



Original Communication

Healthcare issues of detainees in police custody in London, UK

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ABSTRACT

Little is known about the general healthcare needs of detainees in police custody. The aims of this study were to: determine the level of general health issues, diseases and/or pathology for detainees in police custody, and to determine how well those general health issues, diseases and/or pathology are being managed. This was done by a detailed analysis of healthcare issues of a cohort of detainees and reviewing intended and prescribed medication needs with current medication availability. In August 2007, a prospective detailed, anonymised, structured questionnaire survey was undertaken of 201 detainees in police custody in London, UK. Of these 83.6% consented to participate in the study. 85.1% of subjects were male; mean age was 33.9 years; 70.8% had English as a first language; 13.7% were of no fixed abode; 70.2% were registered with a general practitioner (primary care physician); 25% were already in contact with other healthcare teams; 7.1% had previously been sectioned under the Mental Health Act 1983; 16.7% had previously intentionally self-injured; 33.9% were dependent on heroin, 33.9% on crack cocaine; 25% on alcohol, 16.6% on benzodiazepines and 63.1% on cigarettes. 56% of subjects had active medical conditions; of those with active medical conditions 74% were prescribed medication for those medical conditions; only 3/70 had their medication available. 28/70 were not taking medication regularly, and many were not taking it at all. Three subjects who had deep vein thromboses were not taking their prescribed anticoagulants and six subjects with severe mental health issues were not taking their anti-psychotic medication. Mental health issues and depression predominated, but there was a very large range of mixed diseases and pathology. Asthma, epilepsy, diabetes, deep vein thrombosis, pulmonary embolism, hepatitis, and hypertension were all represented. The study has achieved its aims and has also shown that – in part because of the chaotic lifestyle of many detainees – appropriate care was not being rendered, thereby, putting both detainee, and potentially others coming into contact with them, at risk.

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1. Introduction

Compared with many other countries, detainees (prisoners) held in police custody within England and Wales have a substantial number of rights. The conditions for detention are laid down in statute by the Police & Criminal Evidence Act 1984.¹ Codes of Practice related to the Act are published and regularly updated. Code C, in particular refers to care and treatment of detainees and how health and related issues must be managed.² Historically, registered medical practitioners have provided healthcare to detainees in police

custody. Such doctors, called forensic physicians (FP), may be appointed by police services and their job titles referred to variously as police surgeons, divisional surgeons, or forensic medical officers. Within the Metropolitan Police Service in London, UK, the term forensic medical examiner (FME) is used. Following changes in April 2004 to the Police and Criminal Evidence Act of 1984, a revised Code of Practice permitted other 'healthcare professionals' to become involved alongside FPs in the care and treatment of detainees. A 'health care professional' was defined as 'a clinically qualified person working within the scope of practice as determined by their relevant professional body'. The Code further states 'whether a health care professional is 'appropriate' depends on the circumstances of the duties they carry out at the time'.²

Within the police setting there are two main areas of healthcare needs: (a) those that are within the realm of expertise of a general

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practitioner/primary care physician (e.g. the treatment and management of asthma or diabetes) and (b) those issues that may have a direct relationship with the reason that a person is in custody, and which may require additional expertise over and above that of a primary care physician. Such issues include: drug and alcohol misuse; mental health diagnoses; and wound assessment, as well as the documentation and management and relating these to the forensic setting. Thus 'forensic healthcare needs' and 'general healthcare needs' may overlap.

Studies that specifically explore in detail the general healthcare needs of police detainees in the United Kingdom do not exist. A number of studies have looked at some forensic medical aspects of detention but have not addressed the 'ordinary' medical needs although much has been written regarding the care of detainees in custody and identifying relevant health issues.^{3–7} There is a current lack of any data as to the actual general healthcare needs of detainees in police custody. In many police forces within England and Wales there are systems and operating procedures to deal with such issues as drug and alcohol misuse and mental health. Initial input is provided by a forensic physician (and if within their competence, other healthcare professionals), but the system is much less organised in terms of follow-up and management of 'non-forensic' general healthcare issues. The severity of these issues in this context are such that they would appear to require appropriately trained and qualified medical practitioners to identify and determine appropriate management pathways for all police detainees, using other healthcare professionals and services.

This study was designed in an attempt to define more clearly the healthcare problems for the detainee population in police custody and identify their potential needs.

The aims of this prospective study were to:

1. Determine the level of general health issues, diseases and/or pathology of detainees in police custody.
2. Determine how well those general health issues, diseases and/or pathology are being managed by the detainee by reviewing their intended medication needs with their current medication availability.

2. Methods

2.1. Ethical approval

This research was conducted in accordance with the University of Ulster's ethical policies; the project was assessed and ratified by the local Research Ethics Committee. Approval was also sought and given by the multiprofessional Commissioner's Advisory Panel of the Metropolitan Police Service.

2.2. Data collection

In August 2007, detainees ($n = 201$) who were seen while in police custody by forensic medical examiners in police custody were invited to participate in a detailed questionnaire study exploring their health issues. All subjects were detainees held within police stations within the Metropolitan Police Service area in London, England. Each detainee was informed of the nature and purpose of the study and asked to provide their consent. After the routine medical examination and assessment the questionnaire was undertaken. The questionnaire contained questions with yes/no and free text responses. The data were anonymised. Exclusions included those detainees who were unable to give valid consent or those below the age of 16. Questionnaires were completed by forensic medical examiners (FMEs) undertaking sessional forensic medical work at the request of the police in August 2007.

3. Results

Responses to the questionnaire were entered into an Excel spreadsheet. Results are given as total numbers and percentages of responses of those who gave consent. Consent was sought from 201 detainees. 168 (83.6%) gave consent. Of those not giving consent to participate in the study, the reasons for not obtaining consent were, intoxication with drugs or alcohol – $n = 3$ (1.5%); no interpreter – $n = 3$ (1.5%); no reason given – $n = 23$ (11.4%), and aggressive behaviour – $n = 4$ (2%).

Within the study 143 (85.1%) subjects were male and 25 (14.9%) were female. The mean age was 33.9 ± 10.4 years (mean \pm SD). Self-reported ethnicity is shown in Table 1. 119 (70.8%) had English as a first language. The reasons for arrest are shown in Fig. 1. Of those 29 (17.3%) had never been arrested previously, 69 (41.1%) had been arrested on 1–5 occasions, 14 (8.3%) on 6–10 occasions and 51 (30.3%) on at least 10 occasions. Reason given for examination and assessment of the detainees (at the request of the police) are shown in Fig. 2.

Twenty-three subjects (13.7%) were of no fixed abode and 112 (66.6%) were unemployed. 118 (70.2%) were registered with a general practitioner (GP), and out of those 106/118 (89.8%) were able to provide the GP details. Forty-two (25%) of detainees with other healthcare teams, including mental health, drug and alcohol referral teams, an ulcer team; and an HIV/AIDs team.

Sixty-seven subjects (39.9%) had previous significant medical conditions, 62 (36.9%) had previous significant surgical conditions and 41 (24.4%) had previous significant mental health or psychiatric conditions all of which were not necessarily relevant at the time of the study. Of those with previous mental health or psychiatric conditions, 12 (7.4%) had been admitted under one of the sections of the Mental Health Act 1983 and a further 3 (1.8%) had previously been in-patients in psychiatric units as informal patients. Twenty-eight (16.7%) had previously intentionally self-injured, including cutting themselves, overdosing, burning themselves and attempted hanging. Table 2 shows the numbers of those with self-reported dependency on drugs or alcohol or cigarettes. Of those using heroin or crack cocaine, 18/57 (31.6%) were using an intravenous route of administration. Thirty-three percent ($n = 56$) of the total population admitted consuming alcohol in the previous 24 h and 33% ($n = 56$) had consumed illicit drugs in the previous 24 h.

Table 1
Ethnicity of study group (16 + 1 ethnicity classification system)

	Numbers	%
<i>White (W)</i>		
W1 British	51	30.4
W2 Irish	6	3.6
W9 Any other White background	21	12.5
<i>Mixed (M)</i>		
M1 White and Black Caribbean	5	3
M2 White and Black African	2	1.2
M3 White and Asian	1	0.6
M9 Any other mixed background	3	1.8
<i>Asian or Asian British (A)</i>		
A1 Indian	2	1.2
A2 Pakistani	0	0
A3 Bangladeshi	14	8.3
A9 Any other Asian background	6	3.6
<i>Black or Black British (B)</i>		
B1 Caribbean	30	17.9
B2 African	13	7.7
B9 Any other Black background	2	1.2
<i>Chinese or other ethnic group (O)</i>		
O1 Chinese	0	0
O9 Any other ethnic group	4	2.4

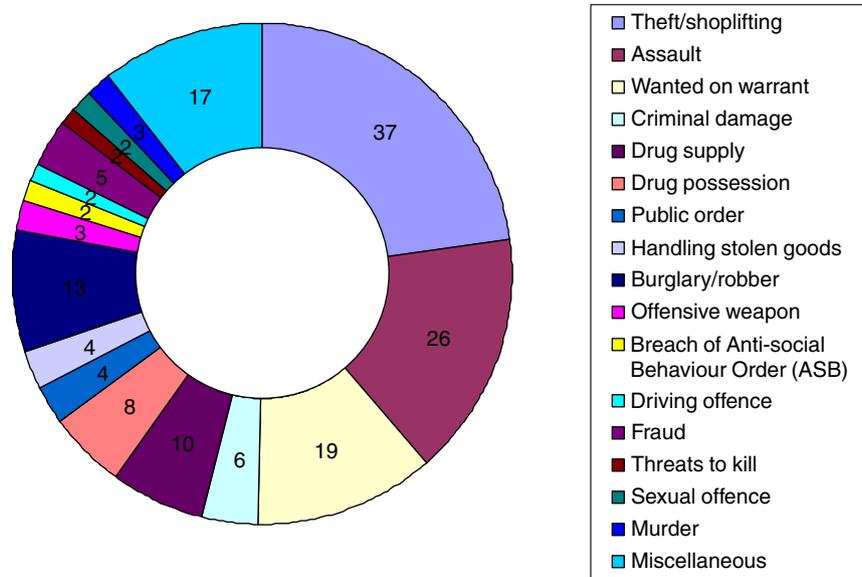


Fig. 1. Reasons for arrest (total numbers).

Mean body mass index (BMI) for the entire study group was 22.9 ± 4.38 (mean \pm SD). There were a total of 96 active healthcare issues requiring current management and assessment in 94 (55.9%) of subjects. Fig. 3 shows the numbers of reported active medical conditions. Of those with active medical problems as shown in Fig. 3, 70/94 (41.7% of the total study population) were supposed to be receiving currently prescribed medication. Of those only 3/70 had their medication available at the police station for administration at the time of examination. If the prescribed drugs were not at the police station the following responses were obtained as to the current location of the prescribed medication: 35/70 had their medication at their home address; 7 of those on methadone prescriptions had to undertake daily pick-up of their dose from the pharmacy and had not attended due to being in police custody; the remaining 28 did not have any access to their prescribed drugs. The following responses were obtained as to when medication was last taken: 14/70 had already taken that day's dose; 21/70 had taken it the previous day; the remaining 35 had not taken it for several days with 11/70 having not taken it for at least 2 weeks. If the medication was not available the reasons for non-availability and non-compliance were sought and if given, the responses are shown in Fig. 4.

The questionnaire proforma also sought out significant medical findings found at examination and whether new, comorbidity or

other diagnoses had been established – such new or other diagnoses are shown in Table 3, along with any specific referral or management advice.

4. Discussion

Individuals may be deprived of their liberty for a number of reasons, and for varying lengths of time. Within England & Wales individuals will rarely remain in police custody for more than 24 h, although exceptions may occur. Prison custody is longer-term custody, for example individuals who may have been convicted and sentenced for a crime, or those on remand pending trial, and for a small number other reasons including control orders under anti-terror legislation. The healthcare issues and needs of those detained in police and prison custody may be different for a variety of reasons. Examples in the police custody setting include – acute intoxication or withdrawal from illicit drugs and/or alcohol, mental health issues, sampling of biological specimens and assessment, management and interpretation of injury.

A recent study⁸ undertook a review of the evidence of the healthcare needs of prisoners in relation to gender, age and ethnicity, drawing from a larger systematic overview of the policy and research literature concerning primary care nursing in prisons in England and Wales. Findings from that study showed that

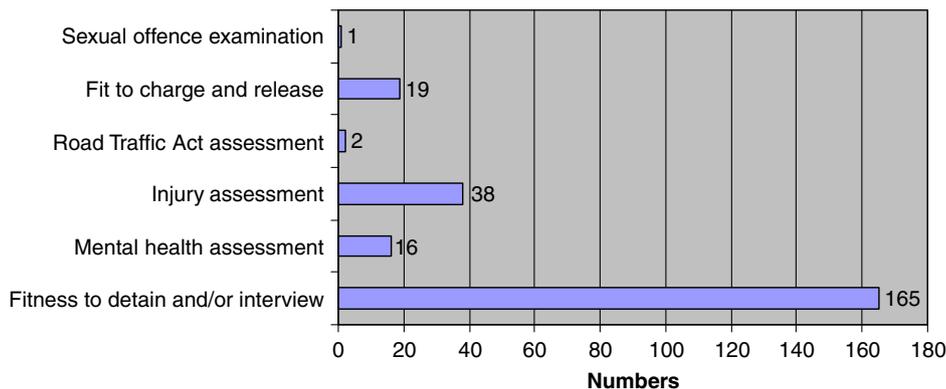


Fig. 2. Reasons for examinations.

Table 2
Self-reported dependencies

	%
Nicotine (cigarettes)	63.1
Heroin	33.9
Crack cocaine	33.9
Alcohol	25
Cannabis/skunk	21.4
Benzodiazepines	16.6

prisoners suffer from significantly higher rates of mental health problems, substance abuse and worse physical health than the general population.

The forensic physician plays a number of roles, and some of these may interact when the physician assesses a detainee in police custody. Three facets of medical care that may conflict have been identified: first, the role of a medicolegal expert for a law enforcement agency; second, the role of a treating doctor; and third, the examination and treatment of detainees who allege that they have been mistreated by the police during their arrest, during interrogation, or during the various stages of police custody.⁹

This study utilised techniques of obtaining information via self-reporting of individuals. Although this technique may not be ideal it has been demonstrated that reasonable information can be obtained using this methodology.¹⁰ Police forces in England & Wales utilise risk assessment proforma that provide specific direct questions to be asked of each detainee in order to assist in the risk and health assessment.¹ However, it should also be recognised that there are situations where the information supplied to the police by the detainee may be incomplete, inaccurate or deliberately misleading. In order to undertake a full healthcare assessment, a history must be taken appropriate to the detainee's situation, followed by an appropriate examination based on that history. A medical practitioner is more likely to elicit appropriate information from detainees compared to a police officer. Within this study 83.6% of those who were asked gave consent to participating, an excellent response rate for this type of research. The absence of an interpreter in two cases, with no common language between

FME and detainee may have prevented two further assessments. Despite 29.2% of detainees not having English as a first language, communication was not generally a problem, partly because of the use of English as a second language and the availability of interpreters within the Metropolitan Police Service area. Perhaps surprisingly only three detainees were so intoxicated with drugs or alcohol that valid consent could not be obtained, and only four were too aggressive to provide valid consent.

Approximately 50% of deaths in police custody related to alcohol, drugs or self-injury. Between 1995/1996 and 2004/2005, the annual rate for deaths in custody that occurred police care or custody in England & Wales, ranged from 18 to 65.^{11–17} This study confirms that 'forensic' health issues are still particularly relevant for this population, with respectively 40% and 38% dependent on heroin and crack cocaine. These figures are generally higher than those reported from a number of previous studies that have explored the spectrum of workload of forensic physicians, and those which have examined the type and spectrum of call-out relating to alcohol, drugs, injury and mental health issues.^{18–23} A more recent study published in 2003,²⁴ analyzed a similar population found similar figures for heroin and crack cocaine usage but with increased representation of alcohol and benzodiazepine (25.2% and 21% self-reported dependence, respectively). 21.4% of the study population considered themselves dependent on some form of cannabis. Due to recent change in legislation in England & Wales in July 2007, whereby smoking cigarettes is not permitted within police stations, a dependency recorded by 63.1% of the study population may be significant in respect of risk factors for near miss incidents such as impulsive intentional self-injury (ISI). Recent work has explored the possible effects of these and other factors in the initiation of near miss incidents that had the potential to cause harm or even death.²⁵

The study in 2003²⁴ found that almost 30% of detainees were not registered with a general practitioner (GP) and thus may not have access to regular medical or healthcare advice. The current study has similar results (29.8% not registered with a GP). Of those registered (70.2%) 89.8% were able to provide the GPs name and details. A smaller proportion compared with 2003 were of no fixed abode (13.7%) compared with 29%.²⁴ The absence of a GP increases

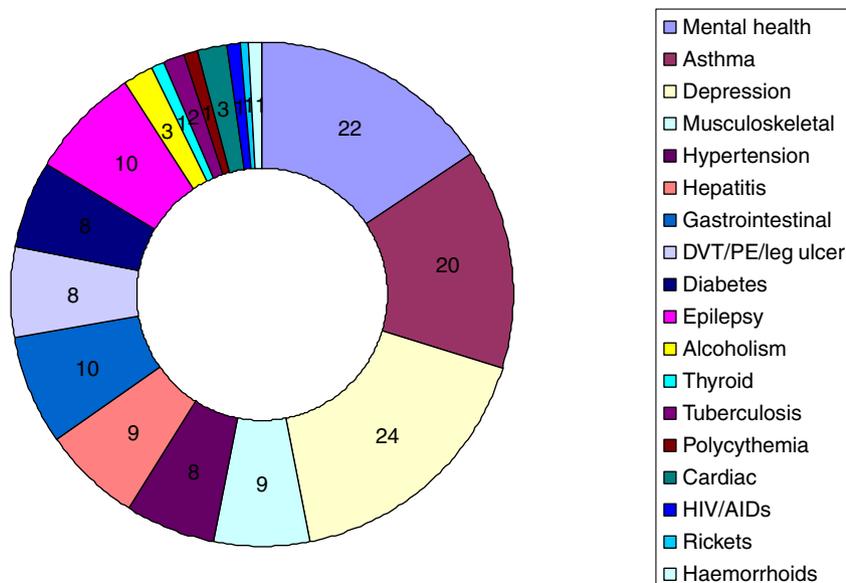


Fig. 3. Active diagnoses (total numbers).

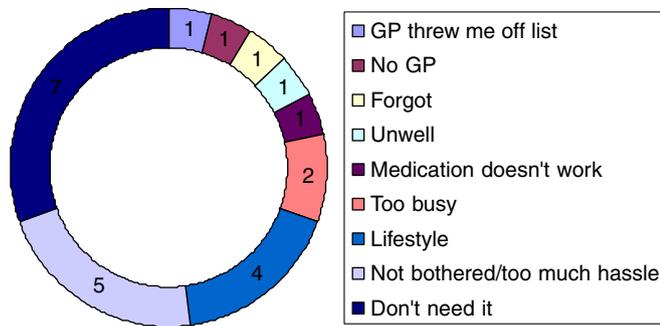


Fig. 4. Reasons given for non-compliance (total numbers).

the risk that those who should be undergoing regular review, and who are on prescribed medication, may be non-compliant with treatment. The number of those unemployed is 66.6%. This study did not explore how many of these individuals had never been employed and this must be an appropriate area to explore in future research. The availability of other health agencies was reinforced with 25% of detainees being in contact with some form of agency.

However the disparity between the percentages of those in contact with a drug team and those with drug dependence is of concern, as it suggests that only a minority of those with drug dependence are currently engaged with appropriate teams. This study showed that just under one-quarter of detainees had suffered previous significant psychiatric or mental health issues, with 9.2% previously admitted informally or under one of the sections of the Mental Health Act 1983. 16.7% had intentionally self injured, which is of great significance when considering detainee safety.²⁵ An HIV/AIDS clinic and an ulcer clinic both had a single contact represented. Only 17.3% had never been arrested before, reinforces the knowledge that a 'revolving door' scenario exists for many detainees.

The reasons given for arrest (Fig. 1) cover the broad spectrum of offences, with theft and shoplifting predominating, followed closely by assault. The link between crime and substance misuse has previously been explored.²⁶

General healthcare issues were explored in a number of questions. An attempt was made to assess body mass index (BMI) for the study group as a whole. Weighing scales were not available in examination rooms and weights were estimated by detainee recall, but each detainee has their height recorded at arrival at the police station. Despite the high incidence of dependence on drugs and

Table 3
Examination findings, new or renewed diagnoses and referrals

Subject number	Examination findings	New or renewed diagnosis	Referral
1	Opiate withdrawal		
2	Abdominal signs	? Acute appendicitis	Surgeons
9	Opiate withdrawal		
10	Multiple grazes	Psychosis	Mental health team
11	Severe alcohol withdrawal		Close supervised nurse monitoring
12	Opiate withdrawal		Drug team
13	Opiate withdrawal	Groin abscess	Emergency unit
14	Opiate withdrawal	Undiagnosed 10-day-old scaphoid fracture	Emergency unit
15	Signs of liver disease		GP
16	Psychosis		Mental health team
17	Opiate withdrawal		
18			Drug team for consideration of methadone script renewal
19	Hepatomegaly	Ascites	GP
20	Wheeze	Asthma	GP
21	Injuries from assault	Eczema, dermatitis	GP
25	Opiate withdrawal		
28	CS spray exposure	Corneal burn?	Emergency unit
30	Opiate withdrawal	16 weeks pregnant	Booking clinic
31		Radial nerve palsy (3 weeks)	Orthopaedic team
33		Periorbital haematoma	
36	Psychosis		Mental health team
37	Alcohol withdrawal	Alcohol dependence	Drug and alcohol team
46		Clinical posterior rib #, chest infection	Emergency unit
47		Clinical peptic ulcer	GP advising endoscopy
49		Tonsillitis	
53	Opiate withdrawal		
54	Handcuff injuries	Mental health issues	Mental health team
55		Cuts to extensor tendons	Emergency unit
57	Opiate withdrawal		
59	Severe alcohol withdrawal		Drug and alcohol team
62		Mental health issues	Mental health team
63	# left elbow	Had removed POP	Fracture clinic
64	Alcohol withdrawal		Drug and alcohol team
65	Asthma, depression		GP
68	Hypertensive		GP
69	Postural hypotension	Unknown	Emergency unit
70	Blood sugar high		GP
77	Psychosis		Mental health team
79		Back and neck pain	GP
80	Intoxicated, old craniotomy	Bilateral periorbital haematoma, # nose	ENT unit
81	Intoxicated with alcohol, ascites		Drug and alcohol and homeless teams
82		# metatarsal	Emergency unit
87		Mental health issues	Mental health team
88	Broken down post-phlebotic ulcer		Ulcer clinic
91		Hypertension	GP

(Continued on next page)

Table 3 (continued)

Subject number	Examination findings	New or renewed diagnosis	Referral
93	Haemoptysis, chest signs, DVT	Pulmonary embolus	Emergency unit
95	Intoxicated	Large chest mass	GP for surgical referral
96	High blood pressure	Hypertension, moderate obesity	GP
99		Alcohol dependence	GP
101	Opiate intoxication		
104		Drug induced psychosis	Mental health team
105	Opiate intoxication		
106	Opiate withdrawal		
108		Mouth ulcer (? neoplasm)	Dental department
112	Crack intoxication		
114	Alcohol intoxication	Sexually transmitted infection	Genito-urinary medicine clinic
115	Opiate withdrawal		
116	Alcohol intoxication		
117		Absent reflexes	GP
119		Learning difficulties, alcohol misuse	Drug and alcohol team
120		Cannabis dependence	Drug and alcohol team
122		Drug dependence	Drug and alcohol team
123	Pain left thigh	Foreign body – femoral vein	Surgical team
124		Mental health issues	Mental health team
125	Benzodiazepine intoxication		Drug and alcohol team
127		Stigmata of drug use	Drug and alcohol team
129		Bite to arm	Emergency department
130		Drug dependence	Drug and alcohol team
131		Depression, alcohol dependence	Mental health team
135		HIV – Central nervous system signs	HIV team
136	Mental health issues	Relapse – non-compliance	Mental health team
137	Intoxicated	Mental health issues	Mental health team
138	Injuries	Drug dependence	Drug and alcohol team
140	Alcohol intoxication	Penile tear	Self care
142		Fractured arm	Emergency department
143	Painful knee	Morbid obesity	GP
144	Crack intoxication	Crack dependence	Drug and alcohol team
145	Cardiomyopathy, obesity		GP
147	Radial nerve compression		Orthopaedic team
151	Swollen foot	Fracture	Emergency department
152		Depression	GP
154	Opiate withdrawal	? Diabetes	GP
156		Suicidal depression	Hospital admission
157	Leg cellulitis		
158	Hand and elbow injury		
166	Soft tissue injury	Drug-induced psychosis	Mental health team
168	Opiate intoxication		Drug and alcohol team

alcohol, there was no demonstrable general malnutrition noted within this population. The mean BMI (22.9) is within the normal range for adults (18.5–24.9). Further research needs to be undertaken with accurate weighing and assessment of nutritional indices of drug and alcohol dependent individuals in police custody.

55.9% ($n = 94$) of subjects reported active health issues which required management during the time of their detention. Mental health issues and depression predominated making up 32% of such issues, but there was a very large range of complex, mixed disease and pathology. Asthma, epilepsy, diabetes, deep vein thrombosis (DVT) and pulmonary embolism, hypertension, gastrointestinal disorder, hepatitis and musculo-skeletal issues, were all present with >5% representation. Of these, the first six are capable of developing acute and significant deterioration without proper assessment, treatment and management. Other significant pathologies including tuberculosis, hepatitis and HIV also present potential risks for health and safety.

Of the 94 detainees with current active medical conditions, 70 were currently prescribed medication by their GP for their condition. Worryingly, only 3/70 had that medication in their possession at the police station for administration. The police have powers to hold individuals 24 h prior to charging (more than 24 h in certain cases) and, once charged with an offence, may keep them in custody until presented to court. Thus, many individuals may remain in custody for greatly in excess of 24 h. Clearly an individual, who is stable on prescribed medication for a medical condition, is at risk of deteriorating in the absence of appropriate medication. It was of

concern to note that 35/70 were not taking medication regularly, and many were not taking it at all. Fig. 4 shows the reasons given for not taking medication and it is apparent that a mixture of chaotic lifestyle and perhaps lack of understanding of the importance of compliance with prescribed regimens, predominates. Of particular concern were three subjects who had DVTs, who were not taking their prescribed anticoagulants and six subjects with severe mental health issues, who were not taking their anti-psychotic medication.

Table 3 shows the outcome of the full history and examination of those subjects seen in this study. It is clear a large range of clinically relevant conditions have been identified, diagnosed and referred on to appropriate units. The range of conditions was large, embracing a wide range of medical conditions including opiate withdrawal, other drug misuse, mental health issues and alcohol dependence. These factors are well recognised in the police custodial setting. However, this study has additionally identified in this small sample, untreated or undiagnosed conditions which include: surgical and orthopaedic pathology respiratory medicine; wound management, diabetes, asthma, severe alcohol withdrawal, hypertension and epilepsy. Many of the subjects of the study had multiple diagnoses.

Recently, there has been Home Office (now Ministry of Justice) recognition of the need to address such healthcare needs in police custody. The Home Office has stated 'The police are the first contact point with the criminal justice system for members of the public. Many of the people police have contact with have chronic or

acute healthcare needs which may not be being addressed. Together with National Offender Management Service and Healthcare Partnerships (Dept of Health), the Police Leadership and Powers Unit has launched a project examining healthcare provision and access across all police forces. The project will concentrate on those on the pathway from the street through the police station to the next agency or on the release of the subject. It will be necessary to consider where at any point in this process diversion to other agencies could be more effective, how this could be communicated and how risk will be managed. The focus of the project will be on substance and alcohol misuse, alongside mental health and other healthcare needs'.^{27,28}

Previously there has been a lack of any data as to the more general – non-forensic healthcare needs of detainees in police custody. In many police forces there are systems and operating procedures for issues of drug and alcohol misuse and mental health issues, with initial input from a forensic physician (and if within their competence, other healthcare professionals), but much less so in terms of follow-up and management of 'non-forensic' general healthcare issues. This study has shown convincingly that these issues are substantial. The two aims of this prospective study were to determine the level of general health issues, diseases and/or pathology for detainees in police custody; and to determine how well those general health issues, diseases and/or pathology are being managed by the detainee by reviewing their intended medication needs with their current medication availability. It is clear that 'general' health issues are a major concern for the detainee group studied. The range and extent of the conditions have been better defined. This study has also shown that – in part because of the chaotic lifestyle of many detainees – many of these conditions are not being treated or managed appropriately, putting both detainee, and potentially others coming into contact with them, at risk. The range, extent and severity of these medical conditions, often in association with drug and alcohol misuse are such that it would appear – as with the prison population – that it is entirely appropriate to ensure that such detainees are assessed by properly trained and qualified healthcare professionals. The high incidence of under-treated and untreated medical conditions, and the 29.8% incidence of no primary care contact, coupled with the high rate of recidivism suggests that the police custodial setting may be the only location that has the potential to provide some degree of appropriate continuity of care. Assessment by history taking and clinical examination, diagnosis of illness, disease or pathology and management of such issues is at the essence of basic medical training. Other healthcare professionals with less broad training and skills – in terms of examination, diagnosis and management – and who are tasked with the care of vulnerable individuals will not necessarily have the competencies to deal with the multiplicity of issues relevant to the study population. Recent work has attempted to assess the operational impact of a police custody nursing service in one police service in the north of England.²⁹ The study demonstrated that response times by nurses in attending detainees were faster and consultation times were comparable (although the authors state 'for legal and security reasons it was not possible to analyse clinical consultation times'). It is notable that the study did not address in anyway what the consultations achieved – nor indeed, the opinion of the examinee. It did not address any issues regarding the type of consultation undertaken, nor the clinical findings and outcome of consultations. It does however make the important point that 'Nurses can assist FMEs by screening the need for a doctor to be called out to a police station and could help prioritise the clinical needs of detainees'. This study has defined more clearly the healthcare problems for the detainee population in police custody and what their potential needs are. In addition, it provides further information that may render feasible a larger study using epidemiological methodology (such as that described for prisons)³⁰ to appropriately match ser-

vice requirements. Further study is also required to explore further the needs of those failing to comply with treatments initiated by their medical teams and also the large minority of those with no primary healthcare contact. A focussed approach on their specific medical needs would be as reasonable as the focussed approach applied to other patient groups with multiple pathologies. The Home Office (since May 2007 – the Ministry of Justice), the police and the Department of Health have all indicated the need to identify healthcare problems in this population, and this has been the first study to quantify the spectrum of 'non-forensic' health issues in the police custodial population in England.

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