5. Place your hand just above the knee and roll the casualty towards you and on to their side

6. Adjust the uppermost leg so that both the knee and hip are bent at right angles

7. Tilt the head back to keep the airway open

8. Ensure medical assistance has been summoned
9. Check breathing regularly. If there is any doubt about the presence of normal breathing, start CPR
10. If the casualty has to be kept in the recovery position for more than 30 minutes, turn them to the opposite side to relieve the pressure on the lowest arm

**Note:-** A pregnant casualty should be placed into the recovery position on their left side.

## Review:

You can approach the casualty, assess circumstances and place the casualty in the recovery position ☐

## Learning Log:

How will what you have learned in this module impact your day-to-day role?

Are there any skills or knowledge you would like to develop further following this module?

## End of Module

**Unit 1**
**Lesson 4**
**Choking**

## Introduction

Recognition of choking (airway obstruction by a foreign body such as food) is of key importance to a successful outcome.

It is important not to confuse choking with other conditions such as chest pain, seizure or other respiratory conditions.

Foreign bodies may cause either mild or severe airway obstruction.

### Lesson Aim:

The learner will be able to recognise and treat a casualty who is choking

### Learning Outcomes:

The learner can:-

1. Identify the treatment for a mildly obstructed airway (pg. 2-3)
2. Identify the treatment for a severely obstructed airway (pg. 2-3)
3. Describe the treatment for an unconscious choking casualty (pg. 2-3)

## General Signs of Choking

- Attack occurs while eating
- Casualty may clutch their neck

## Signs of Airway Obstruction

- Response to question “Are you choking?”, or casualty may respond by nodding
- Casualty speaks and answers "yes", or physically indicates so (**Mild obstruction**)
- Breathing sounds wheezy
- Casualty may be able to cough and take rasping breaths
- Casualty unable to speak if the airway is completely blocked or attempts at coughing are silent (**Severe obstruction**)
- Casualty may respond by nodding
- Casualty may be, or become unconscious

## Treatment

- Firstly, ask the casualty “are you choking?”

### Adult Choking Sequence (also suitable for children over the age of one year)

1. If the casualty is showing signs of an airway obstruction, encourage them to cough. If the choking is only mild, this should clear the obstruction.

If the obstruction is not cleared:

2. Provide up to 5 back blows:-
    - Bend the casualty forward slightly
    - Give up to 5 firm blows between the shoulder blades with the heel of your hand
    - Check between blows and stop if the obstruction has been cleared

3. If the obstruction has not been cleared, give up to 5 abdominal thrusts (not suitable for children under the age of 1 year):-

- Stand behind the casualty
- Place both your arms around their waist
- Make a fist with one hand and place it just above the casualty's belly button (below their ribs), with your thumb inwards
- Grasp your fist with your other hand, then pull sharply inwards and upwards. Do this up to 5 times
- Check between thrusts and stop if the obstruction has been cleared
- If the casualty is obese or pregnant, attempt thrusts by squeezing the casualty's chest instead
- If the obstruction has not been cleared, continue alternating 5 back blows with 5 abdominal thrusts
- If the treatment seems ineffective, an ambulance should be requested, but do not interrupt the back blows and abdominal thrusts sequence

- If the casualty becomes unconscious and is not breathing normally, begin CPR
- After successful treatment, any casualty who has received abdominal thrusts and any casualty with a persistent cough, difficulty swallowing or with the sensation of an object still in the throat should seek immediate medical attention

**Note:-** Do not attempt to remove an object from a casualty's mouth or place your hands on a casualty's throat to prevent swallowing.

## Review:

- You can identify the treatment for a mildly obstructed airway ☐
- You can identify the treatment for a severely obstructed airway ☐
- You can describe the treatment for an unconscious choking casualty ☐

## Learning Log:

How will what you have learned in this module impact your day-to-day role?

Are there any skills or knowledge you would like to develop further following this module?

## End of Module

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PROBATIONER TRAINING PROGRAMME

**Unit 1**
**Lesson 5**
**Chest Pains**

## Introduction

The first step in saving a life is being able to recognize an emergency. Know the warning signs of a heart attack. Anyone who is unresponsive should receive emergency care. If you are with someone who complains of chest pain and then collapses, odds are they are having a heart attack or is in cardiac arrest.

The heart is supplied with blood via the coronary arteries, which divide and sub-divide like the branches of a tree. If one of the arteries becomes blocked, the part of the heart muscle that is supplied beyond that blockage site will be deprived of oxygen, resulting in damage.

### Lesson Aim:

The learner will be able to recognise and treat a casualty who is experiencing chest pains

### Learning Outcomes:

The learner can:-

1. Describe the recognition features of a person experiencing chest pains (pg. 2)

2. Explain the treatment protocols for a person experiencing chest pains (pg. 2)

## Signs and Symptoms

Not all of the following signs and symptoms may be present:-

- Severe chest pain or discomfort (often described as a vice-like crushing weight or tightness)
- Pain which radiates across the chest, up into the jaw and/or down the arms
- Cold, Pale and clammy skin
- The casualty may be feeling sick, or may vomit
- Breathlessness
- Anxiety
- The casualty may become unconscious

## Treatment

- Call an ambulance
- The aim is to reduce the workload of the heart
- Have the casualty sit in a position which they find comfortable. A half sitting position with the knees raised is often the best ('W' position)
- Loosen any tight clothing
- Allow the casualty to take any prescribed medication such as a GTN spray
- Reassure the casualty
- Remove any cause of stress or anxiety if possible
- If the casualty becomes unconscious and stops breathing normally, begin CPR

## Review:

You can describe the recognition features of a person experiencing chest pains ☐

You can explain the treatment protocols for a person experiencing chest pains ☐

## Learning Log:

How will what you have learned in this module impact your day-to-day role?

Are there any skills or knowledge you would like to develop further following this module?

## End of Module

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**Unit 1**
**Lesson 6**
**Seizures**

## Introduction

A seizure (also known as a fit or convulsion) is caused by a sudden, temporary burst of electrical activity in the brain. This interrupts the brain's normal electrical messages which become mixed up or halted. The type of seizure will depend on where in the brain the electrical activity is, how widely and rapidly it might spread.

Common causes of seizures include head injury, drug intoxication, poisoning and stroke. Those with epilepsy have recurrent seizures ranging from frequently to long periods in between seizures.

There are two main types of seizures:

- Partial or absence seizures
- Convulsive seizures

### Lesson Aim:

The learner will be able to recognise and treat a casualty suffering from a seizure

### Learning Outcomes:

The learner can:-

1. Describe recognition features of a convulsive seizure (pg. 2)
2. Describe recognition features of a partial/absence seizure (pg. 2)
3. Describe the management of a convulsive seizure (pg. 3)

## Partial or Absence Seizures

Partial or absence seizures involve electrical activity in just a part of the brain. In a partial seizure there may be localised jerking or twitching, the casualty may pluck at their clothes, smack their lips, swallow repeatedly or wander around (daydreaming/dazed). Sometimes the casualty may be aware of what is happening, sometimes not. Generally these only lasts for a short time

A partial seizure may be followed by a generalised seizure if the excess electrical activity spreads to the rest of the brain.

### Management of Partial/Absence Seizures

- Guide away from dangers
- Stay with the casualty until they become fully alert
- Advise the casualty of the event
- If the casualty is unaware of their condition, advise them to see their doctor

## Convulsive Seizures

A convulsive seizure involves electrical activity in the whole brain, so usually the whole body is affected. It is common for a seizure to start as a partial seizure and then become generalised if the excess electrical activity spreads to the rest of the brain resulting in unconsciousness and convulsive movements.

- ‘Tonic’ phase - Every muscle in the body suddenly becomes rigid. The casualty may let out a cry and become unconscious. Breathing may stop and the lips may become blue. This phase typically lasts less than 30 seconds
- ‘Clonic’ phase - Breathing resumes but may be shallow and could be loud like snoring. The limbs of the body make sudden, violent jerking movements, the eyes may roll, the teeth may clench, saliva may drool from the mouth (sometimes blood-stained as a result of biting the tongue) and breathing could be loud like 'snoring'. The casualty may lose control of the bladder and/or bowel

## Management of Convulsive Seizures

Gently cushion the casualty's head to help avoid injury. This can be done simply with a folded coat or similar soft item.

- Loosen any tight clothing around the neck to help the casualty breathe
- Move any objects from around the casualty that may harm them
- DO NOT PUT ANYTHING IN THE MOUTH
- DO NOT try to hold the casualty down or restrain them
- Only move the casualty if they are at risk of further injury.
- Take note of the exact time the seizure started and its duration

### Call an ambulance if:-

- The seizure lasts more than 5 minutes
- The casualty's levels of response do not improve after the seizure within 5 minutes
- The casualty has a second seizure
- The casualty is not diagnosed as epileptic or this is their first seizure
- The seizure lasts 2 minutes longer than is 'normal' for the casualty
- You are unsure

### As soon as the seizure stops:-

- Check Airway and Breathing - Perform CPR if indicated
- Place the casualty in the recovery position if they are breathing normally
- Keep the casualty warm
- Monitor Airway and Breathing
- Check the levels of response regularly. Call 999 for an ambulance if they don't improve within 5 minutes (or for any of the reasons mentioned above)

**Key Information** KI

Immediately following cardiac arrest, blood flow to the brain is reduced to virtually zero. This may cause a seizure-like episode that can be confused with epilepsy.

## Review:

- You can describe the recognition features of a convulsive seizure ☐
- You can describe the recognition features of a partial/absence seizure ☐
- You can describe the management of a convulsive seizure ☐

## Learning Log:

How will what you have learned in this module impact your day-to-day role?

Are there any skills or knowledge you would like to develop further following this module?

## End of Module

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# Unit 1
# Lesson 7
# Positional Asphyxia

## Introduction

Officers/staff should be familiar with the danger of Positional Asphyxia. Positional Asphyxia can occur when a person is placed in a position that interferes with inhalation and/or exhalation, and cannot escape that position, usually when placed on their front. It is most commonly found in persons intoxicated with alcohol and/or drugs, or with a reduced conscious level from head injury. Persons who have been sprayed with irritant spray are also at an increased risk.

Death can occur rapidly as a consequence, and there have been cases where Police Officers have been found liable.

## Lesson Aim:

The learner will be able to explain the risk factors associated with Positional Asphyxia

## Learning Outcomes:

The learner can:-

1. Describe the risk factors that increase the risk of Positional Asphyxia (pg. 2)

2. Describe the ongoing management of Positional Asphyxia (pg. 2)

The risk factors which contribute to the condition are:-

- Physical position (in car/van foot wells, cage vans where the casualty may be slumped forward or face down)
- Restraint
- Alcohol and or Drugs
- Age
- Obesity
- Exhaustion/Fatigue
- Respiratory illness
- Disability

During prolonged restraint, where the subject is placed in a prone position, ventilation can become more difficult, due to the internal organs exerting pressure on the diaphragm. Where the person's hands are restrained to the rear, the effect is an isolating of the pectoral muscles, which further restricts breathing ability.

## Signs and Symptoms

Officers/staff must pay close attention to the person for the following signs and symptoms:-

- Body position - restricted to prone, or slumped forward
- Gurgling or gasping sounds
- Behavioural changes - an active person may suddenly become passive or a loud person may become quiet
- Panic
- Person verbalises that they cannot breathe

## Treatment

- Officers/staff must remove a person from the prone position as soon as reasonably practicable following restraint
- Any cases of Positional Asphyxia must be treated as a medical emergency
- If the casualty becomes unconscious and stops breathing normally, begin CPR

## Review:

You can describe the risk factors that increase the risk of Positional Asphyxia ☐

You can describe the ongoing management of Positional Asphyxia ☐

## Learning Log:

How will what you have learned in this module impact your day-to-day role?

Are there any skills or knowledge you would like to develop further following this module?

## End of Module

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**Unit 1**
**Lesson 8**
**Acute Behavioural Disturbance**

## Lesson Aim:

The learner will be able to recognise and manage a casualty who is suffering from Acute Behavioural Disturbance

## Learning Outcomes:

The learner can:-

1. Summarise the recognition features of Acute Behavioural Disturbance (pg. 1-2)
2. Describe the ongoing management of Acute Behavioural Disturbance (pg. 3)

## Introduction

Acute Behavioural Disturbance (ABD) is the accepted terminology adopted by the UK Police Forces, the Ambulance Services and the Faculty of Forensic and Legal Medicine2. There is no standard definition, but it comprises a triad of acute delirium, severe agitation or aggression, and autonomic disturbance (e.g. hyperthermia). It is usually associated with drug use, or acute substance withdrawal, but can also be caused by other medical conditions or serious mental illness. Around 10-20% of cases of acute behavioural disturbance are caused by pure psychiatric disturbance.

Sudden death occurs in around 10 percent of presentations.

**Acute Behavioural Disturbance is characterised by three factors:-**

- Delirium (altered thought processes, confusion, hallucinations)
- Agitation and/or aggression
- Abnormal physiology (raised body temperature, fast heart rate, metabolic abnormalities)

Persons suffering from ABD can die suddenly, or shortly after a violent struggle, while at hospital or in custody. There are no warning signs to indicate when a person may suffer cardiac arrest.

There are a number of possible causes for ABD, these include:-

- Drug intoxication (including Psychoactive Substances)
- Cocaine is the best known cause of drug induced ABD but other drugs are equally likely to cause it
- Alcohol intoxication
- Drug or alcohol withdrawal states
- Psychiatric illness
- Acute brain injury
- Acute illnesses resulting in brain inflammation, metabolic problems or limited supply of oxygen to the brain
- Hypoglycaemia (low blood sugar)

## Signs and Symptoms

Persons suffering from ABD may present the following signs and symptoms:-

- Constant/near constant activity
- Abnormal strength
- Abnormal tolerance to pain
- Irritant sprays may not work
- Hallucinations, hiding objects, running around, or pulling their clothes off
- Non-responsive to presence of authority figures/unable to follow commands
- Rapid breathing or panting
- Resistant to fatigue
- Violent, shouting or panicking
- Sweating, possibly profusely
- Skin may be hot to the touch
- Attracted to/attempt to destroy glass and reflective objects
- May suddenly become subdued or even collapse after a bout of extreme violence

**Key Information** KI

Officers/staff must treat persons suffering from ABD as a medical emergency.

## Management of Persons with ABD

It is recognised that controlling a person suffering from ABD will always be very difficult. Officers/staff may have to place the person face down on the ground in order to restrain and handcuff them safely. Whilst the risks of Positional Asphyxia affecting a person who are presenting symptoms of an ABD are far greater than for a normal violent person, sudden death as a result of cardiovascular collapse and extreme abnormal physiology is more likely.

Persons experiencing ABD must be examined at hospital - even if they suddenly calm down before they get there. They can collapse very suddenly and attempts to resuscitate are usually unsuccessful. Be mindful that:-

- Once handcuffed, officers/staff should try not to hold the person face down
- Immediately after the person comes under physical control, they should be placed onto their side or into a sitting, kneeling or standing position. Prolonged restraint in the prone position must be avoided
- Call for immediate emergency medical assistance and transfer to hospital
- Observe the person's condition continually whilst being restrained, as cardiac arrest can occur suddenly, and develop beyond the point of viable resuscitation within seconds rather than minutes
- If the casualty becomes unconscious and stops breathing normally, begin CPR

**Note:-** Collapse can occur even in the recovery position, especially if the person continues to struggle against the restraint.

## Review:

You can summarise the recognition features of Acute Behavioural Disorder ☐

You can describe the ongoing management of Acute Behavioural Disorder ☐

## Learning Log:

How will what you have learned in this module impact your day-to-day role?

Are there any skills or knowledge you would like to develop further following this module?

## End of Module

**Unit 1**
**Lesson 9**
**Head Injury**

## Introduction

A head injury has the potential to be a very serious condition. Injuries to the head can often lead to unconsciousness, which in turn compromises the airway. Head injuries may result in permanent damage to the brain.

Common head injuries include concussion, bleeding within the skull and fractured skull.

It is important that officers recognise that alcohol/drug intoxication, hypothermia, stroke and low blood sugar levels can present with similar symptoms to that of a head injury. It is also important to remember that any casualty with a head injury could also have a neck injury.

### Lesson Aim:

The learner will be able to recognise and manage who is suffering from a head injury

### Learning Outcomes:

The learner can:-

1. Describe recognition features of a head injury (pg. 2)
2. Describe the ongoing treatment for a head injury (pg. 2)

## Possible Signs and Symptoms

- A history of an occurrence which would support the consideration of a head injury
- Blood or clear fluid (cerebrospinal fluid) leaking from the ears or nose
- Confusion, irritability and behavioural issues
- Short term memory loss (particularly of the incident)
- Bleeding, swelling or bruising
- Soft areas of the skull or deformities such as depressions

## Treatment

If any of the above signs or symptoms are present call an ambulance or seek medical attention. Then:-

- Control any bleeding
- Maintain and monitor airway and breathing
- Call for an ambulance
- Provide reassurance
- Place the casualty in the recovery position if unconscious