Alcohol and drugs

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Individuals who may have consumed alcohol to any extent or have consumed or packed drugs require an increased level of supervision and monitoring if they are held in police custody.

Alcohol

Where there is evidence of drunkenness, police officers should apply the same process to the custodial process as they would to operational incidents.

Custody officers should assess the effect the alcohol has had on the individual so that they put the correct risk assessment and care plan in place for the detainee.

The custody officer is responsible for ensuring that the correct level of observation and monitoring is carried out.

In the case of **R v Tagg** [2001] EWCA Crim 1230, the Court of Appeal determined that the everyday meaning of ‘drunk’ should be used, as it is not defined by statute. The noun ‘drunkenness’ is described by the judge in s.4 of the case as:

‘Affected by alcohol in the body to such an extent that one is without full or proper control of one’s faculties or behaviour’.

They accepted the Collins English Dictionary and Oxford Dictionary definitions as being materially the same, ie:

- intoxicated with alcohol to the extent of losing control over normal physical and mental functions (Collins)
- having drunk intoxicating liquor to an extent which affects steady self-control (Oxford)

Differing levels of drunkenness pose different risks to the detainee. Not only can alcohol be lethally toxic in itself, but it can also mask the effects of head injury, drug abuse or physical and mental ill health, which could have lethal consequences. The most serious risk is posed by a person who is drunk and incapable.

Drunk and incapable

For the purposes of this guidance, a drunk and incapable person is someone who has consumed alcohol to the point that any of the following applies:

- they cannot walk or stand unaided
- they are unaware of their own actions
- they are unable to fully understand what is said to them

If someone appears to be drunk and is showing any aspect of incapability which is perceived to be as a result of that drunkenness, officers should treat that person as drunk and incapable.

Drunk and incapable individuals are in need of medical assistance in hospital and officers should call an ambulance immediately.

If a drunk and incapable person who is under arrest declines or is refused medical treatment, officers should only take them into custody at a police station as a last resort. The fact that a person has declined or has been refused treatment does not absolve the police or the medical services of their responsibility.

The **Mental Health Crisis Care Concordat** states that intoxication is not a reason to refuse a person access to a health-based place of safety when officers and staff suspect that person is experiencing mental health issues.

Forces should agree a protocol with local healthcare agencies for dealing with people who are drunk and incapable. This protocol should include escalation procedures for quickly resolving issues of responsibility for drunk and incapable people.

For further information, see **National Policing Improvement Agency (NPIA) (2011) Template Protocol for the Management of Detainees who are Intoxicated and Incapable in a Public Place** (scroll down the page for documents relating to police liaison).

Under the influence of drugs or alcohol

Officers and staff must risk assess all detainees on arrival in custody and throughout their detention. Where a risk assessment shows that the person is not drunk and incapable but that they have a degree of impairment from alcohol or drugs, the minimum requirement is for level 2 rousing checks for all persons under the influence and subsequent escalation depending on the perceived level of intoxication. Even with level 3 and level 4 observation/supervision, rousing is still required at appropriate intervals – see the **Police and Criminal Evidence Act 1984 (PACE) Code C, Annex H**.

The amount of alcohol and/or drugs that a detainee has taken cannot be readily confirmed and their reaction to them is also unpredictable. Monitoring the response to Annex H rousing checks helps ensure that any underlying medical condition (such as head injury or undeclared drug abuse) is identified as soon as practicable.

A detainee's unwillingness or inability to participate in a risk assessment should be seen as an additional risk factor. Where necessary, officers should consult a healthcare professional (HCP).

Officers must always consult an HCP if:

- the risk assessment indicates that level 3 or level 4 monitoring is required
- a person detained for an evidential breath test registers more than 150 micrograms of alcohol
- a custody officer has particular concerns about a person who is believed to have consumed alcohol or drugs and has been physically restrained
- the person experiences an epileptic seizure
- the detainee shows signs of alcohol withdrawal, especially delirium tremens (DTs) – if an HCP is not immediately available to assess a detainee who has fitted or has DTs, officers should immediately transfer the detainee to hospital

Rousing detainees who are under the influence of alcohol involves using a stimulus designed to elicit a response from the detainee. This method of managing detainees who have consumed alcohol and/or drugs minimises the possibility of missing a more serious underlying medical condition.

Initial care (custody officers and staff)

Custody staff are required to carry out healthcare-related duties in the custody suite when an HCP is not immediately available. This may include initial care for detainees with the following conditions:

- hypothermia
- hypoglycemia (low blood sugar, which, if untreated, may cause brain damage)

Under these circumstances, officers should call an ambulance and seek the immediate assistance of an HCP.

If a detainee is vomiting and has an impaired level of consciousness, officers should transfer them to hospital as there is a risk of choking or aspirating vomit.

If a person appears to have collapsed, officers should check their airway, breathing and circulation and place the person in the recovery position, if safe to do so. The officers should commence resuscitation if required.

Officers should always transfer children and young persons who are drunk and incapable to hospital as they have a heightened risk of complications associated with alcohol intoxication, such as hypoglycemia.

Having consumed alcohol but not (or no longer) under the influence

Officers should be very careful when assessing the effects of alcohol on a detainee on arrival in custody. Some detainees who have consumed alcohol may not display any signs or symptoms of impairment so might not be considered to be **under the influence**. Some detainees may become more intoxicated due to recent consumption and the effects of absorption.

Where there is doubt about the level of intoxication, officers should institute rousing checks along with an appropriate level of observation. They should take into account any additional factors identified in the risk assessment (such as illness or injury, drug abuse) when setting or amending a care plan. People who have consumed alcohol may still need to be checked more frequently than those who have not.

Detainees sober up over time and there may come a point where the custody officer no longer has heightened concerns for a detainee who is not displaying any symptoms of impairment. The custody officer may then decide that the detainee is no longer considered to be under the influence and no longer requires continued rousing in accordance with PACE Code C, Annex H.

All such decisions must be based on current and up-to-date risk assessment. Officers must fully record decisions in the custody record and include the reasons for reducing heightened checks.

For further information see APP on **risk** and the **National Decision Model**.

Additional risks associated with alcohol

Alcohol-related offending accounts for a significant proportion of all arrests. Staff tend to take longer to identify a health problem where detainees are experiencing the effects of alcohol. The health of a detainee who has consumed alcohol is likely to deteriorate more quickly than that of a detainee who has not. The detainee may also have consumed alcohol or be experiencing alcohol withdrawal which, in addition to complicating other presenting signs and symptoms, carries a significantly increased risk of morbidity and mortality if left untreated.

When dealing with persons believed to have consumed alcohol, staff must pay attention to these key risks:

- alcohol is a poison in its own right and detainees can die of alcohol poisoning
- head injuries are often masked by drunkenness – symptoms of a serious injury to the head are the same as common signs of drunkenness (such as slurred speech, drowsiness and vomiting)
- people with diabetes may behave in such a way that they appear to be drunk and/or aggressive
- drug misusers may appear to be drunk when they have overdosed
- where an individual is well known or familiar to police officers and staff, there is an increased risk that symptoms of serious illness or injury may go unnoticed, such as regular detainees associated with alcoholism or drug abuse
- the Police National Computer (PNC) may show that other serious medical conditions are present
- detainees who have consumed alcohol, are withdrawing from alcohol or who are problematic users are at an elevated risk of suicide or self-harm
- detainees should be able to stand and walk unaided and say a few words. If not, they should be transferred to hospital rather than being put in a cell

PNC warning markers include:

- AT – may have medical condition
- MN – may suffer from mental disorder
- CO – contagious

Additional risks associated with drugs

An HCP should medically assess all detainees believed to be under the influence of drugs. The detainee may also have consumed alcohol or be experiencing alcohol withdrawal which, in addition to complicating other presenting signs and symptoms, carries a significantly increased risk of morbidity and mortality if left untreated.

Drugs pose serious risks to detainees, including:

- overdose – including later onset of symptoms which were not immediately obvious on arrival in police custody
- swallowing or packing
- complications linked with alcohol
- drug withdrawal
- mental ill health
- existing physical illnesses, such as heart conditions
- heightened risk of self-harm

Features of toxicity for commonly encountered drugs include:

- cocaine (agitation, dilated pupils, seizures, raised body temperature, fast pulse, chest pains, irregular heartbeat)
- heroin (nausea, vomiting, pinpoint pupils, eyelids closing, respiratory depression, lethargy, drowsiness and difficulty to rouse, loss of consciousness)
- cannabis (anxiety, hallucinations and loss of consciousness)
- amphetamines (nausea, vomiting, dilated pupils, fast pulse, sweating, seizures)

Drugs are often taken in combination, which may alter the features of toxicity seen and may increase the risk of death in custody.

Swallowed or packed drugs packages

Concealing illicit drugs such as heroin, cocaine and cannabis in the body has become increasingly prevalent among drug couriers, known as mules or body-packers. Drug packages may also be hidden in this way around the time of arrest or during transport. Wrapped packages of drugs are either swallowed or concealed in body orifices. It is common practice for persons to swallow drugs to avoid detection by the police.

For further information, see **NPIA (2011) Template Protocol for the Management of Detainees who are Suspected of Swallowing or Having Packed Drugs or Foreign Objects into Body Orifices or Cavities**.

Procedure

If officers know or suspect that a detainee has swallowed or packed drugs, either for the purpose of trafficking or to avoid imminent arrest or detention by the police, they must treat the person as being in need of urgent medical attention and transfer them straight to hospital. Leakage from a package can prove fatal. If a package is swallowed to avoid detection, it is likely to have been prepared hastily and there is an imminent risk that it may come open or burst inside the person. If this happens, death can quickly follow, particularly when the person has swallowed crack cocaine.

The risk from swallowing or packing drugs depends on the type of drug, the number of packages and the type of packaging used. An X-ray may be conducted to determine what has been swallowed.

When drug swallowers are returned to custody from hospital, officers should consider the following:

- before accepting a detainee for return to custody, the escorting officers should ask the doctor in charge of the detainee or the A&E manager to provide clear written advice for inclusion in the detainee’s care plan
- detainees may still have drug packages in their bodies and hospital tests and observation will not always detect them
- the detainee will continue to be at risk of deterioration, which may be either slow or sudden

Policy

Forces, in partnership with healthcare trusts, should develop local policies and protocols for assessing, treating and observing cases where drugs have been swallowed or packed. If the detainee has been brought to a custody suite, officers must call an ambulance immediately. Officers must open a custody record, but this must not delay transfer to hospital.

Border Force may ask custody officers to accept and charge detainees who have swallowed packed drugs. A specific protocol has been drawn up with Border Force to cater for this circumstance. Individual forces should consider local agreement. Forces should designate which custody offices will accept such detainees.

Rousing and consciousness (alcohol and drugs)

Custody staff are required to rouse and speak to any detainee whom they suspect to have consumed alcohol or drugs, or both, at a minimum level of every 30 minutes (level 2). There are particular conditions to look for when rousing and checking detainees who have consumed alcohol. Where a person becomes harder to rouse, the change may be due to serious unidentified medical conditions such as:

- head injuries
- drug intoxication or overdose
- stroke

Where detainees are unusually quiet or snoring, this can be a significant indicator of risk. Detainees who are snoring may have an upper airway obstruction. Officers should rouse and check them at least every 30 minutes (level 2) until they can talk coherently.

Where a detainee fails to respond to rousing at the appropriate level, or if there is a decline in their condition or their level of consciousness (for example, if speech becomes incoherent), officers must seek immediate assistance from an HCP or transfer the detainee directly to hospital.

Officers must record details of the detainee’s condition and level of responsiveness in the custody record following each check.

Police forces and custody officers should ensure staff are aware of the criticality of such checks and forces should have audit systems in place, even where CCTV is present.

Sudden collapse

The vital actions in this situation are:

- check for a response
- if there is no response, open the airway and check for breathing
- call an ambulance, clearly state that there has been a collapse and that it is an emergency
- if breathing is persistent, carry out a secondary survey and put the detainee in the recovery position
- if they are not breathing, start CPR
- if an automated external defibrillator is available, follow the written and verbal instructions provided
- continue until the paramedics are able to take over

Rehabilitative diversion

When considering charges for offences which have involved alcohol or drugs, the CPS has the option of issuing a conditional caution, to which restorative or rehabilitative conditions are attached. For example, a condition may be imposed that the detainee must attend an alcohol or drug awareness course or similar with a local agency.

Such referrals are most effective when directed to offenders who have committed minor offences where alcohol or drug abuse was a contributing factor, rather than for alcohol or drug dependent people.

Youth conditional cautions can be given under **section 66A** of the Criminal Justice and Immigration Act 2008. See also **CPS (2013) The Director's Guidance on Youth Conditional Cautions**.

Police can liaise with local health and social care services to divert a detained person with alcohol and/or drug dependency into treatment or to offer them support, taking into account their particular psychological or psychiatric needs.

Tags

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