The weaponising of COVID-19: Contamination prevention and the use of spit hoods in UK policing

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Abstract
The COVID-19 pandemic has produced a radically changed world for everyone, but its effects on police officers has been particularly acute. Officers have been subject to increased cough and spit attacks as offenders have sought to weaponise the coronavirus, and forces have responded by encouraging officers to use enhanced methods of contamination prevention. The controversial argument of whether using ‘spit hoods’ is a necessary tool in policing has been resurrected, although evidence of their ineffectiveness in the fight against COVID-19 has been brought to light more recently. Drawing on interview data obtained from 18 police officers in 11 UK forces over the summer of 2020, this article draws on interview narratives discussing contamination prevention, policing the pandemic, and the use of spit hoods.

Keywords
Coronavirus, COVID-19, policing, police, spit hoods, contamination

Introduction
At the end of December 2019, the first cases of an unusual pneumonia strain were reported in Wuhan, China; 1 week later, the coronavirus was genetically sequenced and became known as the respiratory disease ‘COVID-19’ (WHO, 2020a). At the time of publication, there were over 160 million active COVID-19 cases and more than 3.3

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million deaths worldwide. The risk of contracting COVID-19 has been very concerning for those working on the front-line, and anxiety is arguably higher for those working in countries where the virus has taken a stronger hold, and transmission is more likely. The UK for instance, has one of the highest COVID-19 death rates per capita in the world and is currently in sixth place behind the US, India, Brazil, France and Russia. The coronavirus pandemic has redefined life globally and brought new challenges and hazards to policing. There is a large body of literature discussing how policing is regarded as one of the most stressful occupations and poses a serious challenge to the psychological well-being of its workers (Elliot-Davies, 2021; Fielding et al., 2018; Liberman et al., 2002) even before the pandemic. Although it is well established that organisational factors contribute to police stress (workload, inadequate supervisor support etcetera), effective and supportive responses to officers have been the focus of more recent research (Bullock and Garland, 2018, 2020; Fielding et al., 2018). Perceptions of danger may be useful in policing because it forces officers to undertake protective working practices to avoid contamination from the clientele that the police interact with on a daily basis, such as the use of spit hoods to avoid disease and virus transmission (De Camargo, 2019). Front-line police officers are regularly subject to physical abuse; there were 30,000 assaults on British officers in 2019–2020 (ONS, 2020), and it is reported that the most dangerous part of the job may well be psychological and not physical (Fielding et al., 2018). A recent survey (published February 2021) which was completed by 12,471 Police Federation members during the COVID-19 pandemic, found that mental health and well-being issues affected 77% of serving officers, with the majority of these (90%) indicating psychological difficulties which had been caused, or made worse, by working in policing (Elliot-Davies, 2021).

During the pandemic the police have faced an impossible task in that they face an invisible disease which regularly presents asymptomatic, as well as facing the ‘usual’ hazards from more well-known viruses, diseases and ailments. The use of personal protective equipment (PPE) has always formed an important part of a police officer’s toolkit (De Camargo, 2019) and The Health and Safety at Work Act (1974) is the primary legislation regarding occupational health and safety in the UK and requires the employer to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees (see Section 2 of the Act). PPE is defined as equipment and clothing designed to protect against an identified hazard, and when the hazard cannot be eliminated or controlled to a safe working level, PPE is used to bring the risk down to a minimum (HSE, 2020). Contamination prevention has become even more important during the COVID-19 pandemic, and in addition to PPE, one of the ways in which police officers reduce the risk of contamination is the use of spit hoods (also known as spit guards, spit mesh, or mesh hood).

The use of spit hoods was approved by the Association of Chief Police Officers (ACPO) in 2007; 32 of 43 forces were using them by 2018 (Gyford, 2018), but their reception has been the subject of heated debate within policing circles and the media. Hooding has been described as ‘degrading’ (Davenport, 2019), ‘cruel and dangerous’ (Sheerin, 2017), ‘primitive’, ‘inspir[ing] fear and anguish’ (Geoghegan, 2016: 9) and ‘reminiscent of hoods used at Guantanamo Bay’ (Dodd, 2016; see also Hales, 2016). In February 2019, The Metropolitan Police’s New Scotland Yard announced the roll-out of spit hoods in London; prior to the pandemic a Metropolitan Police Federation study
showed that 95% of officers supported the regular carrying of the hoods. Although previously there was ‘no reliable information’ on spitting incidents, other forces provided figures ‘often to justify’ the decision to use spit hoods (Joyce and Maverick, 2018: 146). Before COVID-19, the likelihood of contracting serious illnesses (HIV, tuberculosis or hepatitis C for example), was reportedly low, but odd cases did exist (Gellert et al., 1994; see also human bite wounds and HIV studies – Merchant et al., 2003). These ‘war-stories’ of pollution and disgust exacerbated the expectance of danger, now ever more acute with daily news reports about coronavirus-related police deaths around the world heightening fear and anxiety. Sergeant Simon Kempton, the operational lead for COVID-19 at the Police Federation of England and Wales (PFEW), told UK MPs in April 2020, ‘now more than ever, COVID-19 is being weaponised, we need those spit guards in the pocket of every single police officer, not just in custody, on the street as well’. Offenders have been known to ‘arm themselves’ with their illness in order to pose a danger to officers, Geoghegan (2016: 6) found that ‘individuals can and do choose to use their own illness as a weapon against police officers and will even self-harm to provide a source of contaminated blood with which to spit’.

In recent months, the threat of disease transmission has increased exponentially with the arrival of the COVID-19 pandemic and many police deaths from coronavirus had been reported across the world. Although reporting practices differ and we are yet to see the true number of deaths in policing for some time, there are at least 17 police officers dead in Peru, 95 in China (The Federal, 2020) and over 250 law enforcement deaths in the USA (Officer Down Memorial Page, 2020; Police One, 2020).1 Although there are no official figures for the UK yet, London’s Metropolitan Police have reported that five police officers died in just 15 days from COVID-19 (January 2021), and data is yet to emerge from the other 42 forces of England and Wales. A Police Federation of England and Wales survey, entitled ‘Demand, Capacity and Welfare’ (Elliot-Davies, 2021), is run every 2 years to produce an assessment of the main challenges currently facing policing. The latest survey (published in February 2021) incorporated bespoke questions to include officers’ personal experiences of policing the pandemic. The main results showed that 11.7% of officers reported believing they had contracted the virus through work-related activities, and 36% of respondents were ‘very’ or ‘extremely’ concerned about becoming unwell with COVID-19. Nearly 32% of officers reported incidents where a member of the public who was believed to carry the virus had purposely threatened to breathe on them or cough on them ‘at least once’ over the past 6 months, and 24% said that someone had actually done so (Elliot-Davies, 2021: 3). To the question, ‘how often have citizens, that you believed to have COVID-19, directed the following towards you during the last 6 months?’, the answers were as follows: threatened to spit at you (30%), threatened to breathe or cough on you (32%), attempted to spit at you (21%), deliberately attempted to breathe or cough on you (24%) (Elliot-Davies, 2021: 12), demonstrating the very real threat of weaponising COVID. This research was conducted to develop previous research on spit hoods (De Camargo, 2019) and to explore police officer fears and anxieties of contracting COVID-19 during the pandemic.
**Weaponising COVID-19**

In theoretical understandings of the social construction of risk, it is claimed that workers must first feel personally vulnerable before they perceive a situation as risky (Rosenstock, 1974). Factors that may contribute to these vulnerabilities and perceptions of danger may be the lack of knowledge around COVID-19, particularly at the beginning of the pandemic in early 2020. The risk of communicable diseases has been discussed mainly in terms of well-known ‘older’ maladies such as HIV, tuberculosis, meningitis, poisonings etc. but these cases are thankfully, few and far between. Pre-pandemic, the argument for contamination prevention was supported by reference to British police constable Christopher Wilson who died in 1977 after contracting meningitis after being spat on at a football match; and in 2016, Ukrainian officer Arina Koltsova died after becoming infected with tuberculosis when arresting an infected suspect (NPCC, 2017). The likelihood of these events occurring, and the rate of mortality and morbidity is so low, that the perception of risk is further decreased. The conclusive short and long-term effects of COVID-19 however, were largely unknown at the beginning of the pandemic and thus the perception of risk was much more pronounced, particularly as there were emerging reports of young, healthy individuals succumbing to the virus. A study of 3000 COVID-positive adults in the US, aged 18–34, who became ill enough to require hospital care, 21% required intensive care, 10% required intubation, and 2.7% died (Cunningham et al., 2021). The knowledge that an individual has, to make judgements about hazards that others are exposed to, is used as a reference point to assess personal risk (Ferguson, 1997). Therefore, risk theory argues that individuals understand their own risk levels to be higher if they perceive others to be at increased risk, therefore mounting reports of police deaths across the world can only serve to amplify this anxiety.

The police in England and Wales have responded to the crisis by changing the way that they have contact with the public; Wells et al. (2020) noted that ‘many police organisations have introduced different types of communication technology, such as online crime reporting and answering queries, and the use of social media’. However, this does not apply (and cannot apply) to all, if not most, public-police interactions and has afforded some offenders the opportunity to weaponise COVID-19. Pre-pandemic the Metropolitan Police reported 264 spitting incidents between 2014 and 2016 (Cresswell et al., 2018). In contrast, ‘cough/spit attacks’ were reported on a dozen separate occasions in West Yorkshire in just 1 week in April by ‘people suffering from, or claiming to have, COVID-19’ (BBC, 2020a), a Daily Telegraph investigation into the 43 forces of England and Wales revealed there were 200 cough and/or spit attacks per week on police officers since the outbreak. Additionally, the Crown Prosecution Service confirmed it was now dealing with dozens of cases every day against front-line workers (The Telegraph, 2020).

Pre-pandemic, The Assaults on Emergency Workers (Offences) Act 2018 recommended compulsory provision of ‘intimate samples, without reasonable excuse’ from those accused of spitting on emergency workers, with ‘refusal to provide such specimens punishable as an offence’. Interim guidance has been issued by the Sentencing Council to include ‘spitting or coughing’ as an aggravating factor in common assault offences to the Assault on Emergency Workers (Offences) Act 2018 and has introduced a new high
culpability factor of ‘intention to cause fear of serious harm, including disease transmission’. Although cases are being fast-tracked through the courts with a number of people already given custodial sentences, there are claims that some judgements are too lenient and there are inconsistencies in strictness across the country; for example, in Newcastle a 39-year old woman was sentenced to 21 weeks after coughing at police as she was being arrested, but in East Sussex, a 39-year-old man ‘was spared jail for coughing in a police officer’s face and saying he wanted to infect his family with COVID-19’ (Marano, 2020). These reports encouraged the Police Federation to actively support the use of spit hoods as a contamination prevention tool. The controversial argument to promote hoodying has been resurrected to protect officers from what the Police Federation has described to MPs as ‘the appalling weaponization of COVID-19’.

Even pre-pandemic heightened levels of fear regarding virus contraction can compromise a police officer’s job and have been associated with emotional fatigue, stress and anxiety (Bullock and Garland, 2020). More recently, the Police Federation’s ‘Demand, Capacity and Welfare’ survey, which was undertaken during the pandemic, reported that 32% of officers had taken sick leave due to stress, depression or anxiety (Elliot-Davies, 2021), although whether COVID was the reason is unknown. It has been heavily documented that police officers have one of the most stressful occupations, which makes them particularly vulnerable to psychological complications, this is still an under-researched area (Deschênes et al., 2018). Workers in front-line roles, particularly during highly stressful events, such as war, or a global pandemic, can suffer from emotional job burnout and stress-related physical complaints (Randall and Buys, 2013; Waters and Ussery, 2007). During the pandemic, officers were reportedly in some cases, ‘repeatedly exposed to trauma’ as they were called to homes where people have died from COVID-19, with ‘one officer responding to 15 deaths in 24 hours’ (The Independent, 2020). The vice-chair of the Police Federation of England and Wales, Che Donald, promised that ‘work was underway to ensure officers can access support, amid fears of significant mental health related absences after the coronavirus outbreak’ has ended (ibid.). This article uses data from 18 UK police officer interviews and explores anxieties around contamination, the use of spit hoods, and how working practices have changed.

Methodology

Officers were recruited via a ‘call for participants’ on Twitter asking for volunteers. Not all officers use social media although there has been a growing interest in Twitter since 2008 from UK police forces’ wanting to engage with the public and it is used as a tool for knowledge sharing in an official capacity (Crump, 2011). Although wanted the plan was to interview front-line officers using a purposive sampling method, a type of digital snowballing took place (O’Connor et al., 2014), in which existing police contacts helped to recruit future subjects by sharing and ‘retweeting’ the call for participants. As a result, there were 131 retweets, 45,380 impressions, and 2768 total engagements with the original tweet. Although these retweets resulted in significant engagements, only 31 officers in total contacted by private message expressing interest, of which two were personally known to me. Four expressed interest, but upon receiving the participant information forms, did not contact or reply again. Around a third of these officers did
not identify themselves as working for any police force in their biographies, although positive identities were established upon sending a participant information sheet, consent form, data management plan and project summary through to a requested official police email address before participation was officially agreed. Five officers withdrew and did not rearrange after setting up interviews because of the Black Lives Matter protests and they understandably had refocused priorities and shifts rearranged. Four other officers said that they would have to ‘get the go-ahead’ from their ‘research centres’ before agreeing and did not reply after that. There are challenges to accessing police officers for the purposes of research due to long-standing reservations of ‘outsiders’ (Brown, 1996) and uncertainties about whether researchers will make ‘intentional or unintentional misrepresentations’ of events (Matrosfski et al., 1998: 2). This is even more problematic without familiar prior connections; Twitter was chosen due to its potential to access a diverse range of participants, network connections, and is generally used as a platform for ‘widespread conversation and the sharing of ideas’ (Forgie et al., 2013: 8).

As previously mentioned, it had been reported in the news that forces were enforcing restrictions and experiencing the pandemic differently (procurement of personal protective equipment/imposing regulations etc.), and therefore hoped to interview officers from a range of forces so force preference/location was unspecified. The intention was to access the ‘behind-the-scenes reality’, and not the potentially ‘sanitised public version’ of officer experiences (Rugg and Petre, 2006: 111–112). As I did not know most of the participants personally, it is difficult to sift exaggerated ‘story-telling’ from candid accounts, but data cannot be omitted because of this as the motives for participation ‘are likely to be both multiple and elusive’ (Litoselliti, 2003: 23). This study, with 18 participants, is exploratory in nature, and as officers were from 11 different constabularies across England, generalisability is unviable. However, this was not the intention of this qualitative project, and it was designed to access the experiences of the officers who participated. Similar to Bullock and Garland (2020), the officers who volunteered were self-selecting, and the resulting accounts proved to be quite negative, particularly regarding the attitudes and support from management. Officers may be ‘more motivated to speak [to researchers]’ (Bullock and Garland, 2020: 823), to perhaps air grievances in their force’s handling of the pandemic. These accounts are not intended to be representative of overall officer experience in that particular force, or of the police in general; after all, the value of the interviews lie in how officers personally make sense of events (Bullock and Garland, 2020).

There was no planned recruitment window, but due to the time sensitivity of the ongoing problems with PPE, sharp increase of infection rates, and increasing anxieties (De Camargo, 2021), it was desirous to interview officers as soon as they contacted and consented to the research. Interest tailed off after 2 weeks and no more officers made contact, nor were any officers/roles rejected for interview. Interviews took place over Zoom between May and June 2020, resulting in over 20 hours of semi-structured interview data recorded with the platform’s recording function, and officers were informed verbally and in the emailed forms that all data would be anonymised and they were permitted to withdraw their participation at any time during the interview or post interview up to a specified date.
Zoom was launched in 2012, its popularity soared as a conference platform at the start of the COVID-19 pandemic, and although the academic literature predominantly refers to Skype when discussing digital interviewing, the advantages and disadvantages can be similarly applied to Zoom – participants did not have to have a Zoom account to take part (unlike Skype), and joined the meeting via an emailed link. Interviewing in this way encourages participants where there are time and place limitations (in this case, social distancing and lockdown restrictions), and as all of the interviews took place either in the participant’s homes (14 out of 18), or in a work office (4 out of 18), this provided convenient conditions (Janghorban et al., 2014). However, despite the benefits of digital interviewing, necessity of access to a high-speed internet, familiarity with online communication, and having digital literacy can affect the nature of the interview (Deakin and Wakefield, 2014). Fortunately, all interviews were conducted without problems, and interviewing participants in their homes (with views of kitchen, living rooms, personal belongings and the like) afforded an unusual level of intimacy and informality.

Of the 18 officers, 11 were male, 7 were female, and they ranged from 22 to 54 years of age (average 35 years). 16 officers were married or in a relationship and 15 lived with their partner (1 lived with parents, 2 were single and lived alone), and 11 officers lived with children/stepchildren. The officers’ experience ranged between 2 and 25 years (average 10 years), and the following roles were identified: 15 police constables/response/special/authorised firearms officer, and 3 sergeants/custody sergeants. The interviews were conducted with 18 participants from 11 different forces: Metropolitan Police, Norfolk, Lancashire, Durham, Thames Valley, West Mercia, Cumbria, West Midlands, Sussex, Yorkshire, and Suffolk. Ideally these interviews would provide some insight into an ethnically diverse group of officers, but this was not possible as the respondents self-identified as white British (n = 16), white Irish (n = 1), and Latin American (n = 1). The lack of diversity limits this study and it would be pertinent to investigate issues of diversity and intersectionality in any future work on this topic. In the sections that follow, officer’s narratives of their fears and anxieties around the weaponising of COVID-19 are explored.

Interviews were professionally transcribed verbatim using only the audio recordings from Zoom with interviewees anonymised and given pseudonyms. To make sense of the data extracts presented, participants (P) are identified numerically and by force, although on occasion, officers were fully anonymised due to the identifying nature of events. They were analysed thematically via processes of data familiarisation, coding, and then formation of themes. Using nVivo software, various nodes were produced such as ‘fears of contraction’, ‘the use of spit hoods [pre- and post-COVID]’, ‘use of force’, and ‘management support’ etcetera. Clarke and Braun (2018) described thematic analysis as the process of identifying, analysing and reporting patterns within data, and within this process immersion with the data was conducted by reading and familiarising with the transcriptions and producing initial observations. Initial themes (codes) were generated pertinent to the research aims and applied systematically using nVivo across the whole data set. This was an ongoing process of refinement and review in which quotes were chosen to illustrate themes.
Policing and the risk of communicable diseases

Spit hoods have been a topic of controversy for at least the last decade. Made of a lightweight mesh, these hoods are instruments of restraint, which when placed over a person’s head, help minimise the risk of contamination from communicable diseases (NPCC, 2017; PFEW, 2019). It also helps to curtail the injuries associated with a suspect biting, spitting or coughing, and although it cannot prevent the physical biting injury, it can reduce the transfer of bodily fluids. Previous devices have been considered which involved the police officers themselves wearing goggles/masks but were found to be ineffective as it offered no protection from biting or contamination into open wounds, or contamination onto the officer’s person (NPCC, 2017). It must not be underestimated that aside from the obvious health implications, the unwanted transfer of bodily fluids is a distasteful experience in itself. COVID-19 is most easily contracted through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces (HSE, 2020), it must not be ignored that there are many other objectionable side effects of fluid transfers aside from COVID-19, such as bacterial infections (e.g. tuberculosis), or variations seen in viral infections such as the flu. Geoghegan (2016: 2) argued that those considering the policy and application of spit guards ‘must be under no illusion that being spat at is a real-world and deeply unpleasant experience’. Pre-pandemic, police forces primarily advocated for spit hoods on the basis of risk of transmission of infectious diseases. It was previously claimed that this risk had been ‘exaggerated’ by forces and that there was ‘little or no justification for the use of spit guards for protection against infection’ (Kennedy et al., 2019: 149). P16 (Thames Valley) recalled an incident:

About two years ago, someone spat at me, it landed on my wrist. It was horrible, it’s a horrible feeling on you ‘cos you know it’s come from someone’s mouth […] and a year before that, I had someone spit in my face and it got in my eyes and stuff. It goes in your mouth, it goes in your eyes, ‘cos you’re arresting people face to face and your hands are on their hands, there’s only one thing left and it’s them spitting in your face.

The HIV epidemic offers similarities in that fear and anxiety surrounded the unfamiliar nature of the virus, particularly as transmission was also not accompanied by noticeable signs or symptoms. Police officers were tasked with working in an environment of unknown danger in the 1980s. A perceived inability to manage the risk of HIV contraction intensified fear and stress for officers, and much like the COVID-19 pandemic, officers had only limited information (Jermier et al., 1989). COVID however, transmits differently from HIV, and the mode of coronavirus transmission was known very early on; only 10 days after the first reports from Wuhan, the WHO released comprehensive advice on known modes of transmission of respiratory viruses like COVID-19, and included infection and prevention control guidance for airborne and aerosol generating procedures (WHO, 2020c). Conversely, the way that HIV transmits through contamination blood particles was not discovered until much anxiety and stigmatisation had occurred. In 1981, the centres for disease control and prevention (CDC) identified San Francisco resident Ken Horne as the first patient of the AIDS epidemic in
the US, although the origin of the virus can be dated back to the 1920s in what is now the Democratic Republic of Congo (Faria et al., 2014). It was officially recognised as a new health condition in the US in 1981, but it wasn’t until 1983 that the HIV virus was identified by researchers at the Pasteur Institute in France. For at least a couple of years, the absence of conclusive evidence about HIV and its link to AIDS heightened and stigmatisation surrounding the virus (Farmer, 1992). In 1989 police officers in New York were advised by senior officers to put on gloves to deal with gay demonstrators at a rally against the Catholic Church, out of a ‘misguided fear’ of contamination (Sindelar, 2012) and the wearing of medical gloves served to evoke feelings that clientele were subhuman (Twigg, 2000). Although there is much more evidence available about the risk of contracting HIV in 2020, controversy and misinformation remains; in 2006, a 42-year old HIV-positive man in Texas, was sentenced to 35 years in prison for using his saliva as a ‘deadly weapon’ by spitting at a police officer during his arrest for drunken disorderly (Bernard, 2008). The case outraged UK HIV organisations, who claimed (correctly) that HIV cannot be transmitted via spittle. It has been argued more recently that HIV being used within narratives of ‘danger’ and ‘disease’ is outdated science as the modern preventative treatments now available ensures that HIV is far less harmful than it was in the 1980s (Ashford et al., 2020). The coronavirus pandemic was likened by an officer to the HIV epidemic; officers still seemed troubled about the contraction of certain viruses and the HIV stigma evidently remains:

I would say that, if you were bitten or spat at or bled on by someone who had hepatitis or HIV or something like that, I would say that those would still probably be more worrying and triggering than it would be if someone were to cough on you and they said they had COVID. Now, I think that’s probably not based on evidence – it’s probably just based on preconception of, you know, HIV or hepatitis. (P17)

Although there have been no recorded cases of occupational HIV transmission in the UK, it is still one of the viruses that the police are most concerned about contracting at work (BHIVA, 2014). Before the pandemic the actual transference rate of illness and disease was comparatively low; COVID-19 however demonstrates a very real and dangerous threat to front-line workers. The WHO has recommended a distance of at least 1 metre (3 feet) between individuals as the virus is transmitted by bodily contact, droplets and fomites. The nature of a police officer’s job, much like healthcare workers, is the proximity in which they work to individuals which cannot be avoided, particularly if they have to arrest or move potential offenders making social distancing impossible. Although COVID-19 seems to severely and predominantly affect already high-risk groups, a significant number of people with no underlying health conditions have died. These risks were not overlooked by officers:

I have noticed that any officers that have been to a COVID death ended up with COVID symptoms afterwards and [have gone] home […] there seemed to be a distinctive pattern of people who have gone to the deaths. (P13)
There is a definitely an atmosphere of fear [. . .] I think that COVID still isn’t particularly understood. I don’t think the risk or the long-term risks of actually contracting the virus are very understood. So, I think people probably still underestimate it. You know, the death tolls are massive out there, I still think people underestimate how deadly or debilitating this virus can be. \( P17 \)

Everyone was – erm, not – frightened’s not quite the right word, but there was a lot of apprehension around it and a lot of ‘how are we gonna do this?’ \( P2 \)

Although they did not necessarily underestimate the hazardous nature of the virus, officers reasoned their job is consistently dangerous and COVID-19 was just another risk:

I don’t fear getting it. Just put it this way, which is greater? The chance of me dying on a blue light run responding to an emergency or dying from COVID being fit and healthy, I’m more likely to die on a blue light run, aren’t I? So, what do we do? Stop blue lighting? Do we stop responding to incidents? Well we don’t, do we. We calculate that risk. We manage that risk and we’ve shielded our most vulnerable [. . .] police officers take a risk every day and we take a calculated risk on based on the information that’s available to us. So, if we went into work fearful of that risk every day, it would be a very, very painful existence. \( P15 \)

In the early stages [of the pandemic], we weren’t really sure what to make of it [. . .] but obviously my viewpoint has changed in line with the data. For me, work’s always been a high-risk environment, and my personal risk tolerance is very, very high [laughs]. The jobs that I end up in tend to be sort of high-risk, so I suppose it’s something I don’t really sit there and worry about. \( P18 \)

The HIV outbreak in the 1980s demonstrates the problematic nature of heightened anxieties surrounding the contraction of ailments whose characteristics are largely unknown at the time. The wearing of gloves, surgical face masks, and the usage of hand-sanitiser, although somewhat effective against the spread of COVID-19 (De Camargo 2021b), are not effective enough protection when the virus is weaponised. As nearly 30% of the 12,471 surveyed Police Federation officers reported incidents of the public seeking to weaponise COVID-19 (Elliot-Davies, 2021), the topic of spit hoods as a necessary contamination prevention method is important to explore, particularly because the Police Federation have always been insistent of their use, but even more so since the start of the pandemic.

**The controversial use of spit hoods during COVID-19 and officer use of force**

Maximising safety and minimising risk are two of the central themes in designing frontline working practices of emergency personnel. As there is a desire to predict offending behaviour and ‘maximise certainty in an uncertain world’ (Kraska, 2004: 280), there
exists a need to risk manage criminal behaviour. As the police are forbidden to use the ‘warning markers’ present on the Police National Computer (PNC) to establish whether an offender has displayed previous cough or spit behaviours, officers must react quickly to a potentially very dangerous situation. Although there are sometimes (for want of a better phrase) ‘sound warnings’ of an incoming spit attack, these cannot be used as predictive tools, unlike in the US correctional services where prison officers are trained to treat all inmates as if they are HIV-positive and are proactive in their prevention of transmission (Alarid and Marquart, 2009). Officers found the restrictions in the UK frustrating:

We carry warnings on the PNC – that’s the whole reason that they’re there is to tell us on previous occasions someone has spat, punched, kicked at, bitten, has HIV or whatever. So, we have these warning marking to inform our decisions about what we do, and yet you’re constrained and inhibited by the training. You’ve got to wait until the point that they’re saying ‘I’m gonna spit in your face’, or they spit in your face and then that’s the point you sort it out. It’s stupid. (P18)

I mean I understand that you can’t use the fact that they’ve spat at officers every other time as a reason to use it, I get that, but a leopard can’t change its spots: if you’re a spitter, you’re a spitter. (P5)

Perhaps most controversially of all, was the admittance by an officer in Thames Valley that hooding was now being used as a preventative measure for detainees during the pandemic:

There has been a slightly different tweak because officers are being allowed the option to use them as a preventative, which has never been the case before […] We have made a policy that during this [pandemic] if somebody is under arrest, they will [be made to] wear a mask and gloves which are obviously supplied by us. If they refuse to wear a mask whilst being transported, they will be put in a spit hood. (P6)

Officers admitted that although they generally had access to spit hoods either in the station or personal issue, most did not use them. Officers saw them as a ‘last resort […] because it’s not nice to put that on someone’ (P11). Interviewees fortunately had little experience of spitting incidences, although they all knew of at least one other colleague that had been spat on in the past or during the pandemic and were aware of the media reports: ‘It is an issue, you hear those jobs come in on the radio quite a lot – people coughing in officers’ faces and biting, spitting. You know, it is really common actually’ (P9). P16 conversely perceived his risk to be low:

[I’ve been spat on twice] it’s not a pleasant experience, but I know it’s incredibly hard and unlikely to contract a disease via that method. I mean a lot of people keep banging on about that Ukrainian officer who died after being spat at in the face, but I think you’ve got to be very unlucky; I think I’m more likely to win the lottery than go that way.
Section 3 of the Criminal Law Act 1967 authorises ‘such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders’. Similarly, Section 117 of the Police and Criminal Evidence Act 1984 enables officers to use ‘reasonable force’ in the exercise of any power. Prior to the use of spit hoods, a person who was biting or spitting at officers would either be put on the ground or restrained with their head forced down, which is arguably more harming:

People talk about them being degrading, but for me, the alternative is that we wrap someone’s t-shirt over their head, and we force the head down, like down between their legs. For me, what’s more degrading, is it putting a spit hood on, or is it doing that. I would argue that a hood is less degrading. (P15)

Similarly, PFEW’s John Apter argued that the hoods were an effective and less restrictive method of preventing biting and spitting. The Metropolitan Police released a statement advising that its ‘medically supervised tests [show that hoooding] presents no risk to a suspect’s breathing’ (BBC, 2020b). Similarly, a 2019 study found that the use of a spit hood produced ‘no clinically significant changes’ in the ability to breathe, provided the detainee was healthy; in summary hooding is safe unless a person has an underlying condition (Lutz et al., 2019). This caveat seems most significant in the use of spit hoods during the pandemic as it is these very symptoms of the coronavirus that can severely hamper a person’s ability to breathe, and officers have no way of knowing of underlying health conditions. Officers may be inclined to use them more readily due to current events and awareness of media reports of cough and spit attacks. In addition, officers surprisingly expressed the desire to use even more potential injurious measures:

I can’t see why [forces] wouldn’t have [spit hoods]. What would they rather? You keep hitting them in the face? Because if someone spits at me in the face, I’m gonna hit them in the face, or hit them and get them away from me. So, you could just use a hood and use minimum force – it’s less paperwork, there’s less to write. (P16)

I mean, to be honest, this is the ugly side of it; if you know someone’s about to spit you tend to get a pre-emptive strike in. Whether that’s grab hold of their head and turn their face away, or give them something else which I won’t say . . . (Officer anonymised)

There was a chap biting his cheeks, like he was threatening to spit at me, so I just put the spit hood on straight away, I didn’t even wait for him to try it, so you can do it with a threat, and we can use force to put masks on people now as well, so if they are threatening then we have been told that we can use necessary force to put a mask on. (P12)

The last quote is perhaps even more interesting considering a few years ago Sussex Constabulary was successfully sued for £25,000 compensation for police brutality against victim Paul Smith using PAVA spray and a spit hood. Donaghue solicitors, who represented Mr Smith, specialise in civil actions against the police and regularly blog
about police brutality and have called for the removal of spit hoods. Other officers noted increasing use:

Yeah, I have used it on a girl that spat at us. We’ve probably used it more than we have done [pre-pandemic]. Anyone that’s threatening to spit, anyone in the back of the van that’s spitting, as soon as they come out the van now, they’ve got a spit hood on. (P13, Lancashire)

Yeah [we’re using them more]. West Yorkshire has always had a very liberal approach to the use of spit hoods […] We’re positively encouraged to use them. It astounds me, honestly astounds me that the Met have only just brought them in. (P15, Yorkshire)

In response to increased reports of weaponising COVID-19, officers in X Constabulary have only been spit hood trained ‘in the last few weeks [May 2020]’ (P5) although this was perceived to be a delayed copycat response to the Metropolitan Police finally allowing officers to use them:

X didn’t routinely allow them and then they basically said ‘Okay now that the Met has…’, so really when the Met finally grew a spine and decided to protect their officers [we followed suit], although I was laughing at the training so apparently when you use [the spit hood], you’ve got to bear in mind the dignity of the spitter. Right [laughs]. (P5)

Even before the law about wearing masks in some public spaces came into force, some officers expressed actively encouraging detainees to wear PPE:

‘The last few times I’ve arrested people, [custody staff have] not asked them but they went through a phase of ‘they need to put this mask on’.

I say ‘would you like some gloves, would you like a mask? Is that something you would like to wear?’ If they say no […] then that’s just a risk we manage’. (P18)

As explored with the examples in this section, officers agreed with the use of the spit hoods, with P5 disparaging the Metropolitan Police for ‘finally’ deciding to ‘protect its officers’. In line with the Police Federation’s support on the importance of spit hoods, particularly during the pandemic, there were admittances of (over)use of force, and even instances of using the hoods as a preventative measure (i.e. a ‘pre-emptive strike’). There is currently no conclusive evidence of their safe use on people who have, or may have, COVID-19, and in June 2020 Amnesty International, the world’s largest human rights organisation, called for the devices to be withdrawn from use pending detailed studies, evidence of their effectiveness and the likely risks. This request has so far been ignored, which is ‘in stark contrast to other types of policing equipment that has to undergo rigorous medical and scientific testing before they can be authorised for use’ (Corrigan, 2020).
Spit hoods and the increased risk of COVID-19: The new evidence

Although the act of hooding has always been controversial, their use has been, perhaps understandably, encouraged by police forces around the UK during the pandemic. At the onset the Police Federation in Northern Ireland called for the immediate introduction of spit and bite guards to protect officers after many reported cough attacks. This national roll-out was justified on the grounds that hooding proving increased protection against COVID-19. At the beginning of the pandemic PFEW’s Simon Kempton originally argued:

COVID-19 is not only transmitted via aerosol means, through the air, but by contact with contaminated surfaces. The spit guards help to prevent the saliva, phlegm or other bodily fluids being weaponised and contaminating surfaces [...] This protects not just officers, but the wider public we serve. And actually, as important it is for all of us to be mindful of COVID-19, my colleagues face contact with many other communicable diseases when subjected to a spitting or biting assault.

More recently in June 2020 however, in probably one of the most controversial volte-faces, Amnesty International secured a police admission that spit hoods ‘offer no significant protection against COVID-19’ (AIUK, 2020). Amnesty UK (AIUK) called for the immediate retraction of the recommendation that every officer should carry spit hoods during the pandemic. Evidence from the manufacturers has now explicitly shown that the most widely used hood in UK policing, the ‘Spit Guard Pro’, provides no protection against coronavirus spread and may actually increase the risk of transmission. It now transpires that the process of fitting the hood would result in a ‘cloud of virus particles’ and the subsequent struggle is likely to be a ‘significant aerosol generating event’ (AIUK, 2020). Oliver Feeley-Sprague, the police programme director for AIUK said that the hoods ‘could actually be seen as an un-safety device’, and admitted the latest admission is ‘startling, especially for any police officers who might have previously been under the impression that these devices would help keep them safe’.

Hooding requires officers to supervise offenders wearing them at all times, and under no circumstances are officers allowed to use them on suspects that are vomiting, bleeding from the nose or mouth, or having difficulty breathing. Due to common practice of officers handcuffing offenders prior to putting the hood on means that the user is unable to remove it in an emergency. This is concerning with reports of at least 10 spit-hood related deaths in police custody since 2001, although the direct link has yet to be proven (Watkins, 2020). It is known that COVID-19 causes severe breathing difficulties (WHO, 2020c), including damage to the lungs and airways. AIUK (2020) has expressed concern that any use of force in hooding presents additional risks of the offender panicking, increased stress and anxiety, and can amplify the risk of restricting or impairing breathing ‘irrespective of the breathability of the hood itself’.
Conclusion

Policing is a source of chronic stress and arguably one of the most mentally taxing occupations, particularly when combined with lack of public support and heightened risks of contamination. Police officers suffer from numerous mental health problems at a much higher rate than the public (Hartley *et al*., 2011), and the significant problems that officers have faced during the crisis have increased the potential for stress and anxiety exponentially (Elliot-Davies, 2021). Stogner *et al*. (2020) noted that police officers are more likely to be heavily impacted than the general population as a result of the pandemic because they are ‘essential workers’, required to continue to work in close contact with the public while others shield from the virus at home. As well as experiencing increased stress risk ‘due to the prolonged threat of virus exposure’, they are now much more likely to come across individuals suffering from existing mental health problems which have been aggravated by a ‘fear of contagion, economic uncertainty, resource shortages, and isolation’ (Stogner *et al*., 2020: 2). After the terrorist attacks of 9/11, over 20% of New York emergency responders reported PTSD symptoms more than 4 years later (Pietrzak *et al*., 2012), and as the long-term effects of the virus are still unknown, we are unlikely to grasp the full repercussions of COVID-19 for several years to come.

The long-term effects of policing the pandemic are yet to be seen – it is likely that most of the serving police officers around the world will not have dealt with a crisis of this magnitude, particularly for such a prolonged period. Previous traumatic events, such as the 7/7 attacks in London and 9/11 in America, are comparatively much shorter in duration. The sustained exposure over several months (with no end date in sight) may limit police officer capacity to engage in positive coping strategies (Stogner *et al*. 2020). The executive director of the US-based Officer Down Memorial Page, Chris Cosgriff, told The Washington Post, that by the end of the pandemic, ‘it is very likely that COVID will surpass 9/11 as the single largest incident cause of death for law enforcement officers’ (Ingraham, 2020). At the time of publication, England was in the ‘third wave’ of the pandemic and the whole of the UK was emerging from full lockdown. Before this, local lockdowns were being regularly implemented across England which may have added to the stress of policing areas deemed to be more high-risk, and perhaps more worryingly, Interpol (2020: 13) reported that ‘infected individuals may deliberately move from affected areas to non-affected areas, despite their medical condition and potential travel restrictions in place’.

On a positive note, on the 9 November 2020, the UK government announced the breakthrough of a COVID-19 ‘milestone’ vaccine offering more than 90% protection (Pfizer, 09/11/20). The first vaccine, licenced by Pfizer, was given in early December and at the time of writing (April 2021) there were three vaccines being rolled out in UK: Astra-Zeneca, Oxford and Moderna. Those who are in high-risk categories were prioritised first for the vaccine, although this did not include police officers – perhaps unsurprisingly considering the Office for National Statistics does not actually include police officers as being in a ‘higher exposure occupation’ (ONS, 2020b). On the 4 January 2021, John Apter, the head of the Police Federation of England and Wales, urged the government to ensure the police received ‘priority access’ to the COVID vaccines, and advised that the situation is worse than ever, with one in six officers off with COVID-
related absence (*The Telegraph*, 2021). On the 26 February 2021, Phase 2 of the UK’s vaccine roll-out was announced, although the decision to distribute the vaccine based on age (and not occupation, unless NHS or care home staff) has been strongly criticised by the Police Federation. John Apter, has angrily spoken out against the Vaccination and Immunisation Joint Committee’s decision calling it ‘a deep and damaging betrayal that will not be forgotten’ after the plans did not include any specific vaccination provisions for police officers (McCulloch, 2021). Coupled with many officers’ experiences in this study and telling results from the Police Federation Survey (Elliot-Davies, 2021), it seems that the weaponizing of COVID-19 is not lessening. With a third of officers being subject to coughing and spitting attacks (or threat of), it is perhaps unsurprising that such a large proportion of officers support the use of spit hoods.

Understanding factors that influence perception of risk is important to disentangle the complex concept of ‘risk’ and danger to police officers. These will directly influence officer behaviour in relation to police-public interactions, risk-taking behaviour, work attitudes and the discretionary use of controversial contamination prevention methods such as spit hoods. The officers interviewed for this study expressed their worry about the unknown nature of the virus and argued that forces were actively encouraging the use of spit hoods, and in some cases justifying their use as a proactive precautionary tool as it was ‘better to be safe than sorry’. However, since the AIUK presented damning evidence from the manufacturers of the most widely used spit hood that they were not effective and actually may increase the risk of the COVID-19 transmission, we have yet to see a volte-face from UK police forces. Individual areas may have discouraged or withdrawn hooling from use but this has not been reported publicly; and as interviews took place before Amnesty’s report, it would be interesting to explore officers’ reactions to the new evidence. As an small exploratory study, it is difficult to draw any conclusions about officers’ experiences, but the data provides a snapshot of some officers’ fears and anxieties during the first few months of the pandemic. Another welcome area for future research would be international comparisons between urban and rural areas particularly as Stogner *et al*. (2020) noted that following 9/11 the stress levels of officers were affected much further outside the specific attack locations. Presently, the coronavirus seems to be concentrated mainly in cities because urban areas are more densely populated and have ‘greater potential to turn into hotspots for contagion and diffusion of disease’ (Enenkel, 2020). Consequently, officers may have different perceptions of disease transmission based on whether their force area has been hard-hit by COVID-19 (De Camargo 2021) therefore affecting perception of risk. The very welcome news of the vaccine allows some hope for officers that they will be vaccinated in the next few months (if the current swift roll-out rate is continued), and it would be interesting to interview officers at various stages throughout (pre- and post- vaccine for example) and indeed, post-pandemic (whenever that may be), but it must not be forgotten that there will inevitably be questions that need answering about the government’s handling of the pandemic. The data from this study, and indeed the 12,471 responses from the Police Federation survey, highlight that police officers are under significant stress resulting in negative impacts on their well-being. John Apter, following the publication of the survey results, has again lobbied the government insisting officers ‘must be heard’, and argued ‘they must be given all the protection they need to protect themselves and this includes
being prioritised for the COVID vaccine’ (PFEW, 2021). In the meantime, personal protective equipment, and the use of spit hoods, may still be officers’ preferable choice of contamination prevention until the pandemic is over.

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Notes
1. These figures have been collated from various newspaper articles as there is no international database recording police deaths worldwide. A non-profit memorial charity has reported that the coronavirus pandemic has been responsible for more police officer deaths in the line of duty than any other cause combined in 2020 (Officer Down Memorial Page, 2020).
2. ‘Call for participants: I am looking to interview front-line police officers policing the pandemic (ethics approved). I am interested in the fears and anxieties of contracting COVID-19 during this time – Interviews will take place over Zoom and will last approximately 1 hour. Please DM [direct message] me if interested. I am looking for around 20 officers as it is an exploratory/pilot study. Please retweet to your policing networks.’
3. Conversely several officers asked for reassurance that their interviews would be anonymous – interestingly these same officers also asked for the link to my university profile to ‘check credentials’ even though my job, university workplace and real photo is on my Twitter profile.
4. British Society of Criminology ethical guidelines were adhered to and approval was sought from the university ethical committee before undertaking this study. All participants provided written and verbal consent to take part in the research and guarantees of anonymity were made.
5. The first lockdown in England started on the 23 March 2020, with restrictions easing on Saturday 4 July. The second lockdown began on the 5 November 2020, with all areas in England entering ‘tiered’ restrictions. The tiered restrictions for each area were decided based on five factors: ‘case detection rates in all age groups, case detection rates in the over 60 s, the rate at which cases were rising or falling, the number of positive cases detected as a percentage of tests taken, and pressure on the NHS including current and projected occupancy’ (O’Reilly,
2020). The third lockdown started on the 4 January 2021 and restrictions began to ease on the 12 April was yet to end at the time of writing.

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