HOUSE OF COMMONS

Home Affairs Committee

Oral evidence: Spiking, HC 967

Wednesday 19 January 2022

Ordered by the House of Commons to be published on 19 January 2022.

Watch the meeting

Members present: Dame Diana Johnson (Chair); Ms Diane Abbott; James Daly; Simon Fell; Tim Loughton; Stuart C. McDonald.

Questions 67-136

Witnesses

I: Dr Adrian Boyle, Vice President, Royal College of Emergency Medicine; and Jade Quittenton, Night-time Economy Lead, St John Ambulance.

II: Councillor Jeanie Bell, Member of the Local Government Association Safer and Stronger Communities Board and Cabinet Member for Community Safety at St Helens Council; Paul Fullwood, Director of Inspections and Enforcement, Security Industry Authority; and Michael Kill, CEO, Night Time Industries Association.

Written evidence from witnesses:

- Local Government Association (SPI0021)
- Royal College of Emergency Medicine (SPI0017)
- Security Industry Authority (SPI0015)
- St John Ambulance (SPI0009)

Examination of witnesses

Witnesses: Dr Adrian Boyle and Jade Quittenton.

Q67 **Chair:** Good morning, everybody. This is the second session of the Home Affairs Committee's inquiry on spiking. We have two panels this morning. The first panel is Jade Quittenton, night-time economy lead from St John Ambulance—you are very welcome—and, on Zoom, Dr Adrian Boyle, who is head of emergency medicine for the NHS, it says here, but I am not sure that is the right title.

Dr Boyle: For the Royal College of Emergency Medicine.

Chair: Thank you. We have a series of questions for both of you. We are very pleased to have you with us. I will start by asking how widespread spiking is. We on this Committee want to look at data. We have been very struck so far by the lack of data on spiking. Dr Boyle, could you start us off with your understanding of the prevalence of spiking, and say what data is available?

Dr Boyle: You are right to identify that there is a gap in our knowledge around the epidemiology of drink and needle spiking. It is largely based on anecdote. We see quite a few people who present to our emergency departments with allegations of spiking, but that data is not recorded in any particular format. We recommend—it is only a recommendation and guidance—that this be recorded under what we call the ISTV, or information sharing to tackle violence. That is a system in which receptionists record data about assaults, whatever the cause. That is done in an open area, so there are problems with disclosure. That information is collated and shared with community safety partnerships on a monthly basis, to inform the activities of the community safety partnership.

There is no hard, reliable data on the prevalence of spiking at the moment. There are a few, low-quality research studies, in which people have looked at what happened with people who turned up at hospital and alleged drink spiking, but we cannot quantify that properly.

Q68 **Chair:** Thank you. Jade, would you like to give your understanding of the prevalence of spiking?

Jade Quittenton: Yes, of course. I do have some data; I don't know if this is a good time to share that information. It is worth noting that this data was collected from 12 November to 7 January. At the time, night-time economy projects were running 12 services across the country. We collected data on spiking reported across 10 of those services; of those involved, 32 were female, 10 were male, and two preferred not to state their gender. Looking across all genders, it was predominantly females in the age range of 18 to 25.

Chair: We have some questions about the projects that you have been running. I turn to James Daly to ask some questions.

Q69 **James Daly:** I thank the witnesses for the work you do on this. We have a briefing in front of us setting out the work you do, but could you talk

briefly about your work in this area, as organisations and individuals?

Jade Quittenton: Yes, of course. Our night-time economy service operates across the country. Back in 2019, we operated with four services only: Newcastle, Norwich, Birmingham and Manchester. As time has gone on, the intention has been to expand the service, predominantly because there is a need for this type of service.

We operate Friday and Saturday evenings from 9 pm to 3 am, although that can go on longer. We are there predominantly to reduce hospital admissions and give support. At the treatment centre, we can treat people there and then; they don't have to be transferred to hospital if we can treat them. That said, the purpose is to treat those who are intoxicated, and there may have been an assault or a head injury.

Q70 **James Daly:** So the very valuable work that you do may involve people who are under the influence of some substance, for any one of a number of reasons, and you are there to help and assist. As part of that service, you are able to ask questions that give you data on the prevalence of spiking.

Jade Quittenton: Yes.

Q71 **James Daly:** I just want to ask about the link. You have very helpfully given us some data on spiking. Apart from the help, assistance and treatment you provide, do you have any interaction with the police or the authorities when somebody says something about spiking?

Jade Quittenton: We do, yes. In terms of the work that we do, every night-time economy service is unique. Particular services work closely with local police teams; they are on site with us to support the volunteers and to deal with situations that may arise. A lot of requests for this type of work do come from councils and local authorities. We don't at this moment share that type of data.

Q72 **James Daly:** It is really helpful to have before the Committee an organisation that is involved with this on the ground, and that can give us information on the areas involved in your work, but I am interested in the link. We can talk about the physical act of spiking, but when we were speaking to witnesses in the previous evidence session, we came on to what the criminal justice sanction will be, if spiking has happened. I wondered what happens when somebody comes to you with the suggestion that there has been spiking. Does a call go to the police to say that there is an allegation? Perhaps the police are already there. Could you give us examples of the immediate response from the police when an allegation of spiking is made to them?

Jade Quittenton: I haven't had any interaction with the police in that type of situation. From the St John Ambulance point of view, the main purpose is to treat the patient who is presenting to us, and to treat them with dignity and respect, without any judgment. We want to make sure that the person is safe and well. The main priority is to get that person to hospital, if need be. I can't personally speak to what the police do with that information.

Q73 **James Daly:** Of course. Jade, that is very helpful; thank you. Can I ask two very quick questions to Dr Boyle? You are doing an incredible job in the NHS in general, but also in this area. I am sorry if this is a naive question, but when somebody comes in, how does one establish whether they have been spiked? I am not asking for the physical signs; I am asking for the response, in terms of you, the NHS, and the person coming in.

Dr Boyle: It is not a naive question at all. It is actually a very pertinent question. Lots of people turn up who are concerned that they may have been spiked in some way, and it is usually from alcohol; there is concern about whether something was put in their drink. Needle spiking is a much smaller problem.

A number of research studies show that in the majority of cases, when people attend emergency departments with concerns about being spiked, and blood and urine samples are taken and sent off for detailed toxicology analysis in a research laboratory—that is a much more detailed look than we could take in a hospital for clinical practice—no sedative drugs are found. Now, it is perfectly possible that alcohol was used as a spiking agent. Adding a bit of extra vodka to a drink that was not expected to have that amount of alcohol in it may achieve the perpetrator's desired effect.

When patients turn up at emergency departments, we are not there to provide a forensic service. There is often a lot of unhappiness that we are not taking samples and sending them off, to find out what happened. When people turn up at emergency departments with an allegation of spiking, our first job is asking whether there is a threat to life. Is this causing a medical problem that requires the attention of a doctor? Have they become acutely psychotic? Are they seeing things, or hallucinating? Are they becoming unconscious? Are they developing some other consequence of ingesting poison? The vast majority of cases that we see don't have any of those, and we tend to send them home without doing any testing.

Q74 **James Daly:** Obviously, data is an issue in respect of all those matters. I go back to the point I was asking Jade about. People have gone through a terrible experience. Anecdotally or from your personal experience, are these cases self-referred, in that people come in off their own bat because they feel that an act has happened? Or have the police asked people to come to you, or to contact you on these matters, as a doctor in the NHS?

Dr Boyle: The police will contact us if they have concerns about the medical health of a patient. I do not get the impression that they do that a lot. What we do see quite a lot of is people becoming slightly unwell outside a nightclub and being directed by people working in the night-time economy to go to the hospital—particularly if there is an allegation. There is a perception, certainly in the night-time economy, that you go to A&E and they'll do everything there. That is simply not the case.

James Daly: That is very helpful indeed. Thank you.

Q75 **Simon Fell:** Thank you to our witnesses. It is fair to say that, when we had our first session last week, this was an area with quite a steep learning curve, so it is helpful to dig into some of these issues. I will follow up on some of James Daly's questions around data and prevalence.

Dr Boyle, I am interested in what good reporting would look like. You talked about ISTVs and those feeding through to the community safety partnerships, but I am interested to know, in your mind, what good data could be collected, either by you in the NHS or by the police, and how that would shift things, in terms of the response that people who have become victims of spiking might see.

Dr Boyle: Again, we are dealing with a lack of hard evidence of effect in this area. The perception is that spiking is a relatively new thing. There is good data sharing with the ISTV, which is an NHS England-supported activity; it is also supported by the Royal College of Emergency Medicine. It shares anonymous aggregate data each month with the local community safety partnership and allows identification for police and licensing authorities of problem hotspot areas. It has also used the Cardiff model, developed by Professor Jonathan Shepherd, a professor at Cardiff University.

All emergency departments are supposed to do this, although there are a lot of things that we are all supposed to do that we do not do as well as we would like. Where this is effective, and there are a number of places that do this very well, such as Arrowe Park in the Wirral and some of the London hospitals—my hospital does it quite well—it is really powerful. It allows the police to identify hotspots and take appropriate action.

Q76 **Simon Fell:** Thank you. That is helpful. You mentioned, on drug testing, that if a patient presents to you, looking after them and ensuring that they are safe is rightly your primary concern. I am wondering what shifts the way that you treat a patient and whether they might be tested. Under what circumstances would you run those sorts of tests? On a wholesale basis, what would make that standard operating procedure for you?

Dr Boyle: We would use these tests if we were trying to answer a clinical question, and where we thought it would change management. If a patient reported to us and they were hallucinating, a test like this would be very useful for us, so that we could distinguish whether they were suffering from a consequence of drug overdose, or whether it was a primary presentation of a serious mental illness, such as schizophrenia.

Likewise, if someone was brought to us unconscious, and we were trying to piece together whether they had suffered a serious head injury, were drunk, or had been poisoned, then a test like that would be useful. The vast majority of spiking cases do not fall into those categories.

Q77 **Simon Fell:** Thank you. That is helpful. My last question in this bracket is this: if more hard data was available to you, what difference would that make to you, in terms of how you treat people who present?

Dr Boyle: I do not think that it would actually make very much difference to the way we would treat patients. I think we would continue to encourage people to go and make reports to the police. We would continue to encourage them to use existing services that do not require the full facilities of an emergency department, and we would continue to advocate for emergency departments working well as part of local community safety partnerships.

I don't think that hard data would change what we do very much. The outcome data from people who present to emergency departments, which we put in our briefing paper, is that most of them will be medically fine. They may be very distressed and go through a torrid time emotionally afterwards, but medically, most of them will be just fine.

Q78 **Simon Fell:** Thank you. Miss Quittenton, on that data point again, you mentioned in one of your last answers that you are not currently sharing data. I am wondering what the barrier is to your doing that, or whether that is a policy decision from your end.

Jade Quittenton: There are no barriers at present. The information that we are collecting at the moment is very small-scale. We intend to do this data collection continually to learn and improve. I would love to be able to share this information with other partners. I do not see a reason not to; we are all one team and working together at some point across the night-time economy, so there are no barriers to that.

Q79 **Simon Fell:** Thank you. On prevalence, I am keen to understand whether, from your perspective, spiking is a new thing, or whether it is increasingly reported, and that is why we are talking about it more, but has always been going on in the background. What is your view?

Jade Quittenton: Data would suggest that we are seeing an increase in spiking. However, we have not had data at this level of detail before, so it is really hard to say whether it has always been going on, or whether the increase is because of the media interest around it. We will continue to report this type of information, and I am really happy to share information with the Committee, so that we can refer back in future.

Q80 **Simon Fell:** Thank you. My last question is for both of you. In the work that you are doing, are you seeing particular groups of people who are most susceptible or vulnerable to spiking?

Jade Quittenton: The very small set of data that we have insinuates that it is predominantly females between the ages of 18 and 25 but, again, I do not think that that information can be used to conclude anything or spot themes or trends as it is on such a small scale. It is worth adding that the night-time economy service is not in every town and every city, so we can only go on the information that we have.

Simon Fell: Fantastic, thank you. The same question to you, Dr Boyle.

Dr Boyle: As for allegations of drink spiking, people have always attended emergency departments. I think it has been a little bit driven by increased awareness, but there has always been a problem.

Q81 **Simon Fell:** Is there a particular trend, in terms of the groups that may present more?

Dr Boyle: I would certainly say that this is predominantly a problem of violence against women and girls—not exclusively, but predominantly.

Simon Fell: Thank you very much.

Q82 **Ms Abbott:** I want to ask you about prevalence—I know colleagues have raised this. I understand that you have not had the data very long, but anecdotally, what was your colleagues' experience of spiking before it became a sort of media thing?

Jade Quittenton: That question is hard for me to comment on, because I do not have that information to hand. When volunteers report information to me about spiking, it is solely around the treatment of the person, as opposed to why someone carried out such a vicious attack, if you like. I would like to grow the data, and maybe that is something that our organisation can start to filter into this type of data collection. As to why people are doing it, unfortunately that is not information that I have.

Q83 **Ms Abbott:** So when people come to you with some sort of injury or harm, or something about their personal state, you do not keep records of how and why it happened.

Jade Quittenton: We do keep records on why a person is presenting to us, but this data collection is predominantly around numbers and figures. That is something that we will take away, and will perhaps start asking that question going forward. However, a person will not always have the capacity to answer that question if they are in that state. It all depends on the situation.

Q84 **Ms Abbott:** One of the aims of the St John Ambulance's night-time support is to reduce pressure on the NHS, specifically A&E. Do you think you have achieved this?

Jade Quittenton: Absolutely. This is a small amount of spiking incidents that have taken place. This does not take into consideration our work with those who have not been spiked, whether that is an assault, an attack or an existing medical condition. The data that I have definitely suggests that those people do not need to be conveyed to hospital. Again, I am happy to share the information afterwards.

Q85 **Ms Abbott:** At what point do your volunteers decide that a spiking victim needs to go to A&E?

Jade Quittenton: It is worth noting that I do not have a medical background, and I have expressed that throughout the evidence. The volunteers are highly trained and skilled in identifying needs through clinical observations, and they will make the right decision based on the person who presents themself.

Q86 **Ms Abbott:** Who funds the St John Ambulance night-time economy services?

Jade Quittenton: The night-time economy is unique. It is a more personalised service, depending on the customer. In some situations, the police fund the service if the request came from them. Local authorities may fund the services, as could business improvement districts, or it could be a mixture of all those. It is a unique service to whichever town or city requests the support.

Chair: Dr Boyle, I think you wanted to come in on one of those questions.

Dr Boyle: Yes. I just wanted to comment that we are enormously supportive of third sector support, particularly St John Ambulance. Their work out of hospital and in reducing unnecessary conveyances to hospital is valuable and recognised as being extremely helpful to emergency departments.

Q87 **Tim Loughton:** Jade Quittenton, we know that there is a real problem with lack of data when trying to see how prevalent spiking is. However, are your volunteers who are out with the night-time economy services seeing more cases of people who could have been the victims of spiking? Is it becoming more of a thing?

Jade Quittenton: Based on information that we have to date, we are seeing an increased number of spiking incidents. However, I must stress that that is not confirmed spiking, but suspected spiking only. The number of those who present themselves has increased over time on that very small scale. I would be interested in continuing to collect the information and seeing how much it changes, even over the next month or so.

Q88 **Tim Loughton:** As a result, are you training your volunteers, who do this, in a different way? Are you doing awareness courses? Volunteers need to be conscious that somebody may not be there just because, of their own volition, they have had a bit too much to drink, but that there is a malign side to what has happened to them.

Jade Quittenton: Absolutely. I think it goes without saying that, whether it is a case of spiking or intoxication, we would treat the person in the same way. They still need that care and support and they are presenting themselves to us for a reason. That being said, there has been a lot of awareness of this piece of work internally and externally. We have conversations with volunteers around clinical briefings just to give them that extra layer of support and explain what additional information we can provide.

Q89 **Tim Loughton:** Sure, but in some respects your good work may mask some of the underlying problem because your job is to pick up people on the streets late at night, make sure they are safe and determine whether their condition is so serious that they need to go to A&E, rather than people going straight to A&E or being found in a heap on the street.

You may be treating somebody who has had a skinful, for want of a better word, or you may be treating somebody who has been spiked, and you may send them home safely, whereas if they went to hospital, there is a greater chance of their being picked up as a spiking victim, unless your

volunteers are specifically looking out for that and perhaps asking questions. Even though the person might not be in a position to answer them, they may have friends with them who say, "This is all very strange; one minute, my friend was sitting there having a"—whatever—"and the next she was a gibbering wreck". Are you more proactively saying, "Hold on. There is something a bit more to this," in which case you need to encourage people to report the incident to the police or go to A&E?

The alarming thing from last week—this is reflected in the written evidence—when we had three witnesses, was that two out of the three did not go to the police. They also said that, when they went to A&E, there was a bit of a culture of disbelief—"Oh it's just another person who's had too much to drink," or "It's a drug reaction gone wrong," rather than, "This could be spiking and it's no fault of their own." Do you think that there is potentially a bit of a deficiency in the evidence because your volunteers are doing such a good job?

Jade Quittenton: Anyone who presents themselves to the night-time economy service will be clinically observed by a healthcare professional to make the decision on whether they feel that person does or does not need to go into hospital. I do not think that therefore means in any way that people should not report this, and we still encourage people to do so. There is a fine line on whether someone has been spiked through alcohol or through drugs, and obviously we are there to support those who are intoxicated, but the clinical observation decision will determine which pathway to take.

Q90 **Tim Loughton:** Thank you. Dr Boyle, this is a feature that has come out: I'm not saying that there is a lack of sympathy in A&E, but the assumption is that somebody has had a skinful and we are just treating them for having had too many to drink, or it could be a drug reaction, rather than "Is there more to it? Has this person actually been the victim of spiking?" Is there greater consciousness now in A&E that there may be more to it, or do you think that is still a problem?

Dr Boyle: Emergency medicine staff read the papers just like anyone else, and I think there will be more awareness, but I do not think it changes the way that we will do things. If we look at the evidence in our submission, we will see that the majority of cases who allege that they have had drug spiking do not have drugs in their system when we have done detailed toxicological analysis. We completely accept that alcohol would be a very effective spiking agent and would not show up. In a way, our job is not really to judge whether somebody may or may not have been assaulted; it is to know whether they are medically ill and require intervention, or can be safely discharged home.

Q91 **Tim Loughton:** Do you think that you do need to have a duty of care on reporting if there is a suspicion that spiking has been involved, in the same way that if a parent appears with a child with unexplained injuries at A&E, you have a safeguarding duty to report that if you suspect there may be abuse going on of that child? By the same token, do you think there should be some duty of care if you suspect there is more to it than this—

that you should certainly be encouraging that person to report it to the police, or maybe even do so yourself?

Dr Boyle: I would hope that we would expect emergency medicine staff to encourage people to self-report to the police, and I think that would be an existing pathway. Now, we know that there is an awful lot of criminal behaviour that results in emergency department attendance that is never reported to the police, and we have seen this with domestic assault and with all sorts of abusive-type injuries. I think the example around children is different because, as doctors, we have that professional responsibility and professional obligation to raise a safeguarding report. We do not have that with adults unless we think the patient is vulnerable—you know, we are talking about people with learning disabilities or who are physically vulnerable. We are dealing with adults, and my view and my opinion is that we should just be encouraging them to go and get this reported and investigated by the police.

Q92 **Tim Loughton:** Again, we do not have the data about prevalence. You are on the frontline and you obviously have many colleagues on the frontline, and it has obviously been a rather distorted period because the night-time economy has not been operating as it did during the pandemic. However, do you think that this is becoming more of a thing?

Dr Boyle: I do not really know, and I would not want to mislead the Committee just based on my anecdotal opinion. I do not really think so; I think it has always been there a bit. I think needle spiking is new, but drink spiking has always been a constant.

Q93 **Tim Loughton:** That is interesting, because from the evidence we were given last week, one of the organisations that supports victims has done a fair bit of research and some surveying research, and it came up with what sounds like an alarming figure: more than one in 10 students has been the victim of spiking. This is malicious spiking. They were pointing out that there are those people who will put a shot in your drink—"Oh, go on. Get in there. You need to loosen up"—at a private party. A lot of this happens at private parties, rather than being done by complete strangers in a pub or nightclub. And a large number of spikings happen with people who are not drinking. I think something like 25% or 35% was people who had been spiked but were not actually drinking alcohol, so clearly they had not had one too many at all.

So spiking is taking different forms, but malicious spiking, for kicks—again, this is something I didn't quite understand before last week. There is evidence about people who are being spiked because they are then going to be sexually assaulted, which is what we would think is the major reason—that is why it would be predominantly of young girls—and then you have people who are the subject of financial fraud. We have had cases of people who have been spiked and marched off to cash machines and then found that their bank account has been wiped out. One can understand the logic of that, whether it's sadistic or whatever it is, but a lot of spiking was apparently just for kicks. It was done by people who get gratification from seeing people completely immobilised and legless; they

are doing it for laughs. Again, do you see evidence of that, rather than people being the victims of obvious crime—sexual assault and financial fraud?

Dr Boyle: Not really, no.

Q94 **Tim Loughton:** You don't?

Dr Boyle: Remember: I'm very much at the sharp end; I'm very much at the tip of the iceberg. There is a whole bunch of things right down at the bottom that I may be completely unaware of, and my experience and my opinion on those will be no more than that of somebody in the street. But no, our emergency departments are not full of people who are turning up utterly intoxicated because of malicious spiking.

Q95 **Tim Loughton:** That's interesting. Of course, your job is to make sure somebody is physically okay, rather than getting to the bottom of it. But again, you will see people in A&E who are in a terrible state and who usually come in with friends, and those friends may be saying, "Hold on, she only had a couple of shandies," or, "He was all right one minute and then suddenly he was all over the place," which suggests that there is something more to it than just that they have had a skinful themselves. I just wondered whether, anecdotally, you were seeing more of that sort of presentation, but it sounds like you're not.

Dr Boyle: No, not really.

Tim Loughton: Fair enough. Thank you.

Q96 **Chair:** Can I ask a follow-up question in relation to the safeguarding issue? Tim Loughton talked about the responsibilities and duty of care that you would have if it was a child with unexplained injuries. You mentioned, Dr Boyle, in your earlier answer about violence against women and girls, that you saw this as part of that violence against women and girls that we recognise so much more now. I just wonder whether you think that there is an opportunity now to look at and think about whether there should be a duty on NHS workers in terms of spiking, just as there is around domestic abuse and asking the question, "Are you okay? What has happened to you?"—doing a bit more. Or is that putting an unnecessary burden on NHS staff, who I know are already very overworked?

Dr Boyle: I think we need to break that down into a variety of components. We have a number of areas where there is a duty of professional responsibility to report. It came from the House that we were expected to report around FGM, and there have been suggestions about whether we should be doing this for things like acid attacks, or whatever is the current area of interest.

NICE looked at whether health professionals should be reporting around domestic violence. They concluded that routine inquiry and targeted screening in certain healthcare environments was effective in certain areas, but that certainly excluded emergency departments and general practice; I think it was mainly restricted to people receiving mental health care and receiving maternity care. I would be uneasy about making this a

professional obligation. It would be another thing that we would have to do, and I would want, I think, to see some evidence of a beneficial effect.

Q97 **Chair:** And we have a problem, haven't we, because of the lack of data, so it's a sort of chicken-and-egg situation?

Dr Boyle: It would be perfectly reasonable to make the suggestion that emergency departments need to make sure that they are fully represented and fully active within community safety partnerships and that there is information sharing between relevant organisations. Those things are all sensible and possibly more effective.

Chair: Thank you very much. Stuart McDonald.

Q98 **Stuart C. McDonald:** Thank you to our witnesses. Dr Boyle, last week, we were all left with the impression, and the survey that the Committee undertook made quite clear, that there are lots of people out there who think they may have been spiked but do not report it. The tenor of your evidence, or certainly the evidence in the Royal College's written submission, is that there is also a problem of very significant over-reporting, where people will say, "I think I might have been spiked," but there is nothing to back that up and it looks like that it was simply that they probably had too much to drink. Is that a fair summary of the paper?

Dr Boyle: Again, it is looking at the evidence. I think I have said before that alcohol would be a very effective spiking agent. What you are saying is that there are people who may have been spiked with a drug. Usually, that is not the case. It can happen. It absolutely could be a thing, but, actually, the majority of people who present to emergency departments with allegations of spiking do not have illicit drugs in their system.

Q99 **Stuart C. McDonald:** Okay, but in terms of alcohol, there are a couple of studies cited in your paper. It talks of one Australian study for example, with 100 presentations and "nine plausible cases." Is that including alcohol?

Dr Boyle: No, that is looking at drugs abuse.

Q100 **Stuart C. McDonald:** Okay. Moving on to the issue of data and testing, earlier you explained that your focus is on medical treatment and helping the person recover. But if somebody has alleged a crime and, secondly, if we want to get more evidence about what is going on here, somebody has to get some testing. I am guessing the number of times that the police have been involved at an early enough stage to arrive or commission a test that can obtain any useful evidence is pretty rare.

Dr Boyle: The police all run a system by which they have forensic medical clinicians—they used to be known as police surgeons. They will arrive pretty quickly. Quite regularly in my department and in every emergency department, the police will be involved with road accidents. The traffic police will arrive with the patient and will say, "We want to get a blood test for blood alcohol and blood toxicology." They manage to find a forensic medical clinician usually within an hour, because it is also recognised to be time critical. I don't see this as a very different thing to do.

There are concerns about samples taken in emergency departments providing an adequate chain of evidence and being admissible in a court of law. For the police and for the CPS to use evidence that is acquired in an emergency department, they want what they call a chain of evidence—it is a quality assurance process that the sample has been collected under the right conditions, hasn't been contaminated and has been taken directly away, and that is measurable at every stage. Hospitals, where there is point-of-care testing in an emergency department or going into the main hospital laboratory, simply can't provide that level of quality assurance.

Q101 **Stuart C. McDonald:** That is something we will obviously want to take up with the police and explore with them, but are those issues not exactly the same when it comes to investigating road traffic accidents, for example, and whether somebody was under the influence of drink or drugs?

Dr Boyle: I am going to turn it around. Actually, the forensic medical clinicians turn up pretty promptly and are able to collect those samples.

Q102 **Stuart C. McDonald:** What is the answer, then? If we are to establish whether a crime has been committed, and if we are to get reliable data, somebody has to do some testing. What would your suggestion be as to the best way to resolve this?

Dr Boyle: I think what you are asking is what good would look like. I think what I would suggest is: a patient turns up to the emergency department, they are seen, they are not medically unwell, they are encouraged to report that to the police, they phone the police, the police attend and take a statement and say, "Yes, I think this is worth investigating." They send a forensic medical clinician who comes and takes samples from the patients. That may be in a police station, it may be in the emergency department, it may be in the patient's home, but they do that all fairly quickly—they do this within a couple of hours of presentation to the hospital.

Q103 **Stuart C. McDonald:** What about patients whose condition makes it impossible for them to take that action? Can anything be done in those cases?

Dr Boyle: Going back to the road traffic analogy, under the Road Traffic Act, we are not allowed to get in the way of the police obtaining those samples, and we don't—we facilitate it. We recognise that it is enshrined in law that unless the patient requires active medical treatment in a way that is going to interfere, the forensic medical commission should be given as much access to the patient to do that as necessary. I would be uneasy around the issue of consent if a forensic medical commission was taking samples that might be used in a legal case from an unconscious patient who did not have the capacity to consent to that. I do not know what the answer to that would be.

Q104 **Stuart C. McDonald:** Thank you. Finally, Dr Boyle, in needle spiking cases, concerns have been raised with us about the potential for there to be a dirty needle involved. Are tests offered in these situations to preclude illness being spread by a contaminated needle?

Dr Boyle: Yes, absolutely. Screening and risk assessments for exposure to a blood-borne virus are things that we regard very much as our job. The risk of transmission of a blood-borne virus—usually hepatitis B or HIV—from a needle in this sort of scenario is actually fairly low. It is not zero, but it is fairly low. Hospitals have been dealing with inadvertent needlestick injuries for decades. It is in our curriculum; our trainee doctors have to demonstrate competence in it. It is absolutely something we do. In most cases, people would be offered a hepatitis B vaccination and we would take a sample that would be stored, so that if they later developed serious hepatitis or HIV, we could look at that sample to try to get an idea when the infection started. We would also have a discussion about whether post-exposure prophylaxis for HIV would be in the patient's best interest.

Q105 **Stuart C. McDonald:** Thank you very much. One very final question to Ms Quittenton, if I may, and feel free to say the extent to which you feel comfortable answering it. Do you have particular views on what we could look at to improve prevention and support for victims of spiking?

Jade Quittenton: I do not feel able to comment on how to prevent spiking, because I do not understand the reasons why people are spiking at this minute in time. Purely from a personal perspective, one thing I would like to add is that by collecting more data at all levels—police, councils, NHS—and working together to start working through that detail, we could get a broader picture and understand this more clearly.

Q106 **Chair:** Could I ask Dr Boyle one final question? It is about the Norfolk and Norwich University Hospital pilots, where they are using drug-testing kits that can identify 1,600 compounds from a urine sample. How does that compare to the standard tests available in A&Es around the rest of the country?

Dr Boyle: That is much more detailed. The local toxicology tests that we have in most emergency departments test for about 10 to 12 drugs of abuse, and they do not include some of the drugs that would be a spiking agent. The kits that we have—certainly in my emergency department—do not test for ketamine, gamma-hydroxybutyrate or GHB, or for a variety of other substances; they do not test for synthetic cannabinoids. The idea that there is a kit to test for a thousand compounds is astonishing. With that level of information, there will be concerns. You almost might want to get a toxicologist to give you a view on the possibility of false positives in a test with a panel that big.

Chair: Right, okay. Thank you for that. I thank both of our witnesses this morning for their time. I know you are both very busy. We really appreciate you coming along today and helping us to put together our recommendations as a result of our spiking inquiry. We will now move on to our second panel of this morning.

Examination of witnesses

Witnesses: Councillor Jeanie Bell, Paul Fullwood and Michael Kill.

Q107 **Chair:** Good morning. Welcome to the second panel of the second spiking inquiry. This morning we have Michael Kill on Zoom; he is the Chair of the Night Time Industries Association. We have got Councillor Jeanie Bell, who is a member of the Local Government Association's Safer and Stronger Communities board, and cabinet member for community safety at St Helens Council. Paul Fullwood is director of inspections and enforcement at the Security Industry Authority. Thank you for coming today.

We have a series of questions for you; I wanted to start, as I did last time, by asking about prevalence and how widespread the problem of spiking is. I would like to know, from each of you, whether you are keeping any data on spiking and whether you have seen any changes in the trends in spiking? In the survey that we conducted, thousands of people responded to tell us that 75% of spiking incidents took place in pubs and nightclubs. I am wondering how it is, with all the security measures in place, that that is happening in nightclubs? Can we start with Mr Kill on prevalence, and then on what is going on in nightclubs that is allowing spiking to happen?

Michael Kill: Thank you, Chair. As you can appreciate, the NTIA and the wider industry are deeply concerned by the rise in reports of spiking incidents, particularly over the last six months. We are a highly regulated environment, and without a doubt we take full responsibility for the safety of our patrons and our staff. As you have heard from previous witnesses, this is not a new issue; despite the rise in reported incidents, this has been happening for some 20 or 30 years within the industry.

We, as an industry, want people to enjoy a safe night out in our businesses, across the night-time economy, without fear of harm. We have seen, over time, that venues often find an increase in reported spiking cases around the autumn—as students return to university it seems to be more prevalent. Also, venues have similarly seen a rise in reported spiking incidents following the reopening of nightlife spaces after a long period of closure due to the covid-19 pandemic. With the closure of venues over a two-year period, and with almost 850,000 new 18-year-olds coming of age and not having experience of the night-time economy, we have seen the culmination, as described by some police representatives, of a perfect storm.

What we are working very hard on at the moment, as you can appreciate, is trying to tie down the exact prevalence of spiking. It is incredibly difficult to say what the scale of the problem is. Although we, as part of our premises licence, are required to report incidents, the way that we track this is by consistent categorisation of a crime through police forces. We are aware that there is a lot of under-reporting, as was stated earlier. Many of these crimes are not reported until the following morning, or people will walk away and not report them. When they are brought to our attention as an industry, we tend to involve the police, particularly if people need welfare, medical attention or support. For some of those

challenges, as we rightly heard, there is a lack of data. One of the key issues that we have found through working alongside the police is that the legacy data has been placed in multiple categories of criminal offence. I will give you those criminal offences—to cause to be administered any poison or noxious thing with intent to injure, aggrieve or annoy, contrary to section 24 of the Offences against the Person Act 1861. That would also capture many other types of crime. The challenge that we have in understanding the prevalence of spiking, although we have seen this over a long period of time, is that it is very difficult given that categorisation and the fact that it encompasses many other crimes within those categories in terms of the policing log.

Q108 **Chair:** That is very helpful. Can I ask you to address my second point, which was: why is it still happening if there is lots of security and measures are in place in lots of nightclubs and pubs? Why are 75% of spiking incidents happening there? Why are perpetrators able to get away with it?

Michael Kill: Well, we have been working very hard for many years to ensure that we have the measures in place, but these things still go on. They are challenging. We are still trying to drill down into exactly what the prevalence is within our environments. We have worked very hard with police, local authorities and key stakeholders, including the Girls Night Out campaign, to step up the mitigations that are in place. We have accepted that there is work to do. We have worked very hard on staff training and security, enhanced searching, mechanical barriers, welfare training, increasing the number of female security members coming on board, and things like safe spaces.

Q109 **Chair:** I think we will want to come back to a number of those issues. Councillor Jeanie Bell, would you like to comment?

Cllr Bell: In terms of changes in trends and data, we have had a slight increase in reporting. Whether that is due to higher awareness and more media coverage, or to the prevalence and the actual number of incidents that are happening, we cannot ascertain because, as a local authority, we do not hold that data. From an LGA perspective, local authorities generally do not hold that data. However, we do get data via the community safety partnerships.

I know in my local area we have had four cases since November, and we have had a case that went to the press. The young woman involved did not want to report it. It was in the press, and it was a needle incident, but no report occurred from it. That lack of data is a real barrier for us, because there is actually a lot we can do within the licensing context about problem premises or issues happening within premises. We might support the premises holder to get a grip on what is happening; we might give support around training and advice, using public health teams to back that up; or we might take robust enforcement action. All of that is absolutely dependent on the data, which, as we have heard today and last week, is the biggest barrier we have at the moment.

Chair: Thank you. Paul Fullwood.

Paul Fullwood: As colleagues giving evidence have said, there is a lack of data. My own professional view is that this is under-reported quite significantly—that is from the industry, and also probably police officers will give evidence as well. The role of the Security Industry Authority is to protect the public as much as we can, to ensure effective regulation and to raise standards across the industry for those we are responsible for.

Even in the last two years, when we looked at some of our data, we have had only around 7,500 items of intelligence about night-time incidents, and only a fraction of those—25—involve spiking and date rape, which just cannot be accurate. For me, and certainly from our evidence, this is under-reported. That is not to take away from all the hard work going on and the diligence of people trying to look for these things, but it is under-reported. There is a lack of awareness and understanding, and I suppose this inquiry is the start of changing that.

Some trends that we have identified, just based on the information and data we have got, show that most of the offending is in cities and towns. There are no particular locations. We did think perhaps it might be more focused on student locations and student cities. It is pretty widespread from what we can see. It is pretty mixed in terms of the type of criminality, whether it is from drink or drugs. We have no intelligence of spiking by needle that we have found, certainly in the last few months, in our intelligence systems. The way that we work is that, if we receive intelligence, we almost immediately share it with the police or other law enforcement, and across the industry as much we can. That is for public safety and to get the information out there as quick as we can, and then we can respond with that.

From our intelligence, perpetrators and suspects are mostly male, and victims are female—though I don't believe this to be entirely accurate. We know that there is a spread across the industry. In terms of trends and actual venues, from our intelligence it is happening in the night-time industry. However, it would be naive of us to think that it is not going on elsewhere—in festivals and other events. I am pretty sure it is, but we do not have the information or intelligence to suggest that that is the case.

We have tried to tackle this through our violence against women and girls action plan and strategy. Our broader approach is about trying to raise awareness and standards to try to prevent these incidents occurring.

Chair: Thank you; that is very helpful.

Q110 **Tim Loughton:** Mr Fullwood, you said that most of the perpetrators are male. Everyone has spoken about the shortage of data. Last year we were told that something like just over 1,400 cases were reported to the police, which was double the previous year. But there are virtually no prosecutions, so it is not actually taken any further. On what do you base the fact that the vast majority of perpetrators are male?

Paul Fullwood: It is just based on the intelligence we have received in the Security Industry Authority. I am sure the police will give their views on where they are with prosecutions. Our approach is about trying to prevent, educate, raise awareness and get to the front end to reduce these instances as much as we can. That would be our start to this. Based on the information and intelligence we have, it is predominantly male offenders.

Q111 **Tim Loughton:** Where is that intelligence coming from? Based on what is the security industry telling you that?

Paul Fullwood: Intelligence is submitted to us from a number of different avenues. Members of the public can contact us and give us information anonymously, or it could be from Crimestoppers, the police, the private security industry or partners and colleagues. We bring all that intelligence together and that is what we base our facts—and the information I have provided today—on.

Q112 **Tim Loughton:** So it is anecdotal?

Paul Fullwood: Absolutely. It is based on intelligence. It is not evidence from convictions or prosecutions.

Q113 **Tim Loughton:** That is the problem. Everybody has agreed that there is real confusion over the actual evidence. Some surveying work that one of the organisations we had here last week has done was really interesting. It said that the greater prevalence was among the 25 to 30-something-year-olds, rather than, as one would expect, the student age groups. Even that is conflicting. Mr Kill, I have a basic question for you. Why is spiking happening?

Michael Kill: That is very difficult to answer. As you can appreciate, I do not know what motivates people to take this action. We have heard anecdotally that some people do it for fun, as was suggested in the previous evidence session, and some people do it with malicious intent. The challenge we have more often than not—as you have stated—is that there is a lot of evidence, in terms of the data floating around, but there is no solid position. Our industry has been calling for a succinct understanding of the legacy data, which give the characteristics of the crimes that take place—where the settings are, when and how incidents happen and the toxicology. All of that will allow us to tackle this crime more effectively.

At the moment, as you can imagine, there is a huge media presence with regard to the challenges, and there is a focus on the night-time economy. We are aware—this is anecdotal until we can get the data—that there is a prevalence within places like house parties, unlicensed music events and halls of residence. From conversations with the police right the way across the territories, we are seeing a very broad and challenging position. For us, the night-time economy plays its part and takes its responsibility, but there are other settings that are unregulated.

Q114 **Tim Loughton:** I entirely appreciate that. As the Chair has alluded to, we

heard last week that something like 25% of this crime happens within private, familial settings. You just made the interesting comment that you had heard that some people are doing it for fun, and others are doing it maliciously. What is the difference? If you are spiking somebody's drink because you think it is fun to see somebody completely incapacitated and acting as if they are completely blind drunk, that is not fun; that is sadistic. That is an assault, and should be treated no differently than if you had gone up and punched the person in the face rather than spiked their drink. It is the same thing, isn't it?

Michael Kill: Very much so. Anecdotally, I am talking about people who approach it in different ways. As you can appreciate, some of the conversations that we are having within the police force is that people sometimes—as you have heard—put an extra shot of alcohol in someone's drink, thinking that is something they do among their peers. Quite rightly, as you say, that is not acceptable; it is an assault, without a doubt.

Over and above that, there is a malicious intent using either date-rape drugs, or some other drug, with a motive of following down the line of criminal intent. From that perspective, it is hugely challenging for us, particularly to get—

Q115 **Tim Loughton:** Okay. Let's try to pick the low-hanging fruit, because I agree that there is a scale in this. There are those people who are in a group and they want one of their friends to lighten up a bit, so they sneak a shot into their drink. Somebody, even more irresponsibly, might sneak several shots into their drinks throughout the evening, so that they are getting progressively incapacitated or whatever. That is not "fun", and that needs to be called out.

However, that is different from somebody who has slipped a drug into somebody's drink, and they go from being relatively coherent to, all of a sudden, slumped in a heap. That is more noticeable. Your members and colleagues are on the frontline, dealing with people coming out of nightclubs in various states of worse for wear and helping to pour them into taxis or whatever. Are you seeing more people who are victims of the latter—that they have gone from coherent to slumped in a heap, and that there is something more to it than just that they've had a few too many, of their own accord?

I am going back to this: how big a thing is spiking? Are we seeing an increase in it? Is there a trend happening here, and is it down to people clearly acting maliciously, either because they have sexual predatory intent, financial criminal intent or, as we heard last week, because they are doing it for kicks, which is not "fun" but a crime?

Michael Kill: As you can appreciate, it is very difficult to say. The data, once again, is where we have that challenge. Feedback from our industry is very limited in terms of the cases that are being reported or presented from a venue. As you can understand, there are different routes to reporting—whether they go directly to the police or to the NHS.

In many respects, we will not see all the reported cases that are put in front of us, but we will see the incidents that we have and we will be able to deal with those head-on. If either someone is incapacitated at a venue, or it is brought to our attention that someone is in a position where they feel vulnerable, we will then deal with them as a duty of care. We will get them to a safe space, deal with their welfare and, if required, get them medical attention. Honestly, it is very difficult to say that this has got worse, but the reporting has, without a doubt, become more effective.

Q116 **Tim Loughton:** I want to come to Councillor Bell in a moment, but at this point I will just push this. Your members are a very rich source of potential information on this. They know the people going in and out of clubs, particularly if they are regulars. They can detect what is normal "You've had one too many" behaviour and what is, "Hold on, that person is completely incapacitated."

I would have thought that there is more of a job that can be done by the industry to say, "Yes, there appears to be a problem here." If there is an issue about "Well, that establishment doesn't want it to get out that this is a spiking hotspot", then that venue can become virtuous by saying, "This is what we are doing about spiking," and coming up with specifics.

We have had some examples. There is a nightclub in Brighton and other venues that have done all sorts of things to make it a spiking-safe zone—as much as it can be. So we need that sort of information, which you are saying is very hard to collect, from your members, in order to be able to determine where it is going on, how it is going on and, most importantly, how do you catch the perpetrators, prevent them from going in there in the first place and make that a more secure venue, one that is safer for people to go to for a fun night out? Sorry that is a such long question.

Michael Kill: I completely understand it and, as you can appreciate, it presents all sorts of challenges and issues in terms of assessment. One of the things that we have spoken about very clearly is a consistent assessment position and involvement of the police if we feel that any crime has been committed. We have seen this in Devon and Cornwall, where they have a very effective process between the operator conversing with the police and then the reported crime being able to be presented, and evidence being able to be gathered within a short period of time, and progressed if that crime is prevalent.

However, we are not seeing an inordinate amount of these situations within our premises. Without a doubt, we converse and speak very clearly with the police, particularly because these reported incidents are becoming a really important part of building up the data and situation with regard to incidents. And that is something that we convey and work very closely with the police on, passing over information as we go. But without a doubt we are not seeing the prevalence at the coalface being as high as is being suggested in the media and other sources.

Q117 **Tim Loughton:** Okay, that is interesting. Councillor Bell, how aware are local authorities of this as a problem and are there things that local authorities are already doing, or should be doing, to make venues—venues

that your local authorities license—spiking-safe, or however you want to term it? How much of a role do you think local authorities have in this, because you license these premises and without that they could not allow people in?

Cllr Bell: I think we have a key role to play, in all honesty. I am quite passionate about licensing, anyway, but I feel that licensing is at the heart of that response and co-ordination effort in terms of working with premises.

This is almost a twofold problem, where you have under-reporting from people attending venues, and often they will leave the venue before they realise that they have been spiked, but then you also have venues that may be reluctant to come forward to say, "Look, we think we might have a problem here with spiking in our venue. We're not getting reports, but we think there could be an issue," because they are concerned about whether they will then be penalised or there will be licence revocations, because your licensing authority actually has quite a considerable amount of power in terms of managing a premises effectively.

The LGA has some really good practice guidance on this issue on the website. There are loads of case studies, which we encourage local authorities to use as much as possible, in terms of how to run that licensing authority effectively.

If we get reports that there is an issue in a premises from a responsible authority—police, fire, public health—then, as the licensing authority, we can pull the manager of that premises in. And we can look at what is happening, review the CCTV, look at what is happening in terms of the health and safety, the way that the premises is managed, pull them into a committee and members can then review that case, listen to the evidence from the responsible authorities and decide whether they want to act on that, whether by revoking a licence or by putting clauses on the licence, and whether we will work with that premises.

So we need to encourage victims to come forward and we need to encourage premises to come forward to seek support.

Q118 **Tim Loughton:** On that last point, are they coming forward? Is there a problem with a culture of secrecy, because they are worried that if word gets out, first, it will drive away their customers and, secondly, they might lose their licence? Or are they actually coming to you and saying, "Look, we think we have a bit of a problem. We want to do something about it. How can we work with you to make sure that we are a spiking-safe premises"? Are they coming forward, or do your local authorities need to do more to say, "We need you to come and speak to us. If you think you have a problem, we can work together on this, before it becomes a 'You're about to lose your licence' situation"?

Cllr Bell: We absolutely need to do as much as we possibly can. A good licensing authority has a positive relationship with their businesses that is based on mutual support and information. So we need to keep pushing that. The Local Government Association has always been quite clear on

that. There are some really good case studies, and I know that we will talk about Devon and Cornwall, and Brighton.

Also, I know that in my local area we worked on accreditation schemes to get premises covid-safe for when we were coming out of restrictions. We worked with our premises and got them to put certain restrictions and safety protocols in place, and we would then support them by saying, "This is a covid-accredited business" and putting a sticker in the window." There are initiatives like that that we can do to encourage premises to come forward and say, "Give us some support, give us some help and give us some training." We can then reciprocate by saying, "Okay, we'll give you banners and posters to put up to say that you are a safe establishment and take spiking seriously."

Some of the issues that we have within the local authority are about the way that funding is allocated through CSPs. A lot of the projects that we have provided to you from the LGA as evidence is additionality funding through the safer streets fund and the violence against women and girls fund. That funding is often for a one-year project and has really tight turnarounds. You might have two weeks to put a bid in, and it is certainly not hitting all the local authorities and all the areas. There is definitely something I think we need to look at there, and the LGA are calling for the safer streets fund to be expanded from, I think, the current 18 projects to right across all the PCCs, so that everybody has the opportunity to bid in for that. That money really does make a difference. If it can be accessed, it enables you do that bolt-on work.

Q119 **Simon Fell:** I would like to go back to the point about data and reporting, because it keeps coming up and we heard some really powerful testimonies on this last week from some of our witnesses. The Committee put out a call for evidence from victims of spiking, and the data they gave us back was really powerful. Some 74% did not report any incident at all, and 25% did. But what was really interesting was the fact that, of that 25%, where they reported was so dispersed and diverse. A question to you all to begin with is: what do you think an optimal reporting route would be for victims of spiking? I will start with you, Paul.

Paul Fullwood: First of all, we need a national strategy plan so that there is consistency. I see elements of excellence and great initiatives going on, but they are not always shared and not always known, so people are not always aware. We need a very clear reporting plan, so that if there are allegations, suggestions or instances of spiking, there is a response and a whole-system approach from all the agencies and organisations, so that we can respond coherently and work together, sharing information and data, and being as collegiate as possible. That would be an optimal approach, early doors.

Q120 **Simon Fell:** And who do you think should lead that?

Paul Fullwood: I think this is probably the work of the Committee, in terms of how we approach that, but it should involve all of us. I think it involves everybody: it involves Government, it involves law enforcement

and it involves all the people sitting here today—the industry, the night-time economy and the private security industry. We all have a part of play. We all have a duty of care to ensure that, with all the things that we are doing, we try to keep people safe. That involves all of us, so I would say that all of us should be part of that.

Simon Fell: Thank you. Councillor Bell?

Cllr Bell: I suppose it depends on which kind of data you are tackling. We can encourage people to go through Crimestoppers and report anonymously if they do not feel comfortable coming forward. But we cannot get past the fact that we need data on prosecutions and data on reported crime. That is the key data that we need, as well as hospital admissions. For us as licensing authorities, that is the data that we need to be able to take action. Crimestoppers absolutely gives you that anonymous view of what is broadly happening, but we need the hard data. For me, it would need to be led by the police, but there is nothing stopping anybody contacting a licensing authority with a concern about a venue that would then prompt an enforcement visit or a check visit. Part of our statutory duties is around enforcement—going out to make sure that premises are upholding the rules that they need to. We are supposed to do that on a regular basis. If we are getting reports through from the public that are saying, "I don't want to give my name, but I want you to know that this is what's happening in that pub," that can then trigger a process of us going and asking further questions.

Q121 **Simon Fell:** Do the LGA or the licensing authorities have a preferred route that they suggest licensees advertise to their punters, saying, "If you are a victim or are concerned about something, go down this particular route"?

Cllr Bell: I would say, "Always encourage reporting to the police." In Devon and Cornwall, where they are offering the testing kit in pubs, it is very quick and easy to ascertain whether you have been spiked in that environment. You should always encourage people to go forward to the police—always. Ultimately, people need to be held to account. We are concentrating very much on the victims here, but if you cannot get to and deal with the perpetrators, you are not going to stop spiking happening. There needs to be a dual approach: reporting and data collection, and education and prevention. How are we going to do that as well as the data gathering?

Michael Kill: We as an industry believe that this needs to be led by the Home Office, and subsequently—I agree with earlier comments—the reporting would have to come through the police so that we can absolutely understand not only the reported incidents, but the crimes that have been committed and the conviction rates off the back of that.

Over and above that, it allows us to bring together a range of data: profile of victim; profile of perpetrator; settings and environments where incidents take place; time and period of year; how it is being administered; things such as toxicology, which are vital for us to look at when we look at testing; and kits, similar to what Devon and Cornwall

have done. I think there has to be a consistency of reporting across all police forces.

One of the challenges that we have in criminal offence logging, as I suggested earlier, is that the legacy data on spiking is very difficult to bring together. We are now dealing with reported incidents moving forward through the police. That is absolutely giving us data, but it would have been fantastic to gain that legacy data if there were a uniform approach.

For us, the Home Office having a consistent approach to the processes—from the licence operator through to police—and having that consistency across the police forces would be hugely useful. The data would be robust, including for all key stakeholders such as LGA, SIA, NHS, emergency services and so on. There is a huge part to play, but I think it pivots around the Home Office and the police's mechanism for consistently dealing with those incidents and the way that they are reported, so that we have a robust position to build a foundation of understanding and start to tackle these crimes as we all want to moving forward.

Q122 **Simon Fell:** Mr Kill, to go back to our survey, several of our respondents suggested—or at least were concerned—that bar staff were responsible for spiking their drinks. Do you have any evidence of that being the case?

Michael Kill: No. That is the first time I have heard it. I would probably have to resort back to police data on that to understand if there have been criminal offences commitment by members of staff. That is not something that I have seen or that is prevalent across our sector at all. Anecdotally, I have not seen that, but the data will give a clearer picture.

Q123 **Simon Fell:** For the Committee's benefit, could you explain your vetting processes, in particular for bar staff and for people on the door, to ensure that no criminal incidents in their history suggest that they might err towards that sort of behaviour and be a risk to people going through the doors?

Michael Kill: In terms of bar staff, most businesses go through a similar process that people would for employment, and disclosure is part of the application process. On the security side—I am sure that Paul will be able to give us a clear answer—they go through disclosure of their criminal background and vetting, so there is quite a robust position. So there is quite a robust position undertaken in terms of licensed security.

In terms of bar staff, the disclosure process is very similar. It is voluntary, and will go off the back of things like recommendations or—sorry, I forget the word, but it is where they go out to former employers and ask exactly how they have been. That process is just standard, in terms of whether you would go to work in an office or you would come and work in a bar. Without a doubt, the SIA security position on licensing is more robust.

Q124 **Simon Fell:** I will come to you in a second, Paul, but I'd like to follow up on that. We would obviously be really interested in looking at that police data and seeing whether our respondents' fears are borne out in that. In

an incident where that has happened—where a member of bar staff was responsible for spiking and that has gone through a criminal process and they have been picked up by the police—what sort of feedback loop is there into your organisation, so that processes can be refined and people can be better protected in the future?

Michael Kill: It is a very difficult one, as you can appreciate. It is definitely something that I can take back to members and start moving forward on. In terms of going through CRB checks and things like that, it would be very difficult for people taking on part-time jobs, as you can imagine. For part-time bar staff working 12 hours a week over two nights to go through that level of search would be very difficult and probably cost-restrictive for some businesses, though not all businesses. It is something that could be considered, but for the age group and the timing that we would have for those people, and because we have got such a high turnover in staff, it would be very difficult for the industry to adopt, potentially.

Q125 **Simon Fell:** Thank you very much. Mr Fullwood, do you want to add anything?

Paul Fullwood: We regulate just under 400,000 individuals who are SIA licence holders, which is a considerable amount of people and eyes and ears across the night-time security industry. They are men and women—predominantly men, but 10% women. As Michael said, think back many years ago to people's ideas around door supervisors. It has moved on significantly through the work of Michael and his colleagues and many people.

First and foremost, we start with, "Are these individuals fit and proper?" They are scrutinised, in terms of their applications, their UK citizenship, their previous convictions, the type of convictions, the level of convictions, how recent and so on. We then move forward in terms of disclosure. They then have to undergo mandatory training on awareness and around some of the issues we have talked about today, such as vulnerability and awareness of spiking, in terms of GHB and Rohypnol, and how to deal with violence and with individuals.

Very recently, we have introduced first aid training as well for all our licensed operatives, which is mandatory. All of them need to be trained in first aid, not specifically around drug spiking, but around if somebody had collapsed or was unconscious or was ill—they would have the necessary skills to deal with that. In terms of accreditation and training, it is in a far better place now than it has ever been. We can't be complacent—we need to keep moving forward and there is more stuff that we need to keep doing.

Q126 **Simon Fell:** Councillor Bell, have you got anything to add?

Cllr Bell: Training is key—*[Inaudible.]* The additionality of things like first aid is really important. I would love to see training on spiking rolled out—on how to manage that and who to contact, so that bar staff and door staff knew how to signpost. We have got to make sure that we do not put so

much responsibility on staff that they are unable to do their job, but I think them having a way of signposting and knowing who to contact and how to contact would be really useful. I see the licensing authority having a role to play in that in terms of the information that we can hand out to premises. I definitely think we have got a part to play too.

Q127 **Chair:** Before I call Stuart McDonald, I wanted to raise with you what Dawn Dines told us last week, which is that spiking didn't feature at all in her training when she was getting a publican's licence. Do you think that is right? Do you think that should change—that there should be training around spiking, and around other issues as well, for publican licensees?

Cllr Bell: When somebody comes for a licence for a premise, there are statutory things that we have to look at as to whether they are a fit and proper person to be able to hold a licence. They are granted that licence for life, essentially, but that is subject to review. We can review it at any time; we can go out and do enforcement visits if there are any criminal prosecutions, and we can revoke, remove or amend that licence.

I think the question there is, "Whose responsibility is it to provide that training?" If we are saying that it is the local authority and the licensing authority that need to be providing that training, that is fine—we do that for licensed drivers around safeguarding in my authority—but then you need to look at the core funding and responsibility of a licensing authority. If we want to move them into that arena of providing training, they need to be funded appropriately to be able to do that. Funding is always the elephant in the room, isn't it? Really, it is a difficult one, but we do need to take that into consideration.

Q128 **Chair:** But you agree with the principle of some training. You think that would be a sensible thing for a publican's licence.

Cllr Bell: Yes, absolutely. In terms of being a fit and proper person, I've got three children who are all aged between 24 and 17, and I want to know that when they are going out into the night-time economy, they are going into places that are safe. I have to say that the vast majority of licence holders are fit and proper, do a good job and rely on repeat trade, so they rely on their customers feeling safe and secure. They want them to keep coming back into that environment. It is not in their best interests, as a business model, to allow things like spiking to go unchallenged and un-dealt with, so I think it would be welcomed by the trade as well.

Q129 **Chair:** Thank you. Mr Kill?

Michael Kill: I just really wanted to highlight for the Chair that within the objectives of the premises licence, it actually states that you have to uphold public safety, and that would deem this as potentially being a considered part of training moving forward. It is a recommendation that we would support as an industry, in terms of enhancing that understanding and broadening the scope with more intelligence and data: that could form a considerable part of the way that we operate, particularly within operating plans. It is going to require a collective approach, and it has to have key stakeholders involved from police and

the LGA going forward, but without a doubt, I think it has an important part to play, not only with the security licence training but with premises licences. DPSs, in particular—designated premises supervisors—are the people who are in control of that licence during the operational period.

Chair: Thank you very much. Stuart McDonald.

Q130 **Stuart C. McDonald:** I have a couple of questions about capacity. Mr Kill, in the autumn, as well as increased media interest in spiking, there were reports about struggles to recruit door supervisors and a shortage in the industry, and you yourself spoke about how that was possibly putting the public in real jeopardy. Could you just say a little bit more about the extent of that problem, and the degree to which it impacts on the ability to try and prevent spiking from happening?

Michael Kill: I think there are several challenges in this, and thank you for bringing the point up. I also represent something called the UK Door Security Association. We work very closely with the SIA on several challenges around the sector. An anecdotal report or survey that was put out highlighted that the current private security sector within the night-time economy is on about 80% of pre-covid numbers, so we have a 20% deficit in resource. Over and above that, looking at the operators, there is about a 48% impact—in other words, businesses are impacted at a rate of about 48% of the businesses out there having these shortages, either having one or two lost off the top of their resource.

Over and above that, there are conditions in many licences that suggest that people have to have a level of resource in terms of licensed security from a certain time in the evening, or have to have licensed security from the time they open their doors. As you can appreciate, with the resource levels as they are, there is an impact there, so we have seen 20% of businesses either having to curtail their hours of operation, and a very moderate 2% to 3% who have to close altogether. I hope that sets the scene for the Committee.

Over and above that, as you will appreciate, there is an inordinate amount of pressure from a public health perspective with regard to things like covid passports, checking on the front doors and managing extended queues, which would draw people from an internal focus at the early point of admission and as businesses start to fill out, pushing them to go outside and start to manage the public health position in terms of driving people into the business. That is exacerbated by challenges that most of us have in terms of noise and nuisance and pressures on licensing and police to get people off the street and into businesses. As you can understand, the additional checks on public health have caused some challenges, combined with resource level. We are in a position where, given the fact that we are at a deficit at the moment, there is an immense amount of work that needs to be done to try to push more people back into the security sector, with a more diverse level of people engaged as operatives, which is becoming very difficult.

I hope that gives you a compass point, but it does present some huge challenges for the sector, particularly as we are aware that things like the Protect duty are coming along as well, which will also culminate in additional responsibilities for operators and will require further security. But the concern we have at the moment is that early January is a very low business level for many, and as we move into the end of January and start getting into the festival season there will be some additional pressures. So security resource will play a huge part in our being effective at managing vulnerability and managing spiking incidents, but also taking account of the public health requirements that are put upon us in terms of mitigations. Over and above that, there is the potential for the Protect duty position to be undertaken, so we are going to have further considerations over the counter-terror position. I hope that has given the Committee a broader understanding of the challenges for the sector.

Q131 **Stuart C. McDonald:** That is very helpful. Can I push you on how you attract people to this job? I can imagine it is an incredibly difficult job and not always particularly pleasant, so how do you get folk to do this work? Are there particular issues, for example, around the fees involved in having to undertake training and become licensed, or do you think that is a red herring and really it is just broader issues around the labour market and the fact that there are lots of job vacancies just now and really tough competition to recruit?

Michael Kill: I think it is a combination of things. We have some environmental challenges. As you can appreciate, the private security sector has a broader requirement for security, and I can give you examples of offices being protected, retail shops having mitigations that they would need in place—people standing on the floor and managing queues of people going in—and things like covid testing sites. So the requirement within the public domain for private security operatives is much greater. The payment rates for many of these operatives have been static for over 10 years, and that obviously comes down to end user and supply.

There are challenges. Although the industry supports us enhancing the quality of people coming into our sector, we without a doubt have got some challenges around late-night supply need and bringing people into an environment that potentially can be risky for them. The rates are not fantastic. For many of them it is a part-time role. So, as you can appreciate, to go through seven days-worth of training and a first aid course—Paul will clarify this—to do a 12 hour a week job that is part-time, when you have got a full-time job in the week, is not as enticing.

So we have some challenges around the industry presenting a stronger environment for people to come into. We have challenges around rates. We also have Brexit, which has had an impact as well, because a lot of people from the European Union have gone back to their own countries, and that has left us with a deficit across the country. But I think we are seeing more of an issue in terms of resource levels in the north of England. The challenge that we have—this has been discussed with the Home Office and the SIA—is a real understanding of what the market

requirement is, how many licences are out there and how many are active, against what we need in order to step up in terms of that shortcoming. That will make a big difference as we move further into the year. But we are very, very concerned that this is not being addressed more effectively—similar to the HGV issue—because at some point it is going to become a public safety challenge.

Q132 **Stuart C. McDonald:** Mr Fullwood, can I bring you in here? Does your data back up the fact that there is this big shortage? Have you concerns that, given what Mr Kill was saying about the nature of some of this being part-time work, some of the extended training requirements and costs are putting folk off? What more can be done to try to fill these gaps?

Paul Fullwood: There are a couple of things there to clarify. First and foremost, I completely agree: there are shortages within the industry. We have seen that in the last couple of months. There are a number of reasons for that, and Michael has talked about that: the low wage, the poor conditions, the pandemic and the impact of the pandemic. It is worth recognising that this can be a transient industry as well. For example, as has been alluded to, some people will do this as a part-time job and have another job. So there are a number of challenges.

Interestingly, our data shows that, as I mentioned, we have just gone to 400,000 licences across the United Kingdom. Those numbers are really high and continue to increase. Certainly we have been increasing our levels of training and that has not made a difference in that at all, really, in terms of the number of licences and public safety.

In terms of the costs, people who apply for an SIA licence pay a fee. It's over three years; I think it's around £190. Within that, we go through all the various training and the various qualifications and accreditation with them and work with them. And there are a number of things they pay on top of that. But we have certainly not seen that impacting on public safety.

What we have seen is a gap in the market in terms of trying to recruit people into the industry, and we continue to work with colleagues like Michael and other people, trying to see what we can do to bring people in from all walks of society.

Q133 **Stuart C. McDonald:** I will bring Mr Kill in; I see you want to say something further. You spoke about diversity. Is there also an issue about not enough women being attracted into this role, particularly if there are rules that it has to be a woman who would search a woman customer coming into a club, for example? Is that a challenge that you face as well, Mr Kill?

Michael Kill: Yes, it is—without a doubt. My wife is a member of SIA, a female member of security, and for the last 10 years there has been a challenge with getting female operatives into the industry. Just to go back to Paul's point, the challenge that we have is that, even with nightclubs closed, there was an immense amount of applications still going through for DS badges—door security badges. There are two types of badge. You have static security badges, SG badges, and DS badges. DS badges give

you the opportunity to work more widely in the industry, so you can work within static environments but also within frontline licensed premises. The challenge that we have is that many people go for the DS badge, because it costs the same and you go through the same process in terms of training.

So there are some considerations that need to be brought to bat in terms of the type of people who will be applying for these roles, and particularly when it comes to diversity and the encouragement for more women to step forward and take an active part in security and become a security operative. We have some challenges across all the stakeholders, not just the SIA but the Home Office, end users and the industry, in terms of creating stronger environments. But we are working through that process at the moment. We do need to address this, particularly around the spiking and vulnerability incidents. At the moment, we are looking at welfare officers outside the licensed operative position, so that we can start to step up a position whereby women can feel safer at night by talking to same-sex representatives who work for the industry.

Q134 **Chair:** Thank you. Is there anything that anybody would like to say to the Committee that you haven't had an opportunity to say?

Cllr Bell: I suppose one of the points that I did want to get across today is around the issue that we have around court backlogs and the impact on revocations for premises. If we revoke the licence of a premises on the grounds of a significant harm or risk to public safety and the venue puts an appeal in, they are allowed to continue operating. At that moment, that can take several months to get to court, so you have a premises where responsible authorities like police, fire and licensing are saying they should not be allowed to be operating, to the extent that you revoke their licence. They are then allowed to continue operating. There has to be a balance between allowing that premises to be able to have a fair appeal and to have their case heard at appeal, and having that dealt with quickly to ensure the safety of the public. That is a big concern for us, definitely.

Q135 **Chair:** Thank you. Paul, is there anything you would like to say? Then I will come to Mr Kill.

Paul Fullwood: I have four things, and I will be succinct. First, we need a national plan, a strategy, a whole-systems approach. We need to focus on prevention, education and enforcement, in terms of approach.

The second area—no surprise—is data. Data is a big issue for all of us. My plea, really, is about dealing with agencies and law enforcement—the police, for example. We deal with 43 different police forces. We just want one, so that we can try to work through that and share information as quickly as we can.

The third area is consequences. There was talk about offences. In a previous world, I used to be a police officer. I remember some of the charges for these. The reality is that these are only add-on offences for serious sexual offences—rape etc.—so there might be an opportunity to look at this from a legislation perspective and a regulation perspective. We

are currently looking at our regulation under the Manchester arena inquiry. There might be an opportunity to see how we can further improve public safety.

The fourth area is self-reflection. All of us here today on the panel have an opportunity to do far more in this particular world, and certainly we are totally invested in making sure that we do everything we can do to improve public safety.

Q136 **Chair:** Thank you. That was very succinct. Mr Kill? I am sure you are going to be as succinct.

Michael Kill: Don't worry. I think the big thing for the industry at the moment is that we are very clear that we need to have a consistent process, from operator through to police investigation, in terms of clarity about the way that spiking is being recorded. That has to be consistent right the way across the police forces. In terms of the operator and licensing, we will be able to gain that consistency, but that is going to take a Home Office drive.

Security resource, as we have heard, is a challenge, and we are working on it. But without a doubt it would be fantastic to get the support of the Committee. In terms of diversification and women working within the night-time economy, particularly in security, that is important, and we would support an initiative for that.

The other two key things that I think are vitally important are a national training standard in terms of vulnerability—looking at staff training and active bystander and welfare officer training—and a national advertising campaign that is robust and very clear, and that can be adopted by everybody moving forward so that we are all, as key stakeholders, moving forward in the same vein to stamp out this heinous crime. Thank you, Chair.

Chair: Thank you very much indeed to our three witnesses this morning. That has been incredibly helpful. We will be producing a report in the coming months, but thank you for your contributions today—we very much appreciated them.