



Public Health
England

Protecting and improving the nation's health

Health and justice health needs assessment guidance:

Police custody

Part 3 of the health and justice health
needs assessment toolkit for prescribed
places of detention

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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1. Introduction

This document provides guidance which sets out the type of information and data that should be included within a holistic police custody suite health needs assessment (HNA), as part of informing the commissioning of healthcare services in these settings.

It is part 3 of a HNA toolkit and should be read in conjunction with [Part 1](#) which provides background information about the purposes of a needs assessment, the policy context of HNAs in prescribed places of detention and how to get started.

1.1 Who this guidance is for

This guidance is to be used by all partners responsible for participating in the production of a HNA for police custody suites.

It is anticipated that the commissioning of health services within a police force area will be conducted at force level and will consider the health services required across the individual police custody suite estate in that police force area.

The force level HNA will need to analyse and synthesise the needs and issues from each custody suite, giving the opportunity for overall strategic recommendations, as well as specific operational recommendations.

Service commissioners should take into account the duties placed on them under the Equality Act 2010 and with regard to reducing health inequalities under the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities. Guidance for commissioners is available [here](#).

1.2 How to use this guidance

Each section of this document sets out guidance on the type of information that you will want to consider including your police custody HNA. Each section also signposts users to relevant data sources.

Users of this guidance are advised to ensure that they are accessing the latest version by downloading the [correct version](#)

If you wish to contribute to updating the guidance please send content to the Health and Justice email box health&justice@phe.gov.uk. Any suggested amendments or alterations will be quality assured by the HNA Working Group, prior to being accepted and incorporated into the on-line version. Partners are strongly encouraged to contribute to the further development of the guidance.

2. Strategic overview

Various reforms across the crime, policing, health and justice systems have been introduced since 2010. The reforms apply to different geographical locations and reflect devolved responsibilities. Key reforms include the following:

- The **Health and Social Care Act 2012** introduced substantial changes to the way the NHS in England is organised from 1 April 2013, including changes in the commissioning of health services provided for people living in the community and those in a detained setting.
- The **Care Act 2014** clarified the responsibilities of local authorities towards people in prison who have care and support needs.
- The **Police and Social Responsibility Act 2011** introduced **Police and Crime Commissioners** (PCCs). The role of the PCC is to hold chief constables and the police to account. PCCs have been elected by the public; effectively making the police answerable to the communities they serve. PCCs aim to deliver an effective and efficient police service within their force area.
- The **Anti-Social Behaviour, Crime and Policing Act 2014** demonstrates a continuing commitment to protect the public from crime, serious disorder and anti-social behaviour by giving local police forces the ability to take decisions that fit the needs of the area they serve and to ensure that they are accountable to local people for these decisions.
- The **Offender Rehabilitation Act 2014** makes changes to the sentencing and release framework to extend supervision after release to offenders serving short sentences. It also creates greater flexibility in the delivery of sentences served in the community. The Act provides a range of provisions that affect the local delivery landscape including the creation of resettlement prisons, a national probation service and community rehabilitation companies (CRCs).

From a public health perspective, when developing a police HNA it is important to be aware of relevant NHS and public health outcomes, especially those that are a priority for people in prison such as drug treatment outcomes, which are available [here](#)

In 2016 the commissioning of police custodial healthcare will transfer to NHS England. Every police force in England has entered into a partnership board to oversee transfer and the on-going commissioning and oversight of delivery of police custodial healthcare.

3. Executive summary to a police custody health needs assessment

The executive summary for the HNA summarises the main findings, high level themes and consequent recommendations. It is important to ensure that the executive summary provides contextual information about the setting in question and a short overview of the governance arrangements established to develop the HNA and to act on the ensuing recommendations.

The HNA should inform the development of a strategic response by providing evidence based recommendations for securing health services that are appropriate and necessary for the setting(s) in question.

The executive summary should also:

- provide a snapshot of key findings arising from an analysis of qualitative and quantitative data used to establish the health needs of individuals being detained in police custody suites
- be informed by, capture and summarise key parts of the remaining sections of this document
- be written after the remaining sections of this document have been completed
- consider its readership, including all community stakeholders, such as directors of public health, who may wish to engage with the information on a local authority footprint

It is important to acknowledge that some recommendations may have direct implications for local partners including local Safeguarding Children Boards, Strategic Partnerships and Health and Wellbeing Boards. You may wish to highlight which partners will be directly impacted upon by recommendations that are made.

4. Introduction to a police custody health needs assessment

The introduction to the HNA will normally include the following topics:

- aims and objectives of the HNA
- why the HNA is needed and the national and local strategic context, including:
 - how it fits with the commissioning of services in the police custody suites across the force area
 - what needs to be done to ensure health services commissioned meet the needs of individuals detained in police custody suites and provide value for money and effective care
 - review of any previous custody suite HNA findings
- process - description of how the HNA was undertaken and is to be progressed:
 - review of roles and responsibilities of those producing the HNA
 - timescales
 - review and oversight group / membership, including governance of HNA and subsequent action on recommendations

5. Demography and health of the local general population

The local general population may or may not be representative of the population of detainees within a custody suite, but general information on the local population can inform the HNA. In particular, you should consider:

- general population data – numbers, age, ethnicity, etc
- socio-economic factors, including deprivation, employment, housing, etc
- health of the local population – including life expectancy, lifestyle factors (smoking, physical activity, obesity, drug and alcohol, sexual health), long term conditions, mental health

5.1 Data sources that can be used

There are a range of data sources that can be used to inform the HNA:

- census, population demographics can be found [here](#)
- each local authority has a local health profile which gives information about the health & wellbeing of the local resident population which can be found [here](#)
- other general demographic information will be found within the local Joint Strategic Needs Assessment (JSNA) – accessible via local authority websites
- for children and young people ChiMat and Child Health Profiles can be accessed [here](#)

6. Description of the police custody suite and detainee population

Give details of custody arrangements in your area, which should be available on police IT systems and includes:

- detail of the police custody suites for which this HNA applies
- capacity - total number of cells available for adults, children and young people, men and women
- staffing levels and how they vary to manage activity
- policies on custody and dispersal - some forces have a custody dispersal system which means detainees go to the custody suite which is 'quietest' at any one time. This might mean detainees being taken a relatively long way from where they were arrested / their home address. This raises issues in terms of accessing in-reach services whilst that detainee is in custody (such as appropriate adults, mental health services, etc) and can have a big impact on the custody healthcare provider

6.1 Police custody suite workload - population profile

Provide aggregated anonymous data on individuals being detained in the police custody suite including:

- age range / profile
- gender
- provenance of detainees by post code
- ethnicity
- disability
- homelessness
- bailed address
- armed forces veterans (if recorded)
- other routinely collected data eg suicide markers
- custody suite activity:
 - number of adults per annum
 - number of children and young people per annum
 - analysis by day / time of day
 - trends in detainee / arrest profiles (ie type of offence and what time of day (for the past 3 years)
 - numbers seen as voluntary attendance
 - average length of detention (longer detention may mean more healthcare activity for the same individual)
- qualitative data, including detainees, staff, other providers (will require specific survey / focus group, etc)

6.2 Providers of health services for this police custody suite

Give brief details about the current provider(s) of health services to the custody suites, including:

- title and location of health care service providers
- staffing levels
- working arrangements – in-hours and on-call
- mental health services / training
- children and young people provision
- support for vulnerable adults
- other services

If you have a **liaison and diversion scheme**, a street triage pilot or any other area-based programmes or national initiatives in your area that are of relevance to this HNA, please add a brief description and any relevant data. Information available through these schemes will be helpful in developing your HNA. For example, the youth justice liaison and diversion scheme should be able to provide details of care pathways to community healthcare provision and voluntary services and any challenges arising regarding access to any community provision for young people.

Look at the service specification for the custody suite health care provider to see what services are expected, in which locations and when (including working hours, outreach workers, out of hours services).

Provide data on custody suite health care service activity, including:

- volume of current referrals of detained people to health care practitioners
- these referrals analysed into key headings of illness / need
- these referrals analysed by time of day and day of week, to model demand
- an analysis of demand trends over several years (to help predict need)

See also following sections for more detail on different areas of health care need.

6.3 Data sources that can be used

There are a range of data sources that can be used to inform the HNA:

- every police force has a custodial IT system from which data can be obtained on activity within police custody suite. Particular note may wish to be given to custody officer risk assessments of detainees on entry to police custody
- description of police custody healthcare services in place and pathways for access and areas for possible improvement can be found [here](#)

- the Home Office provides comparative police custody data, drug intervention programme returns, and probation data. Relevant data reports can be found [here](#)
- most healthcare providers now have a clinical IT system that will support the development of the HNA. However, some manual correlation with healthcare records may still be necessary; depending upon the level of detail recorded within the healthcare provider IT systems. It may be necessary to cross-reference the clinical records with the custodial records to build a complete picture (this can be done on a statistically significant sample of records, rather than for all detainees)
- qualitative information such as detainee and police custody officer interviews; focus groups can also be generated for the purpose of the needs assessment
- nationally data on police custody activity and proportions seen by a healthcare professional is available through the Police Healthcare Oversight Group
- every force will have a HM Inspector of Constabulary /Prisons (HMIC/P) inspection report which will provide useful information on healthcare provision, available [here](#). Further information may come from deaths in custody and serious untoward incidents.
- calls by custody officers to request an ambulance or a police vehicle to transport a detainee to local A&E department is an indicator of emergency and immediate demand

There is also a range of additional guidance available which you may find helpful including:

- University of Birmingham, Marshal *et al* (2000) 'Toolkit Health Needs Assessmentⁱ', available [here](#)
- Payne-James (2010) Health issues of detainees in police custody in London UK. *Journal of Forensic & Legal Medicine*ⁱⁱ, available [here](#)
- Revolving doors agency (2013) Healthcare in police custody: A users viewⁱⁱⁱ, available [here](#)

7. Immediate care and risk assessments, fitness for detention and fitness for interview

This section of the HNA should establish whether there is a pattern in the type of immediate care that has been required to support detainees. This area should be informed by the initial risk assessments made by custody officers and any subsequent initial fitness for detention and interview assessments made by clinicians. The type of health challenges experienced by individuals detained in police custody suites will vary and be largely determined by the demographics of the geographical location.

Identify care pathway to be used for acute presentation of illness, such as heart attack; What equipment and skills should be present in police custody suite, ie defibrillator and person with resuscitation skills available on all shifts; What acute medical events need to be managed in the police custody suite, ie asthma, epileptic fit, loss of consciousness, hypoglycaemia or self-harm.

Identify referral policies, eg to acute medical care elsewhere (A&E, etc) and activity levels, waiting times (important also for police escorts), etc. See also chapter 10 'Healthcare and referrals'.

7.1 Injuries (head, body or dental injuries)

Head injuries particularly when associated with alcohol consumption or other substance misuse are potentially dangerous cases to manage in police stations. Provide details of number and proportion of individuals that have required medical support for head, body or dental injuries. This should provide details of the types of injuries encountered, seriousness of the injury and action taken to address the injury.

If it is possible you may want to provide links to alcohol consumption and issues around the night time economy by considering completing analysis of timing and location of incidents. The [Cardiff violence reduction model](#) based on data sharing about violence presentations at A&E departments may also be useful.

7.2 Substance misuse

The accurate assessment of morbidities associated with substance misuse, including the degree and severity of dependence and of the need for medical intervention is essential, because both intoxication and withdrawal can put detainees at risk of medical, psychiatric and even legal complications. The overriding principle of care for offenders who are substance misusers and who are in custody must be their safety and the treatment of suffering that occurs as a result of substance intoxication or withdrawal. When care is delivered to a high standard, the correct balance will be achieved between different factors such as the need for due process

in proceedings to safeguard civil rights, treatment needs and other humanitarian requirements as well as enforcement objectives. A detained substance-dependent person who is at risk of complications is entitled to the same quality of healthcare as they would receive in other locations.

7.2.1 Alcohol

Research^{iv} undertaken in two metropolitan areas with late night entertainment areas found that 73% of the 169 individuals brought into custody, between 10.30pm and 3.30am on the days studied, were thought by the researcher to be intoxicated. Those who had been consuming alcohol were also more likely to need medical assistance; 30% of those who were intoxicated were attended by a forensic physician, compared with 17% of those who were not intoxicated.

There are considerable risks associated with the management of a patient dependent on, or under the influence of, alcohol in police custody, especially ensuring that the individual remains safe from injury or inhalation of vomit whilst in custody.

You will need to consider both long term alcohol related challenges as well as binge drinkers and whether it is possible to differentiate between the two groups and those that use illegal substances recreationally or are addicts as the care pathways for these groups will be different. It will be important to identify whether any pathways exist for referral for both adults and children.

7.2.2 Drug problems and acute withdrawal

The police have powers to drug test those arrested or charged with an offence, for specified Class A drugs (under section 63B and 63C of **PACE**^v). The specified drugs that can be tested for are heroin and cocaine / crack. The police require those that test positive to attend up to two drug assessments by qualified drugs workers to determine the extent of their drug problem and help them into treatment and other support, even if they are not charged. Arrest referral schemes for drug-misusing offenders have been in place since 2000.

Drug users are likely to continue to make up a large proportion of those detained in police stations and seen by forensic physicians. In some cases this drug misuse will be driving their offending. In many cases it will be linked vulnerabilities such as mental health problems or homelessness. Specific guidance is provided for the management of substance withdrawal of detainees in police stations. In addition to providing immediate medical care or attention, clinicians also provide guidance and advice to drug users. This can include:

- encouraging/ compelling them to participate in arrest referral schemes (see above)
- providing information about local agencies involved in counselling and treatment of substance misusers
- providing education on the hazards of injecting drugs, particularly needle-sharing

- providing education about the risks of overdose; including advice regarding the loss of tolerance and risk of fatality following reduction in regular use, as may occur in prison or rehabilitation
- making the appropriate referrals to prison-based and the young person's secure estate substance misuse teams (in relation to those given custodial sentences), sharing information with them appropriately

Comprehensive guidance on managing substance misuse detainees in police custody is set out in the guidance (often referred to as the 'blue book' 'Substance Misuse Detainees in Police Custody, Guidelines for Clinical Management', available [here](#)

7.2.3 Data sources that can be used

Every force has a strategic assessment that may include prevalence of illegal drugs in the community, typical prices, hotspots and crime pattern analysis that may be helpful in developing the background for this document

Prevalence information by geographic localities in addition to treatment effectiveness data is available [here](#) and includes information about:

- drug use
- alcohol dependency
- dependency on prescribed drugs
- steroid dependency
- recreational drug use

8. Care of pre-existing medical condition whilst in custody

The proportion of individuals who have been detained and have required medical support for pre-existing medical conditions while in custody should be identified.

8.1 Mental health

People with poor mental health come into contact with the police and criminal justice system for a variety of reasons. There is a range of mechanisms through which mentally disordered offenders may be entered appropriately into the health system rather than the criminal justice system, such as local liaison and diversion schemes. Significant police time can be spent on dealing with people with mental health problems, whether or not an offence has been committed.

You will want to provide prevalence data on mental health across the force area. It may be helpful to align your findings with the relevant NHS organisations. You may also wish to include local data on emergency admissions through self-harm.

Describe protocols in place to ensure Section 136 of the Mental Health Act 1983 is as effective as possible and that police custody suites are not being used inappropriately by holding mentally ill individuals who could be better cared for in a healthcare setting.

Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem^{vi}. A key way in which individuals with mental disorder may have contact with the police is when they are in a public place and are believed to be in need of 'immediate care and control'. In these circumstances individuals can be detained by police officers under section 136 of the Mental Health Act 1983 and taken to a place of safety. A place of safety is defined as 'hospital, police station, mental nursing home or residential home or any other suitable place'. It has long been accepted that police custody is not the most suitable place of safety by HMIC, IPCC and Royal College of Psychiatrists. It has the effect of criminalising people who are in need of medical attention, can exacerbate their mental state, and in the most tragic cases can lead to deaths in custody. Further information is available [here](#).

Research^{vii} conducted by the Independent Police Complaints Commission (IPCC) which examined the extent and use of police stations as places of safety under section 136 of the Mental Health Act. The research collected and collated data from all 43 police forces in England and Wales for section 136 detentions in police custody in 2005/06. The data included the demographics of those detained, the length of time they were held in police custody, and looked at variations amongst police forces, identifying forces with high and low usage of section 136 detentions. Interviews were conducted with police officers and health and social care staff in a number of case study site forces with low, medium and high rates of section 136 use in

police custody. The study sought to identify good practice and makes a series of recommendations for the police, health and social care organisations and other relevant bodies which we believe may help to minimise the use of police custody as a place of safety in the future.

Some detainees may be identified as high risk of suicide, either through their own admission, their activity before arrest, or from previous markers on the police national computer system or health records held from previous episodes in police custody. It is important in the HNA to identify the amount of people presenting with such issues and whether they may be known to mental health services. Some may receive a level of supervision whilst in custody based upon historic information and it would be useful to establish what mechanisms if any are undertaken to review suicide risks, so as to appropriately manage the police/ health immediate response and on-going referral.

Data from a study undertaken by the National Offender Management Service **Surveying Prisoner Crime Reduction (SPCR)**^{viii} also showed that adults in prison are more likely to have a learning disability than the general population. Research also shows that approximately 25% of young people in custody have a learning disability, compared less than 5% of people in the general population^{ix}.

Due to technological advances it is no longer necessary for an individual to be physically present to commit a crime. We are seeing an increase in cybercrime which may affect the profile of offenders whereby some forces are experiencing an increase of offenders who have physical disabilities. It would be useful to establish the physical access provided to police custody suites across a force area.

8.2 Long-term conditions

Conditions which are relevant to acute care in police custody suite such as epilepsy, cardiovascular disease, asthma, diabetes, heart disease, disability can be quantified either directly from custody health care provider data or by using the known prevalence of long term conditions in this or similarly deprived populations, including other custody suite HNAs.

As part of considering diabetes it is important to recognise that difficulties can occur with the management of insulin dependent diabetics in police cells with the necessity to monitor blood glucose levels when required. Additionally, there may be poor arrangements for specified diets if an individual is held in custody for any length of time.

Epilepsy is a surprisingly common complaint amongst detainees, and is often associated with a history of alcohol, or other drug-related withdrawal. It is usually not difficult to manage in police custody – unless the prisoner is an 'unstable' epileptic when hospital attendance will be indicated.

The HNA should identify if a suicide awareness and management strategy exists for the custody suite and that all staff, be they clinical or police are familiar with contents and have the requisite competencies to recognise and manage those with suicidal ideation.

8.3 Data sources that can be used

The Home Secretary agreed that the **Care Quality Commission** – the organisation responsible for regulating the performance of health providers – would undertake a rigorous inspection of the quality of all places of safety over the course of 2013. This reported in November 2014 and is available [here](#) and may be helpful in identifying the quality and effectiveness of health based place of safety provision and thus the impact on police custody.

The Community Mental Health Profiles (CMHP) 2013 presents a range of mental health information for local authorities in England. The CMHP gives an overview of mental health risks, prevalence and services at a local, regional and national level using an interactive mapping [tool](#):

- significant mental illness including schizophrenia, major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder and borderline personality disorder
- affective disorders
- other Personality disorders
- self-harm and suicide
- other mental health issues such as autism and attention deficit hyperactivity disorder (ADHD)

An additional a PHE **Mental Health Group** exists to collate and make available data about mental health care in England collected routinely or through special surveys, by health and social services. It also provides information and advice to commissioners, mental health care providers and national inspection and audit bodies.

It is also important to consider **child health profiles** are also considered.

Identify when acute healthcare needs may need to be met in a hospital setting and the protocols to be followed to facilitate such a transfer of care which are available [here](#).

Data will be available via liaison and diversion services and appropriate adult services as well as the healthcare provider.

9. Communicable disease

Despite the fact it is unusual to have direct contact with other detainees whilst in police custody the setting can still pose risks for the causes and transmission of infection and challenges for control of communicable diseases due to the high throughput of detainees coming through the system.

There are a number of reportable communicable diseases discussed [here](#) . Many of the diseases on the list are relatively rare, however it is important that any HNA takes into account any diseases that have been reported within the custody suite. Unlike in a prison setting, other than relatively minor infectious diseases, such as diarrhoea and vomiting or self-declaration of a previously known communicable disease, such as a blood-borne virus or tuberculosis, it is unlikely that many communicable diseases will be manifested or diagnosed during detention at a custody suite. However it is important to note the risk of infestation if people in custody suites have been living in hostels or on the streets.

It is important though that systems are in place to demonstrate effective infection control and that any communicable diseases reported and identified are recorded including details on signposting to appropriate healthcare providers by the police custody suite. Further guidance about this is available [here](#).

10. Healthcare and referrals

A detainee can only be held whilst the custody officer is satisfied under **Police and Criminal Evidence Act** that the detention is lawful to secure and preserve evidence. Accordingly there are real and genuine challenges to provide detailed health promotion to detainees in police custody because of the limited time in which they are detained (average detention time is 10 hours). Therefore this part of the process should aim to identify and refer individuals for treatment rather than providing actual treatment to detainees. The pathways to community, treatment are therefore more important for both adults and children.

Referral pathways are effectively two types, pathways whilst in police custody, to A&E for example, and pathways to be utilised upon release or onward detention. Establishing the volume of detainees requiring A&E is a useful assessment of the delivery of the custodial service. Such referrals are both costly to the NHS and the police, who have to remain with the detainee in hospital. An HNA should establish the level of A&E referrals, the reason why and what protocols if any exist between the custodial health service and A&E to support smooth reception of a detainee to A&E and information exchange. For example, some NHS commissioners have now negotiated with A&E the ability to book a time of arrival based upon the triage developed by the custodial healthcare provider, thus making the process more efficient.

A HNA should also consider the ability of the healthcare provider to refer to community healthcare either directly or through a liaison and diversion scheme where appropriate. Typical issues to assess include the robustness of such referrals and whether they link into other processes such as police pre-release risk assessment.

Referrals of those who remain in custody will need to be augmented by the person escort record form (**PER**) that follows a detainee through the criminal justice system. It may be helpful to sample the records to establish the extent of the health information within them and whether that is utilised as the detainee moves through the system to court and/ or prison.

Consideration should also be given to how effective the healthcare provider is at referring on detainees to health promotion services that they may benefit from accessing on release, such as:

- mental health promotion and wellbeing
- smoking cessation/reduction
- healthy eating and nutrition, to include BMI assessment
- healthy lifestyles, including relationships and access to physical exercise programmes appropriate to age and needs
- sex and relationship education and parenting classes

- the training of people released from custody through the use of peer educators / health trainers and access to advocacy / mentoring services

Any available data on referrals to such services should be included within the HNA.

A HNA should describe the appropriate community care pathway. However, for the majority of detainees in police cells, the provision of long term care for specialist treatment is not required. Instances where some form of continuing care is necessary are as follows:

- short-term remand detainees: two or three days, usually remanded in custody following a request by the police to enable further investigation to take place
- detainees arrested towards the beginning of a weekend or bank holiday period, which are to be held until the 'next available court', eg offenders with no fixed address, or arrested as a result of a court warrant

10.1 Data sources that can be used

The **Network of Public Health Observatories** (PHOs) is part of PHE. Public Health Observatories (PHOs) produce information, data and intelligence on people's health and health care for practitioners, commissioners, policy makers and the wider community. The websites bring together the national work and products developed by the network of nine PHOs in England (formerly the Association of Public Health Observatories). Each PHO has a policy lead area. This website contains helpful information for those undertaking an HNA and is available [here](#).

Profiles and mapping tools that give more detail about particular health issues exist, much at a local authority level. Some are only present at former Primary Care Trust level but these may still be useful for people undertaking HNAs for people in police custody suite. These are available [here](#).

Local Health Profiles - which will help those undertaking local police custody suites HNAs to identify problems in their areas and decide how to tackle them, are available [here](#). This site provides a snapshot of the overall health of the local population, and highlights potential problems through comparison with other areas and with the national average. Each Health Profile document includes:

- 'at a glance' summary description of people's health in the area
- maps and charts that show how the health in the area compares to the national and local view
- trend information showing changes in death rates over a ten year period of time

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- a 'spine chart' health summary showing the difference in health between the area and the average for England for 32 indicators

This information is also provided via interactive [maps](#) which enable comparison of several areas for all indicators in the spine chart and is available [here](#).

Quality and Outcomes Framework QOF Disease Prevalence (epilepsy, asthma, COPD, diabetes, CVD, cancer, learning disabilities, mental health problems) can be found [here](#) and [here](#).

National disease prevalence can be found at [here](#).

National Male Prevalence LTCS in prisons: Diabetes, CVD, COPD, asthma, epilepsy and blood-borne viruses can be located [here](#).

11. Deaths in custody

Deaths in police custody suites will be referred to the Independent Police Complaints Commission (IPCC) for a death in custody investigation. The death will also be referred to the coroner and it is most likely that an Inquest will occur.

Once commissioning of police custodial health care contracts transfers to NHS England then responsibility for complaints about the delivery of police custodial healthcare will transfer to NHS.

The IPCC longitudinal study on deaths in police custody^x identified that intoxication associated with alcohol or drugs is one of the commonest causes of death in police custody. It is important to recognise that head injuries are another common cause. An extract from the IPCC longitudinal study is set out below:

Between 1998/99 and 2008/09 there were a total of 333 deaths in or following police custody. However, these deaths were not distributed evenly across the time period, with a fall occurring over the 11 years. In 1998/99 there were 49 deaths and it had fallen to 15 in the final year of the study. Using notifiable arrest data the death rate varied from 3.6 per 100,000 notifiable arrests in 1998/99 to 1 per 100,000 in 2008/09.

Rates for police forces varied from 3.8 deaths per 100,000 arrests to 0 per 100,000. Sixty-eight per cent were arrested in a public place, and the most common reasons for arrest were being drunk and incapable/disorderly, public order offences, driving offences and drug offences.

The most common causes of death were natural causes, overdoses, suicide and injuries received prior to detention.

It is vital that all those working in the custody suite are aware of best practice in the management of those who are intoxicated (that can be found in NPCC Authorised Professional Practice and Faculty of Forensic and Legal Medicine websites) being particularly mindful of:

- caring for those suffering substance misuse including alcohol
- risk assessment
- rousing detainees
- custody training
- the clarity of the roles of custody officers when more than one is on duty in a suite simulatenously

11.1 Data sources that can be used

Data sources that can be used to inform this section of the guidance include:

- National Drug Treatment Monitoring System, prevalence of alcohol and drug misuse and actual numbers and type of drugs used is available [here](#)
- IPCC information is available [here](#) and [here](#)
- deaths in custody information provided through a study undertaken by the IPCC is available [here](#). The study examined 'near misses' in police custody, incidents which 'resulted in, or could have resulted in, the serious illness or self-harm of a detainee.
- a study undertaken by the IPCC examines deaths in or following custody over an extensive period in order to identify trends, and, most importantly, the lessons that can be learnt for policy and practice to prevent future tragedies. It is available [here](#)

12. Needs of specific population groups

In January 2014, the Home Secretary commissioned Her Majesty's Inspectorate of Constabulary (HMIC) to conduct a thematic inspection on the welfare of vulnerable people in police custody, "including, but not limited to, those with mental health problems, those from black and minority ethnic backgrounds, and children". Their **report** provides some useful information about the needs of vulnerable people in police custody.

It is important that the HNA considers the needs of specific population groups including:

12.1 Children and young people (individuals under 18 years old)

The needs and behaviours of children and young people (CYP) in contact with the criminal justice system can be very different from those of adults. This can be due to them displaying higher levels of mental health needs than CYP in the general population. In CYP these specific health needs can often manifest themselves in behaviours such as violent and threatening behaviour.

It is important that these mental health needs are identified and addressed at the earliest opportunity to allow treatment and prevent similar behaviour re-occurring.

It is also useful to understand how good the police custodial system, inclusive of the healthcare provision, can also assist in the identification of other issues of vulnerability such as domestic violence, child abuse or child sexual exploitation,

CYP in need in the Youth Justice System will be comparatively easy to populate using national data from ChiMat and reference to the Healthy Children Safer Community strategy. All references to children and young people will need to be framed in the current legislation eg Children Act, UN conventions of the rights of the child relating to children and young people and safeguarding roles and responsibilities of all professionals working with children and young people in custody and transfer to the community or secure settings.

There will need to be an acknowledgement of health care providers delivering age appropriate health interventions which are specifically tailored to the needs of CYP. The police and others working in custody settings will need to be aware of who these practitioners are and referral pathways into local services. Existing information sharing structures with the **Youth Offending Team** (YOT) should be used and, where appropriate, consideration of the role of the YOT in brokering access to required health resource and the range of care pathways.

Any local gap analysis will need to consider the access to practitioners with an understanding of CYP need, and emerging CYP specific best practice to address this within the custody suite, as well as reviewing the efficacy of pathways into mainstream provision such as local community paediatric teams, child and adolescent mental health services (**CAMHS**) (forensic as well as tier 3) and CYP substance misuse services as well as identifying the role of the YOT in brokering access to required health resource.

You may also wish to note referrals to social care/children's services for children and young people who may be victims of child sexual exploitation.

12.2 Women

It can be argued that some women in police custody could be considered vulnerable and that to a certain degree this has driven their offending behaviour. It is useful therefore to understand how good the police custodial system, inclusive of the healthcare provision can identify issues of vulnerability including domestic violence, child abuse, child sexual exploitation, etc.

For example, recent HNAs have identified that women in police custody present more frequently with substance misuse and mental health problems.

Women and young people who are pregnant in police custody must receive access to needs based health services, including services for those who are dependent on substance misuse, if required.

12.3 BME

Police should be able to provide useful data on ethnic mix of detainees, which can be used to inform HNA. It may be helpful to consider any impact on healthcare of a particular ethnic group that may be more predisposed to a particular health need, as defined in the general population in that area.

12.4 Older people

A report from the [House of Commons Justice committee](#)^{xi} into the needs of older prisoners found that older prisoners are the fastest growing group within the prison population; the number of those aged over 60 grew by 120% and those aged 50 to 59 by 100% between 2002 and 2013. We need to be aware of their specific health needs in the police custody setting which may make them more vulnerable. A report by HMIC '[The welfare of vulnerable people in police custody](#)' published in March 2015 usefully describes some of these issues.

12.5 Physical disability

A survey of over 200 detainees held in police custody in 2007, identified "a very large and complex, mixed disease and pathology. Asthma, epilepsy, diabetes, deep vein thrombosis and pulmonary embolism, hypertension, gastrointestinal disorder, hepatitis and musculo-skeletal issues, were all present with [greater than] >5% representation"^{xii}. The level of physical disability and poor health functioning among people from lower socio-economic groups has long been recognised^{xiii}. Only 17% of disabled people were born with their disabilities. The majority of disabled people acquire their disability later in life^{xiv}. The prevalence of disability rises with age: in 2011/12, 6% of children were disabled (0.8 million), compared to around 16% of adults of working age (5.8 million), and 45% of adults over state pension age (5.3 million)^{xv}.

12.6 Learning disability

People with learning disabilities are over-represented among those in contact with the criminal justice system^{xvi} and the needs of this population need to be considered in any health needs assessment of police custody. Lord Bradley's review of people with learning disabilities or mental health problems in the criminal justice system found variation in the quality of risk assessments of detainees^{xvii}. People with learning disability are at increased risk of a range of physical health conditions, including respiratory disease, coronary heart disease, as well as some mental health conditions, including schizophrenia^{xviii}. One in seven adults with learning disabilities rate their general health as not good^{xix}. Coronary heart disease is a leading cause of death amongst people with learning disabilities (14%-20%)^{xx}; respiratory disease is possibly the leading cause of death for people with learning disabilities (46%-52%), with rates much higher than for the general population (15%-17%)^{xxi}. The prevalence of psychiatric disorders is 36% among children with learning disabilities, compared to 8% among children without learning disabilities, with children with learning disabilities accounting for 14% of all British children with a diagnosable psychiatric disorder; increased prevalence of psychiatric disorder is particularly marked for autistic spectrum disorder (OR 33.4), ADHD/hyperkinesia (OR 8.4) and conduct disorders (OR 5.7)^{xxii}.

However, difficulties in understanding and communicating health needs, a lack of support to access services, discriminatory attitudes among health care staff and failure to make 'reasonable adjustments' can create significant barriers in progressing within mainstream healthcare services.

It will be important to record the use of Appropriate Adults (AA) for detainees within the custody suite, including whether an AA was (a) required and (b) attended. It will also be important to consider whether dedicated referral pathways to community provision, aimed at particular target groups, exist and whether they are effective. The [College of Policing guidance](#) also provides useful information regarding addressing people with learning disabilities in custody.

12.6 Data sources that can be used

Further advice on providing opiate substitute medication to pregnant women is available [here](#).

Data on prevalence of physical and mental health needs, health inequalities, and access to health services for people with learning disabilities can be found in [Health Inequalities & People with Learning Disabilities in the UK: 2010](#) Eric Emerson, Susannah Baines, published by the Department of Health, and produced by The Learning Disabilities Observatory

The Prison Reform Trust published a report which contains useful information titled [No One Knows: police responses to suspects learning disabilities and learning difficulties: a review of policy and practice](#), 2008.

13. Wider engagement and views of others

13.1 Views of detainees

To include:

- the activity that you have undertaken – such as questionnaires, interviews, focus groups
- those people you have consulted with
- analysis of the data and level of participation
- key findings

Interviewing detainees whilst in crisis (ie within police custody) may not yield useful information. It may be better to interview detainees in the local remand prison and speak with prisoners who went through the custody suite(s) in that area and get their retrospective views. Their views are more considered at this point (and they are less likely to be as stressed or under the influence of alcohol or other substances, etc).

13.2 Views of custody officers, custody staff, healthcare providers and commissioners

To include:

- the activity that you have undertaken – such as questionnaires, interviews, focus groups
- those people you have consulted with
- analysis of the data and level of participation
- key findings

Healthcare providers may include:

- custody suite main healthcare providers
- approved mental health professional
- drug and alcohol workers
- liaison and diversion workers
- A&E departments

Commissioners may include:

- NHS England local team health and justice commissioners
- local **PHE centre health and justice lead(s)**

13.3 Views of 'appropriate adults'

'Appropriate adults' (AAs) help to achieve a fairer justice system by safeguarding the welfare and rights of children and vulnerable adults in police detention. The responsibilities of Appropriate Adults are laid out in Police and Criminal Evidence Act (PACE) 1984 Code C [here](#).

Further information is available [here](#) and [here](#).

In the case of a juvenile detainee, an appropriate adult is either:

- the parent or guardian
- if in the care of a local authority or voluntary organisation, a person representing that authority or organisation or a social worker of a local authority;
- failing these, a responsible adult aged 18 or over who is not a police officer or employed by the police.

For an adult who is mentally disordered or mentally vulnerable:

- a relative, guardian or other person responsible for their care or custody
- someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police
- failing these, a responsible adult aged 18 or over who is not a police officer or employed by the police.

It is important to gauge how appropriate adults are accessed, etc. Juveniles require an AA by default due to their age whereas adults require an AA due to vulnerability.

13.4 Independent custody visitors

Independent custody visiting is the well-established system whereby volunteers attend police stations to check on the treatment of detainees, the conditions in which they are held and that their rights and entitlements are being observed. It offers protections and confidentiality to detainees and the police and reassurance to the community at large. The Police Reform and Social Responsibility Act 2011 places the responsibility for organising and overseeing the delivery of independent custody visiting with Police and Crime Commissioners for the majority of police forces.¹

The current code of practice issued by the Home Office in December 2012 advises that the Police and Crime Commissioner must seek to ensure that the overall panel of Independent Custody Visitors for their area is representative of the local community and provides a suitable balance in terms of age, gender and ethnicity. Further information is available [here](#)

13.5 HM Inspectorate of Prisons and HM Inspectorate of Constabulary

Information on the “Criteria for assessing the treatment of and conditions for detainees in police custody” which includes information produced by HM Chief Inspector of Prisons and HM Inspector of Constabularies is available [here](#).

13.6 HM Chief Inspector of Constabularies

¹ For the Metropolitan Police the Mayor’s Office for Policing and Crime oversees independent custody visitors in London; for the City of London Police, the Common Council of the City of London is the relevant body.

HM Chief Inspector of Prisons and HM Inspector of Constabularies jointly inspect and report directly to the government on the treatment and conditions for detainees in police custody suites in England and Wales and other matters. Further information is available [here](#).

Occasionally such inspections may result in custodial health and environment improvement plans to amend any deficiencies in the building.

13.7 Serious Incident (SI) reports to NHS England

A definition of a serious incident is an incident that occurred during healthcare which resulted in one or more of the following:

- unexpected or avoidable death or severe harm
- a 'never event' - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death
- allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation

Healthcare providers are accountable via contracts to their commissioners, ie NHS England. The key organisational accountability for serious incident management is from the provider in which the incident took place to the commissioner of the care. Further information is available [here](#).

NHS England local teams will be able to provide information on all recent serious incidents within which can inform the HNA.

13.8 Local performance reports from commissioners

NHS England are developing national Health and Justice Indicators of Performance for police custodial healthcare that commissioners can use to bench mark services. This will be published on the NHS England website by autumn 2015.

13.9 Complaints

Under PACE Code C, if a complaint is made by, or on behalf of, a detainee about their treatment since their arrest, or it comes to notice that a detainee may have been treated improperly, a report must be made as soon as practicable to an officer of inspector rank or above not connected with the investigation. If the matter concerns a possible assault or the possibility of the unnecessary or unreasonable use of force, an appropriate healthcare professional must also be called as soon as practicable.

Post transfer of commissioning of custodial healthcare, low level complaints should be referred to the healthcare provider. Where a Serious Incident is identified this should be brought to the attention of the NHS Commissioner in line with NHS SI policy. Such data will be a useful reference tool for the HNA.

14. Gap analysis, conclusions and recommendations

This section of the HNA should contain a gap analysis, summary of findings and any recommendations and conclusions.

As part of completing a gap analysis it may be helpful to address the following questions:

- what does the information that you have gathered show?
- what are current gaps in the health services and treatment interventions?
- how will this situation be improved and be represented by SMART deliverables?
- what are the commissioning opportunities /solutions?
- what health inequalities exist and how can these be addressed?
- what are the major priorities for health and public health services in the police custody suites?
- how does this compare with previous HNAs?

The HNA should set out recommendations and conclusions that can be drawn from the evidence provided throughout the document. Recommendations and conclusions should:

- identify the main health needs of people detained in police custody
- identify gaps in current provision
- list recommendations
- detail what needs to be delivered and by whom
- set priorities
- reviewing progress
- feed into other local activity
- outline recommendations and plans for their implementation
- outline distribution strategy for HNA with stakeholders

14.1 Data that can be used

This section should be informed by the other sections of the HNA. No additional data sources should be required.

Further reading

NICE, Health Needs Assessment: a practical guide (2005)

http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/health_needs_assessment_a_practical_guide.jsp

Department of Health and the Youth Justice Board, The health and well-being needs assessment model template

<http://www.chimat.org.uk/yj/na/template>

The Faculty of Forensic and Legal Medicine

<http://fflm.ac.uk/libraryby/topic/>

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<https://nvl002.nivel.nl/postprint/PPpp5523.pdf>
- ⁱⁱⁱ Revolving doors agency (2013) Healthcare in police custody: A users view
<http://www.revolving-doors.org.uk/documents/healthcare-in-police-custody-users-views/>
- ^{iv} Policing and Reducing Crime Unit, Drunks and Disorder: Processing intoxicated arrestees in two city-centre custody suites, 2002
<http://www.ohrn.nhs.uk/resource/Policy/DrunksandDisorder.pdf>
- ^v Government legislation, Police and Criminal Evidence Act 1984,
<http://www.legislation.gov.uk/ukpga/1984/60/section/63B>
- ^{vi} IPCC, Annual report on deaths during or following police contact in 2014/15,
<https://www.ipcc.gov.uk/news/annual-report-deaths-during-or-following-police-contact-201415-published>
- ^{vii} IPCC, Police Custody as a “Place of Safety”: Examining the Use of Section 136 of the Mental Health Act 1983 <https://www.ipcc.gov.uk/page/mental-health-police-custody>
- ^{viii} Ministry of Justice, Estimating the prevalence of disability amongst prisoners: results from the Surveying Prisoner Crime Reduction (SPCR) survey,
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278827/estimating-prevalence-disability-amongst-prisoners.pdf
- ^{ix} Hughes, N., Williams, H., Chitsabesan, P., Davies, R., & Mounce, L. (2012) Nobody made the connection: The prevalence of neurodisability in young people who offend. London: Children’s commissioner, http://www.childrenscommissioner.gov.uk/content/publications/content_633
- ^x Deaths in or following police custody; An examination of the cases 1998/99- 2008/09
<https://www.ipcc.gov.uk/page/deaths-custody-study>
- ^{xi} Justice Committee, report on older prisoners,
<http://www.publications.parliament.uk/pa/cm201314/cmselect/cmjust/89/8904.htm>
- ^{xii} Payne-James, J., Green, P., Green, N., McLachlan, G., Munro, M. and Moore, T. (2010) Healthcare issues of detainees in police custody in London, UK. *Journal of Forensic and Legal Medicine*. 17: 1, p16.

<https://nvl002.nivel.nl/postprint/PPpp5523.pdf>

^{xiii} H Hemingway, A Nicholson, M Stafford, R Roberts, and M Marmot. The impact of socioeconomic status on health functioning as assessed by the SF-36 questionnaire: the Whitehall II Study. *American Journal of Public Health* September 1997: Vol. 87, No. 9, pp. 1484-1490. doi: 10.2105/AJPH.87.9.1484

^{xiv} Institute for Public Policy Research article Work for Disabled People:
[http://www.ippr.org/uploadedFiles/research/projects/Social_Policy/Work%20for%20disabled%20-%20Archilles\(1\).pdf](http://www.ippr.org/uploadedFiles/research/projects/Social_Policy/Work%20for%20disabled%20-%20Archilles(1).pdf)

^{xv} Family Resources Survey 2011/12:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206887/frs_2011_12_report.pdf

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(<http://217.35.77.12/CB/england/papers/pdfs/2007/StudyspReport2.pdf>)

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<http://www.rcpsych.ac.uk/pdf/Bradley%20Report11.pdf>

^{xviii} Emerson, E., Baines, S., Allerton, L. and Welch, V. (2011) Health inequalities among people with learning disability in the UK: 2011. Improving Health and Lives: Learning Disability Observatory (<http://www.improvinghealthandlives.org.uk/projects/particularhealthproblems>).

^{xix} Emerson E, Hatton C. Socioeconomic disadvantage, social participation and networks and the self-rated health of English men and women with mild and moderate intellectual disabilities: Cross sectional survey. *European Journal of Public Health* 2008;18:31-37.

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