstanding the information gained which included that Mr Budziszewski was an alcoholic and was a prescribed methadone user. The view seems to have been taken that the medical provider would simply refuse to see a detainee until they were no longer in drink. This carries considerable dangers if the detained person's condition was not actually caused by drink but by a head injury or hypoglycaemic state etc.*

    Healthcare provision to South Yorkshire Police is provided by a private company. The practice of that company is that they will not routinely see a detainee where that detainee is under the influence of alcohol and they have been in custody for less than six hours. The only exception is where the factors referred to in paragraph five are present:-

    a. Detainee registers 150 micrograms on evidence breath test (only applies for OPL detainees)
    b. Particular concerns for detainee such as visible head injuries
    c. Detainee shows symptoms of alcohol withdrawal, especially delirium tremors.

    This issue has been addressed with the healthcare providers in our review meeting of 12th May 2015.

11. *The Inspectors review at 9pm indicates that Mr Budziszewski took medication for his alcoholism (which was not strictly correct, he took Tamazepam to assist him to sleep) and states that the Inspector had informed the custody staff of this. That is incorrect, the Inspector's evidence was that he was to return later on and inform the custody staff who were busy at the time but he never did so.*

    Following this error a review is being undertaken to review the training provided to Acting Inspectors required to carry out custody reviews. This will include a new protocol whereby the custody sergeant will be expected to confirm the Inspector's familiarity with the process. The new custody digital log contains the legal requirements of the review with drop down menus and guidance. There is also a piece of work ongoing to collate a pack to be provided to Acting and Temporary Inspectors which will contain information and guidance on completing a custody review. It is hoped that the review and the pack will be completed by 31st May 2015, Appendix B shows a copy of the electronic form the Inspector will need to complete.

12. *The reviewing Inspector had no training in his task, he was simply given the job because he was an available shift Inspector at the police station.*

    Please see the response to 11.

13. *A significant amount of the handwriting on the custody record (notably including that by the reviewing Inspector) was illegible. Yet nobody sought clarification of what had been written.*

    The use of digital logs within the custody suites will negate this issue in future. This has been fully operational since 17 February 2015.

14. *There was unnecessary confusion between the reviewing Inspector and the afternoon civilian Detention Officer as to whether the deceased would be assessed by a health care professional. No referral took place.*

Although the medical referral would be the responsibility of the custody staff, the Inspector has a role to play in requesting the medical referral where, upon review, he or she believes it is necessary. This will all be included within the pack that will be provided to Acting and Temporary Inspectors. Substantive Inspectors will be reminded of this requirement by 31 May 2015.

15. *The afternoon Custody Sergeant told the IPCC investigators that he did not think his custody suite training was fit for purpose. He claimed that this had already been raised by another Custody Sergeant but was aware of anything happening about it.*

    The training provided to all custody sergeants is in accordance, and based upon, the Home Office standards including the most current guidance. In addition to the training which is provided, new staff are inducted with more experienced colleagues who oversee their initial work.

    As well as the initial training which is provided to custody staff, all are provided rotational refresher training which would provide an opportunity for staff to raise concerns about training which was below standard or not fit for purpose. Training have not been provided with this feedback since 2009 and in any event the rotational training and the custody training is in line with the Home Office standard.

16. *The handover from the afternoon Custody Sergeant to night Custody Sergeant did not include information about Mr Budziszewski being prescribed Methadone, that he was an alcoholic, or that he was on 30 minute checks. This was accepted not to be a full and effective handover.*

    The process for handovers is now documented and is consistent across the force. The process is that the sergeant handing over will summarise to the incoming sergeant personal information about the detainee, details of the offence and the stage of the investigation and any specific risk factors. The focus of the handover is to be around the risk assessment which has been completed. Appendix C shows a completed copy of the handover Sergeants are expected to complete. As this is a live copy, third party data has been redacted out to ensure compliance with the Data Protection Act.

17. *PACE requires a health professional to be called if the detainee is dependent on alcohol or drugs. This did not take place.*

    In relation to the requirement to call a doctor for alcohol related matters in custody, there are five criteria where a healthcare professional must be consulted, three of those relate to alcohol issues:-

    a. Registers 150 micrograms on evidence breath test (only applies for OPL detainees)
    b. Risk Assessment suggests that constant observations level 3 or close proximity level 4 is required;
    c. An epileptic fit occurs
    d. Particular concerns such as visible head injuries
    e. Shows symptoms of alcohol withdrawal, especially delirium tremors.

    It is accepted that if Mr Budziszewski was retching in custody he may have been showing signs of alcohol withdrawal and at that stage a doctor should have been called. It is anticipated that the changes to the first aid training will make identification

of alcohol withdrawal significantly easier for custody staff and this should prevent issues such as these in future.

18. *The oncoming (night) Custody Sergeant failed to review the custody record or risk assessment when he came on duty.*

    This will be resolved with the new handover process which will require presentation of the risk assessment at the handover process. This process came into effect some time ago however in July 2014 this was mandated to all custody sergeants.

19. *The night Custody Sergeant brought a young pet dog into the custody suite with him, which he accepted was wholly unprofessional. Whilst there is no evidence that this provided a distraction detrimental to the prisoner on this occasion that might differ should this conduct be repeated by others.*

    This was wholly unacceptable, the staff member accepts the conduct was unprofessional and it is not something which would be expected or tolerated in custody suites in South Yorkshire Police.

20. *Shortly after 3am it was noted by the night Custody Sergeant that the sound of retching could be heard from one of the cells. Investigation by the night Detention Officer showed this to be Mr Budziszewski. This caused his custody record to be reviewed (for the first time) and earlier notation concerning dependence on alcohol and the use of drugs was apparent. No action was taken to refer Mr Budziszewski for medical review even though the doctor was visiting another prisoner in the custody area at the time. No record of this incident was made in the custody record.*

    The custody sergeant would be expected to have requested a medical review for the detainee following this action. PACE Code C is clear and note 9C is clear that if there is any doubt over the condition of a detainee then medical attention should be sought. As discussed at paragraph 17, custody staff will be reminded of this in writing by 31 May 2015 and also in subsequent training. It is also anticipated that the new electronic risk assessment will trigger the requirement for a medical review when it is completed. The electronic custody log will have to be updated regularly and the time the log is updated will be recorded which will provide for greater accountability.

21. *It is accepted that Mr Budziszewski was asked at this stage if he wanted to see a doctor and demurred. However, expert evidence was given that this was unwise and the doctor should have been asked to engage with the prisoner as this was likely to have resulted in co-operation.*

    Code C is clear that even where a detainee refuses or does not respond to the offer of a clinician being called, the decision should be taken to call a medical practitioner where the custody staff have any reason to suspect there is a medical issue. In this case it is clear that the doctor should have been called even when Mr Budziszewski had not requested one. Custody staff have been reminded of the positive obligation on them by 31 May 2015.

22. *No note was made in the custody record of the decision to place the prisoner back on 30 minute checks after the retching episode so that later officers would be aware.*

    It is anticipated that the electronic custody system will assist in the prevention of this type of issue. It will require updates at certain times and gives an indication when checks are carried out late or not carried out. The log will be updated with the time

the entry is put onto the system and therefore an audit trail of the times of the checks will be available. The log will also be legible and easily accessible for the oncoming staff. The new handover process will mean that the risk associated with each detainee is handed over to the custody sergeant and that all risk assessments are reviewed by the oncoming sergeant.

23. *The Prisoner Escort Form for the forthcoming transfer to the Magistrates Court was completed during the night shift. This makes no reference to the risks which were by now known. Expert evidence indicated that the risk of acute alcohol withdrawal syndrome was increasing as time went by rather than decreasing.*

    As referred to in paragraph two, there appear to have been a number of misunderstandings around the Prisoner Escort Form. These errors have now been retrained to custody Inspectors and will be reiterated to custody staff and the details to be included by 31 May 2015.

24. *The night shift civilian Detention Officer made false entries of having carried out cell checks on the deceased at 0335 and 0430. On the first occasion it was written that Mr Budziszewski was asleep and breathing regularly but in fact this entry (written later) was made on the assumption that a visit must have been made at around that time and that is what would have been found.*

    It is difficult for South Yorkshire Police to comment on this particular point at this time as it remains subject to an ongoing independent investigation by the IPCC. South Yorkshire Police would invite the Coroner to revert back to them in the event that he is dissatisfied with the response stemming from that investigation and requires further clarification of South Yorkshire Police policies in this area. Suffice to say that South Yorkshire Police expects, and it is clear to custody staff that it expects, truthful accounts to be placed on custody records.

25. *Towards the end of the night shift the Custody Sergeant informed the civilian Detention Officer that he could go, thus leaving the Custody Sergeant alone. Although only a few minutes were involved, this;*
    a) *Could have placed the Custody Sergeant at severe personal risk.*
    b) *May well have prevented the Custody Sergeant dealing swiftly and appropriately with an issue such as a prisoner collapsed in the cell (i.e. reluctance to open the cell in case the prisoner was faking an illness, resulting in a delay until other persons could be brought in from the other areas of the police station).*

    Staff have been made aware that lone working in custody should not happen and should not have happened. Staff are aware that they need to request additional staff if there is a staffing issue in custody and that only in extreme circumstances would there be a lone member of staff in custody. This will be mandated in writing to custody staff by 31 May 2015.

    As of April 2016, South Yorkshire Police will have large capacity custody suites rather than the smaller more local custody suites. These will all be multi staffed facilities and lone working will not be sanctioned in any circumstances.

26. *The handover from the night Custody Sergeant to the morning Custody Sergeant was incomplete. Whilst CCTV makes plain that Mr Budziszewski was described as an alcoholic, there was no reference to the retching episode or the change in observations. In consequence of this latter point Mr Budziszewski was inadvertently*

changed back from 30 minute checks to 60 minutes without any consideration of needs.

Unfortunately this was an example of extremely poor recording keeping. That cannot be defended however it is certainly below the expectations of South Yorkshire Police. The custody staff involved have all been spoken to following the inquest and advised of this issue and told of the expectations upon them. It is also anticipated that the new handover process should ensure this does not happen going forward and this process will be regularly trained to custody staff, current and new.

27. *Further, the custody record had been incorrectly marked during the night that Mr Budziszewski had been referred to a doctor which would at least be initially misleading to the morning shift although there was obviously no paperwork from a doctor.*

    This unfortunately sometimes happens and even a new electronic log will not completely remove this risk. It is however more noticeable on an electronic log as it is more legible and can be reviewed more quickly and easily so it is anticipated in the event of such an error this will be corrected more quickly. It is also anticipated that the new handover process should assist in the capturing of these errors as the oncoming sergeant is expected to review the custody log and will therefore be made aware of the current status of detainees. Through this process, in this case it is expected that the oncoming custody sergeant would have seen the entry referring to the doctor being called, and have asked the outgoing custody sergeant whether the doctor had been yet. That way the error has been picked up and can be rectified.

28. *The morning Custody Sergeant only reviewed the risk assessment around three hours after coming on duty, claiming that he only then noticed that Mr Budziszewski was an alcoholic. He told the court that this concerned him because for an alcoholic the checks would have been different and a doctor would have been required. In fact, the CCTV makes clear that the oncoming Sergeant was told that Mr Budziszewski was an alcoholic on two occasions but he failed to take the actions that he himself described as necessary.*

    A proper handover process will ensure that the oncoming custody sergeant receives all the information required to safely manage a detained person in their care. Obviously individual error may remain an issue however the process should reduce the risk.

29. *Expert evidence was given that acute alcohol withdrawal syndrome is associated with a high risk of death if not managed properly. The early symptoms such as shaking and retching (both displayed by Mr Budziszewski) indicate a rather lower risk but that could grow with time.*

    This will be picked up as a specific point within the first aid training to custody staff. Training have already been asked to incorporate this into the current training provided, which as described above is compliant with the Home Office standard.