HMICS HM INSPECTORATE OF CONSTABULARY FOR SCOTLAND

Thematic Inspection
Medical services for people in police custody

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SUMMARY OF RECOMMENDATIONS

The provision of medical services to people in police custody is coming under increased scrutiny by the police service in Scotland and beyond. Such services – whether for treatment, assessing fitness for interview or appearance in court, or a range of other associated purposes – are delivered in a number of different ways across Scotland and are often closely associated or completely integrated with forensic medical services.

The development of forensic medical services has itself evolved in piecemeal fashion over many years. Doctors providing forensic and other medical services to police forces used to be known as police surgeons. This is still the case in some places, although the more frequently used terms today are forensic medical examiner (FME), or forensic physician, even when the service being provided is not just forensic. In fact, forces reported an approximate 85-15% split between the welfare (therapeutic) and forensic examinations respectively that they carry out. The majority of FMEs are also general practitioners who combine police work with their own patient lists.

More recently, changes to contracts, the introduction of modern working medical practices and further legislative requirements have made it increasingly difficult for forces to fulfil their statutory and other obligations to people in custody, and have had a significant knock-on effect on the workings of the criminal justice system. The constant struggle to recruit and retain sufficient doctors, difficulties in securing prompt and/or continuous medical attendance in terms of 24-hour coverage and geographical spread, and general variability in the subsequent quality of service are commonly cited problems.

Following an inspection of current arrangements in this area, HM Inspectorate of Constabulary for Scotland (HMICS) makes the following recommendations:

Recommendation 1: We find merit in the projects currently taking place in Fife involving the Scottish Ambulance Service (SAS), National Health Service (NHS) Fife and Fife Constabulary. Individual police forces are therefore encouraged to work in partnership with local authorities, health and other agencies to establish best practice in dealing with drunk and incapable people, within the context of locally available services and resources.

Recommendation 2: That the police service in Scotland actively participates in proposed research on identifying appropriate means of supporting and dealing with drunk and incapable people including the use of designated places of safety.

Recommendation 3: That, whilst the long-term approach could be to transfer responsibility for medical services to the NHS, forces in the meantime collaborate with the NHS to introduce multi-disciplinary clinical personnel into their custody facilities.

Recommendation 4: That the Tayside Psychiatric Assessment Protocol be viewed as good practice, and that other police forces in Scotland pursue a similar approach.

Recommendation 5: That the Association of Chief Police Officers in Scotland (ACPOS), via its National Custody Forum, create and incorporate common performance management information within the developing national custody system. This would give forces, police authorities/boards, and the health service a shared understanding of what should be expected and delivered across Scotland.

Forces may wish to work together to discharge the recommendations relating to the police service under the co-ordination of the ACPOS health/medical services reference group. In accordance with our statutory remit, however, we will continue to review the arrangements of individual forces.

HMICS is independent of police forces, police authorities and the Scottish Government, and exists to monitor and improve the quality and standards of service provided by the police service in Scotland, and to ensure that the public get the best value possible. In seeking to achieve this HMICS focuses on particular themes across all the police organisations in order to identify, contribute to, and communicate good practice, and to highlight areas of performance that need to be addressed. Often such reviews will, through necessity, cross service boundaries and involve other organisations. This review is no different in that. Whilst a number of our recommendations are aimed at individual police forces, there are also several areas highlighted in the report which would benefit greatly from the commitment and influence of other partners, particularly the Scottish Government and the NHS.

Introduction

1. The current system for providing medical services to people in police custody in Scotland has evolved in a rather ad hoc, often non-standard fashion. This may have been acceptable many years ago, when forensic medical services were just developing, but it is clearly not suitable in today's challenging environment. We are therefore grateful to ACPOS, and in particular to Deputy Chief Constable George Graham of Dumfries and Galloway Constabulary, for bringing this matter to our attention.

2. This report is intended to stimulate improvement and contribute to continuing debate on the manner in which these services are provided. It makes a number of recommendations on the basis of identified good practice, and seeks to contribute to wider discussion about how and by whom such services should be provided. The inspection was carried out by Superintendent Brian Muir (seconded from Lothian and Borders Police) and Chief Inspector Graeme Galloway (seconded from Dumfries and Galloway Constabulary), supported by our senior research officer Dr Emma Fossey, and directed by the then Assistant Inspector of Constabulary, Malcolm R Dickson QPM. We anticipate that the main body of the report will be of interest to all readers, while the annex containing evidence and good practice should be of use to those responding to our findings and to custody practitioners generally. Interested parties are welcome to *contact us* on any aspect of the report or to obtain further detail.

3. The inspection examined the following key areas:

- Existing provision of medical services for people in custody in Scotland.
- Force plans for improving provision in the future – both in terms of the cover provided and the manner in which it is sourced.
- Examples of good practice in other police forces in the UK.
- Examples of good practice in other organisations with a responsibility for the care and custody of individuals. To this end we liaised with Social Services, the voluntary sector and the Scottish Prison Service, as well as with HM Inspectorate of Prisons, all of whom were extremely important sources of advice and instruction.

4. The question of responsibility for supplying these medical services. A large number of police forces across the UK are taking the opportunity to re-assess their approach. Several now use companies from the private sector, while the possibility of moving to a position where the National Health Service assumes responsibility is also actively being explored.

5. In identifying these key areas cognisance was taken of the Scottish Government's five strategic objectives, two of which we felt were particularly pertinent to this review:

- Healthier – help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care; and
- Safer & Stronger – help local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life.

6. In order to establish the current position and enable all interested parties to contribute to the debate, we presented each of the eight Scottish forces and British Transport Police (BTP) with a series of focused questions. As is standard practice in our inspections, we also sought the views of ACPOS as well as the various force staff associations – the Association of Scottish Police Superintendents (ASPS), the Scottish Police Federation (SPF) and UNISON. The evidence provided and the opinions expressed

are summarised in Annex A. It proved very difficult to obtain uniform statistical information across the country, and while we are grateful to forces for their efforts in this respect, it is revealing that there is as yet no common system to provide these data. This matter is considered later in the report.

7. In any inspection of this sort it is clearly beneficial to liaise with as many sources of information and advice as possible, in order to apply more rigour to our examination of current practices, obtain views and comments, and identify possible areas for improvement. With this in mind, we consulted a wide range of individuals and organisations. These included, in no particular order: the Police and Community Safety Directorate and Public Health and Wellbeing Directorate of the Scottish Government; ACPOS health/medical services reference group; Crown Office and Procurator Fiscal Service (COPFS); individual forensic medical examiners (FMEs); Scottish Independent Custody Visitors; ACPOS National Custody Forum; Her Majesty's Inspectorate of Constabulary (for England, Wales and Northern Ireland); Cumbria Constabulary; Humberside Police; Metropolitan Police; Sussex Police; the Scottish Prison Service (SPS), HM Inspectorate of Prisons and private providers. As a result, a great deal of relevant information and advice was obtained and is reflected throughout the key issues section of this document and in the annex.

KEY ISSUES

Responsibility for providing medical services for people in police custody

8. The Scottish Home Department Circular No. 7362, issued on 1 March 1950, made police forces responsible for paying for the medical services provided, inter alia, to people in police custody. Although this document is arguably not legally binding on the Scottish forces it was accepted as the defining directive in this area of policing. Within its contents it details the responsibility for charges incurred in performing the following duties:

- emergency medical treatment – for example, at the scene of a road accident;
- medical treatment or examination of persons in police custody;
- medical treatment of the victim of an offence;
- examinations of a person charged with an offence; and
- post mortem examinations.

9. The section 'Medical Treatment or Examinations of Persons in Custody' states that:

"*the attendance of…a doctor at a police station is* ***sometimes*** [our emphasis] *required to give medical treatment to a person detained in custody….such attendance cannot properly be regarded as required for the purposes of giving emergency medical treatment, since often the patient would be able to attend at a doctor's surgery but for the fact that he is detained by the police. The Secretary of State considers, therefore, that he* [the doctor] *should be paid by the police authority for such treatment. Payment should similarly be made where the doctor attends to examine a prisoner for police purposes (e.g. to see if he is fit to be detained in a police cell)*".

10. This circular is now almost 60 years old and emanated from social and policing circumstances very different from those that prevail today. Its authors could not have envisaged the situation we now face, where a significant percentage of the larger number of people arrested and detained in

police custody require the services of a doctor, nor the level of remuneration that doctors receive for providing this service and its financial impact on the police service.

11. The main aim of the circular appears to have been an attempt to clarify payment arrangements to individuals who were contracted to the then embryonic NHS and those who were not, particularly in emergency situations. It is doubtful that it was intended to be applied in today's environment, where the greater volume of prisoners is further exacerbated by the vast increase in numbers of at risk' custodies passing through police facilities, many of whom are drug/alcohol dependant, have self-harm warning markers or other psychological and/or mental health conditions.

12. In addition, given modern medical practices such as the advent of NHS 24, it is also extremely unlikely that any prisoner would be *'able to attend at a doctor's surgery but for the fact he had been detained by the police'*. Consequently, people coming into police custody today are generally afforded easier access to medical services than they would receive in other circumstances, but at a cost to the police authority. It is also very probably the case that, had they not been arrested, a significant proportion of those people genuinely in need of medical attention or at least examination, would not have sought treatment from a doctor at that time because of their disorganised or chaotic lifestyles. Whatever police/judicial purpose is being served by arrest, people who need medical attention but are least likely to seek it out are obliged when arrested to be examined/assessed/treated. This must be viewed as a major contribution to the Scottish Government's objective of helping '*people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care*'.

13. In light of the above, all the police forces in Scotland believe that it is unreasonable and inappropriate that the police service be expected to retain responsibility for funding and providing medical services to people in police custody and feel that this function should pass to a more appropriate agency. HMICS agrees with this stance and would therefore encourage the Scottish Government to dispense with Scottish Home Department Circular No. 7362 as soon as is practicable.

Providing medical services to people in police custody

14. All forces in Scotland are of the view that the most appropriate organisation to assume this responsibility is the NHS. In England and Wales the NHS already has responsibility for prisoners in HM Prisons. We understand that the Scottish Government is considering a report submitted by a Prison Healthcare Advisory Board, which recommends that a similar approach is feasible in Scotland. We are also aware of moves in England and Wales to seek greater NHS involvement in improving health and social care services for people going through the criminal justice system. It would seem logical for the medical services provided to people in police custody in Scotland to follow a similar route.

15. Discussions with representatives of the NHS in Scotland revealed a strong aspiration for a holistic, through-care medical approach that would achieve 'whole person' care for everyone throughout their life. Such a desire is articulated in the Scottish Government's Action Plan, *Better Health, Better Care*[1], which outlines a philosophy of health improvement, tackling health inequality and improving the quality of health care. NHS Scotland is a public service that seeks '*collaboration*

1 Scottish Government. *Better Health, Better Care: Action Plan.* (http://www.scotland.gov.uk/Publications/2007/12/11103453/9) Edinburgh: Scottish Government, 2007.

with partners in order to support people at some of the most emotionally testing times of their lives'. We recognise that the NHS is not solely responsible for delivering health improvement services and in tackling health and social inequalities. Local authorities, for instance, have a significant role to play in this area, as do many voluntary sector organisations. Research consistently shows that offenders tend to suffer from poorer physical and mental wellbeing, affecting both the individual and wider society. We are therefore encouraged to see in the Action Plan a commitment from NHS Scotland to *'review its approach to the health and health care of offenders and ex-offenders and to consider what more can be done in prisons and custody settings...'.*

16. Efforts to provide a 'cradle to grave' service are greatly hindered when people are taken into police custody. This is because medical data held by the NHS on such individuals are not available to FMEs or custody nurses. Thus information on the medical history, physical or mental well-being, and so on, of people in custody cannot be shared. This is not only at odds with the objectives of the NHS but also makes it difficult for forces to provide the most appropriate care for the people concerned.

17. During our inspection, we learned of the existence of Emergency Care Summary, which is an NHS system that provides a summary of an individual patient's medical history. Currently, this facility is only available to NHS 24, Accident & Emergency (A&E) departments and the NHS 'out of hours' service. However, it could possibly be extended to FMEs/custody nurses with the patient's permission, perhaps by means of a new question within the vulnerability assessment process that is carried out when a person comes into police custody. Nevertheless, we believe that such a development, whilst welcome, does not go far enough. Were the NHS to accept responsibility for providing medical services, then appropriate medical/health information previously captured about an individual could be made accessible to appropriate clinical staff by adapting existing information and communications technology where necessary.

18. It was suggested to us that Health Service provision could be achieved by individual health boards across Scotland forming multi-disciplinary primary care teams, to include FMEs, which would then deliver services tailored to the needs of each local health board area. One potential difficulty with this proposition is that few health boards in Scotland are co-terminus with the eight police forces. However, our view is that such problems are not insurmountable and could be addressed at a national level where necessary. The Health Directorate also indicated that existing funds would have to be re-allocated from the police budget to the health service budget centrally before this change in responsibility could be achieved. We also fully recognise that health care services can only be delivered effectively when health boards work with partner agencies, such as the voluntary sector and local authorities. Local authorities are responsible for and are funded to undertake several health and well-being activities. In addition, further resources and legislative changes may be required in order to achieve the desired intention of moving from a reactive to a proactive health promoting service. This would clearly require detailed discussions involving these organisations and other interested parties, with Scottish Government facilitating this process.

19. A number of private sector organisations have indicated their desire to become involved in administering this process on behalf of the police service. Indeed, some Scottish forces have already entered into such contracts, the implications of which we examine below. However, FMEs and many other contributors to our research agreed that their preferred option was for the Health Service to assume responsibility across the country. This accords with our assessment at paragraphs 24 to 28.

20. A substantial number of police forces in England and Wales have contracted out the provision of medical services to people in police custody to private companies. Reported benefits include the following:

- cost savings;
- uniformity of service;
- coverage i.e. an ability to provide FME cover in environments that normally prove challenging, such as rural areas;
- provision of a single point of contact, not always possible in locally administered FME contracts;
- clinical governance and standards; and
- achievement of 'best value' – in a competitive environment such as this, where there are a number of rivals for the business, market economics are naturally applied which should theoretically have benefits for the police service as a publicly funded body.

21. We consulted a number of police forces currently employing this approach who expressed general satisfaction with the resulting service and its cost-effectiveness. It is interesting to note that many of these forces did not enter into private sector contracts primarily to save money, but rather in an effort to secure appropriate medical coverage.

22. The experience of two Scottish forces who have established similar contracts is also informative. Generally, these forces were comfortable with the services being provided, but had encountered some difficulties in terms of medical service coverage, the availability of doctors, and their ability to meet Crown Office requirements e.g. in securing the return of doctors from overseas for court purposes. Whilst these issues were mostly resolved following discussion, they were a recurring concern for many of the forces with whom we spoke. Tayside Police is currently engaged in a private contract that terminates in October 2008. At the time of our inspection discussions were underway with a view to replacing it with a *pathfinder scheme*, whereby the NHS would assume full responsibility for all medical services of both a healthcare and a forensic nature (see also paragraphs 30 and 31 below).

23. The above experiences notwithstanding, we have little doubt that there are a number of private companies engaged in this field who are able to provide an effective, competitive alternative to the current system for medical provision. However, we have considered this carefully from both a policing and health perspective, both of which seek to achieve the best possible outcome for the public good, and we have concluded that there are at least five factors in favour of the Health Service funding and providing these services.

24. The most convincing factor was the view, expressed by a number of contributors to our inspection, that NHS treatment of people held in police custody is an important stage in an 'end to end' medical intervention service aimed at diverting individuals away from chaotic or chronic substance/alcohol abuse leading to multiple instances of re-offending. Thus the ultimate aims of this approach would be to improve health and reduce crime and re-offending by diverting patients from a life of abuse and crime, while at the same time reducing overall costs to the public purse. Amongst the experts we consulted in Scotland too, there was an awareness of the links between socially excluded members of the population, poor health and offending.

25. Applying commercial interests to the provision of medical services for those who may not have asked for them, and indeed who may be reluctant to co-operate, could result in perverse outcomes. These could include high level of attendance payment with a relatively low level of treatment, unless there is a specific incentive for the medical staff to encourage the patients to co-operate.

26. Providing medical services for people in police custody from a single National Health Service budget would undoubtedly achieve efficiencies due to economies of scale. Furthermore, it would be to the greater public good if these savings were re-invested in public services (policing and/or health) rather than becoming commercial profit.

27. Although policing is largely a local public service for good reasons of local accountability, it is unlikely that police authorities/boards could claim that they are best placed to oversee and hold to account the provision of medical services to those in custody; neither is HMICS best placed to provide professional scrutiny of that service.

28. National oversight of the service should mean that existing inconsistencies and differences in provision and practice, other than for reasons of geographical coverage, should not differ across Scotland and could be replaced by a system that achieves uniform best practice and best value through nationally applied standards.

29. Therefore, taking everything into consideration, we very much favour a move towards the NHS assuming responsibility over private provision. We therefore strongly encourage the Scottish Government to oversee the transfer of responsibility for providing medical services to people in police custody from the police service to the NHS. However, as referred to in paragraphs 1 and 2, we acknowledge that many of the medical personnel currently involved in healthcare services to people in police custody are also involved in forensic medical services. For this reason we do urge all concerned to bear in mind the need for forensic services to be retained.

Pathfinder scheme for providing forensic medical services and healthcare to people in police custody, by NHS Tayside

30. As described earlier, Tayside Police's contract with a private company to provide forensic medical services and healthcare in police custody settings will shortly expire. At the time of our inspection a *pathfinder scheme* was being proposed which will see NHS Tayside supplying medical services, as well as any forensic requirements that may arise, to the force's three custody centres. One of the great advantages of working with a health board in this respect is its established links to other service areas, such as mental health, substance misuse, sexual and reproductive health. It can also provide ready access to medical expertise, including diabetic and respiratory, where this is required. The force envisages that as the scheme develops it will become increasingly multi-disciplinary and less dependant on the involvement of doctors, although doctors will continue to be a vital part of the service. It also intends to develop a referral service for people in custody, linking them with other mainstream services in NHS Tayside such as those described above. The twin aims of the approach would be to reduce the amount of repeat offenders and to improve general health and well-being within the wider community.

31. We were very impressed by this proposal and see it as embodying many of the principles and approaches that we believe should be introduced into this vital area. Indeed, such a model may well become the template for a new approach to providing medical services to people in police custody in Scotland. We will continue to monitor its progress and assist with its development where possible.

Provision of forensic services

32. Notwithstanding the comments above relating to medical services, there remains a need to retain a degree of specialisation in forensic medicine. A proportion of the total costs incurred in this area, approximately 15%, can be attributed to the need to examine accused persons or victims for evidential purposes, or a deceased person following a sudden death. It is accepted that these costs, as they derive from the investigation of a crime, currently fall to the police authorities. There is also, without doubt, an element of professional expertise required in order to carry out these functions. That said, we were interested to note NHS Tayside's intention as part of Tayside Police's pilot scheme to take "*full responsibility for all medical services of both a care and a forensic nature*". This leads us to believe that it may be possible for all medical and forensic responsibilities to move from the police service to the health service, provided that suitable negotiations take place and associated arrangements are agreed to by all parties.

33. In April 2003, a review funded by NHS – Quality Improvement Scotland, entitled *Expertise in the Medical Examination of Suspected Child Sexual Abuse*[2], was published. The report acknowledged that paediatrics, and in particular the medical assessment of children who disclose sexual abuse, is a low volume but highly specialised activity practised by only a minority of paediatricians in Scotland. It also recognised the difficulty in securing both qualified and experienced paediatricians and FMEs. Given these findings, it may be that in very specialised areas such as these a national approach is needed, whereby a cohort of excellence amongst a limited number of FMEs is encouraged. Having one nationally shared resource and possibly centralised specialist facilities would allow a level of expertise, experience and competence to be built up, thus inspiring greater confidence on the part of COPFS.

34. Indeed, however forensic medical services are arranged and provided in future, we suggest that there must be a means by which COPFS and the police service can influence that provision. This is not just a one-off requirement but a continuing need, due to frequent developments in crime itself, investigative techniques, and forensic science. We note with interest developments south of the Border where, because of the outsourcing of forensic science services to a private company, it has been necessary and desirable for the Home Office to appoint a forensic science regulator. The post-holder is in turn influenced by the Forensic Science Advisory Council (on which the Scottish Police Services Authority [SPSA] is represented) and tasked with setting and monitoring quality standards and competencies.

35. If the Health Service in Scotland, whose primary purpose obviously includes neither the pursuit of justice nor law enforcement, were to become the sole arbiter of how forensic medical services were provided this might conceivably prove problematic in the future if, for example, fiscal restraints pointed to the need for changes in practice and levels of service. We therefore suggest that, in addition to the NHS providing '*clinical governance*' of such services, there may also be a role for the SPSA in consultation with COPFS to provide '*forensic governance*'. This would help to bring about a fully integrated national service from "*crime scene through to court*". In light of this, and of the need for many current medical personnel to perform the dual roles of healthcare and forensic medical

2 NHS Scotland. *Expertise in the Medical Examination of Suspected Child Sexual Abuse.* (http://www.nhshealthquality.org/nhsqis/1202.html). Edinburgh: NHS Scotland, 2003.

service provider to police forces/COPFS, the best solution may be for the Health Service to co-ordinate and provide forensic medical services but for the police service and COPFS to pay for these (on the present basis).

Drunk and Incapable

36. We would stress at the outset of the following discussion that what we are referring to here are vulnerable people who are merely drunk and incapable of looking after themselves, often unconscious as a result of apparent alcohol intoxication. We are not referring to people who have committed any additional crime or offence where alcohol abuse is or may be a factor. People arrested for being drunk and incapable are a significant burden on police custody centres, both in terms of the number of people involved and also and most critically because they are a *high risk* group in any medical risk assessment.

37. Although the crime of being drunk and incapable has existed in Scotland for centuries, it appears that few people now come to court accused of this offence. Generally, current practice across Scotland is for forces to arrest such vulnerable individuals when found in a public area, place them in police custody for their own protection and release them when they are considered able to look after themselves. They should then normally be reported for summons, though it would appear that because of societal factors, procurators fiscal are often understandably reluctant to pursue such cases, and charges are therefore frequently dropped before any court proceedings can occur. Thus in effect the police appear to be performing a care function in these circumstances, as opposed to enforcing the law or pursuing justice.

38. We accept that people in this condition certainly need care and attention. However, we would argue strongly that police cells are not the best places for holding them, as the proportion of deaths in custody involving drunk individuals suggests. That is not to say that police personnel involved in the care of prisoners, or indeed police managers and leaders, fail to take account of the needs of people in custody, nor that there is any lack of intention to care for them properly. Rather, police custody suites can be noisy, busy places and police personnel, because their primary policing purpose is not healthcare, can only have limited skills in identifying, assessing and caring for people with medical conditions. Many symptoms of apparent drunkenness can mask other more serious conditions such as head injuries, diabetes, epilepsy, and so on.

39. That the removal of vulnerable drunk and incapable individuals from the streets should be the responsibility of the police may well have made sense in Victorian times, when the police service was the only round-the-clock public emergency service available. Indeed, there is a handcart on display in the entrance foyer to Lothian and Borders Police HQ which was used for this very purpose. But in 2008, Scotland has highly trained paramedics crewing ambulances and other response vehicles, in addition to well-equipped and staffed accident and emergency departments. We are also more aware than ever before of the need to take especial care when dealing with people who are apparently drunk and incapable but may be suffering from other conditions. In our opinion we can no longer expect the burden of looking after people in this condition to fall to police officers and police support staff. As a country that strives to be safer, stronger and healthier, we need to ask ourselves what is the primary need of any person taken into custody – is it more important that a very drunk, vulnerable person be locked up in police custody or that they receive health and social care for intoxication and any possible injuries?

40. The primary duty of course should be the care of the individual whose only crime is to be intoxicated, incapable and alone in a public place. Clearly it will take discussion at a national level to agree which agencies should be responsible and the extent of their remit. We appreciate that, in practice, this is not something that will be resolved immediately. Indeed, it is difficult to envisage a time when the police would have no involvement in this area. Policing is still a 24-hour service whose primary concern is the safety of the public, and it will therefore remain, to an extent, actively involved in dealing with people who are drunk and incapable of looking after themselves.

41. Furthermore, if local authorities were to be considered the appropriate carers in these situations, we fully appreciate that their present structure does not allow them to respond to these demands and that time would be needed to organise resources and arrange appropriate accommodation. However, the health services, via the SAS and A&E units are already actively involved in this area and later in this report we describe a very promising scheme currently being piloted in the Fife area. A great deal of discussion would have to take place between COPFS, the police service, health service, Scottish Government, local authorities and other interested parties in order to establish the most appropriate method of tackling the health and social implications of people who are found alone and apparently intoxicated in public places. We recognise that this is a radical change, nevertheless, we feel that there is a strong ethical and practical case for regarding drunk and incapable people as something other than merely a criminal justice problem. Alternative approaches to this social problem must be explored which, in our view, might well be at least partially funded under the *polluter pays* principle. After the drunken individuals themselves, the people really at fault in these situations are, in some instances, those who continue to supply alcohol long after drunkenness is obvious.

Police/Scottish Ambulance Service's Drunk and Incapable Persons Protocol

42. For some time now a protocol has been in place in Fife between Fife Constabulary and the SAS, whereby people who appear to be drunk and incapable in public places are assessed by SAS personnel initially, 'treated and left' or removed to an A&E facility unless there are any criminal aspects to the case that would necessitate them being placed in police custody. This is looked upon very positively by the wider Scottish police service, and ACPOS has asked all forces to engage actively with their local health boards with a view to introducing similar schemes across Scotland. Some concern was expressed by both the Health Directorate and the SAS on the possible negative effects of this approach on ambulance attendance times and the burden it would place upon hospital casualty departments. However we found that such fears have not been realised thus far in Fife.

43. A much broader joint NHS and SAS *pathfinder project* also underway in Fife during our inspection involved the use of a response team, normally comprising a nurse and a paramedic, able to attend, assess and treat patients in the community and if necessary refer them on for further treatment. The service covers a wide range of medical issues, including people who are drunk and incapable. Initial findings suggest that such a model allows better and more appropriate use of resources, reduces the inappropriate use of 'blue light' services and helps to divert people from busy A&E units. It also corresponds with our preference for a multi-agency approach to such problems.

44. It is well documented that alcohol misuse places an enormous burden on individuals, families, society in general and the wider economy. A raft of agencies including the police, social services, the health service and local authorities are often at the forefront of dealing with the consequences. It is

therefore encouraging to note that the new Licensing (Scotland) Act 2005 is underpinned by the following five main objectives:

- preventing crime and disorder;
- securing public safety;
- preventing public nuisance;
- protecting and improving public health; and
- protecting children from harm.

45. These objectives, combined with the continuing efforts of alcohol action teams and the newly created local licensing fora, provide a legitimised platform for the various agencies, communities and other interested parties to work together in tackling what is recognised as a growing epidemic of alcohol misuse, the fall-out of which is often found in the streets of our towns and cities in the shape of a drunk and incapable individuals. An opportunity to address these issues is available following the recent publication from the Scottish Government entitled *Changing Scotland's relationship with alcohol: A discussion paper on our strategic approach*[3].

Recommendation 1: We find merit in the projects currently taking place in Fife involving the Scottish Ambulance Service (SAS), National Health Service (NHS) Fife and Fife Constabulary. Individual police forces are therefore encouraged to work in partnership with local authorities, health and other agencies to establish best practice in dealing with drunk and incapable people, within the context of locally available services and resources.

Designated places of safety for drunk and incapable people

46. As alluded to above, there is a growing debate in Scotland over the proper handling of drunk and incapable people who come into contact with the emergency services. We were very grateful to be given access to a recent research proposal from the Scottish Government's alcohol misuse team, titled Designated Places of Safety for Drunk and Incapable People, which stated that: *"while little data is available on the scale of the problem, Police Forces, SAS and A&E can be severely stretched by having to provide care and support to individuals who are intoxicated and a danger to themselves or others. This can mean that services' ability to address the needs of other people is reduced, and does not necessarily represent the best model of service provision to meet the needs of intoxicated individuals*".

47. The report, written as part of the Scottish Government's long-term strategic approach to tackling alcohol misuse, relates to designated places of safety for drunk and incapable people of which there are just two permanent such facilities in Scotland. The most notable of these is Albyn House in Aberdeen, which is jointly funded by Aberdeen City Council and NHS Grampian. Another is Beechwood House in Inverness, which is wholly funded by Highland Council. Both facilities offer a bed and support for those found drunk and incapable as an alternative to spending a night in a police cell. Throughout the Scottish police service both are considered to be examples of good practice that could usefully be extended across Scotland.

3 Scottish Government. *Changing Scotland's relationship with alcohol: A discussion paper on our strategic approach.* (http://www.scotland.gov.uk/Resource/Doc/227785/0061677.pdf). Edinburgh: Scottish Government, 2008.

48. Nevertheless, in February of this year Aberdeen City Council announced that it was withdrawing its funding of £400,000 for the facility over the next three years as part of a cost-saving exercise. This would undoubtedly have led to the forced closure of Albyn House, certainly during weekdays and possibly altogether, had NHS Grampian not stepped in. The situation is, however, only temporarily resolved. NHS Grampian will be the sole funding agency for the centre until a review of its services is completed. Thereafter, Grampian's Joint Alcohol and Drug Action team will take on the funding until the following December, in order that the recommendations of the review can be assimilated and acted upon.

49. Given the support enjoyed by these facilities, we welcomed the proposal in the Alcohol Misuse team's report *"…. that it would be helpful to address the information gaps about the scale of the need, the existing models which are available (both in Scotland and elsewhere) and to evaluate their effectiveness, with a view to providing a better evidence base on which local agencies can base their decision-making"*. We were also pleased to note that the Scottish Government has now agreed to fund this research. The resultant study will seek to identify the scale of the problem, highlight good practice and produce a set of conclusions and recommendations on how best to manage people who are drunk and incapable while alleviating undue pressure on police forces, SAS and A&E departments. Depending on its findings, it may be that some support models could then be piloted to help determine the most cost effective and appropriate approaches in a Scottish context. It may also identify early interventions that could seek to prevent people becoming drunk and incapable in the first place.

Recommendation 2: That the police service in Scotland actively participates in proposed research on identifying appropriate means of supporting and dealing with drunk and incapable people including the use of designated places of safety.

Nursing/multi-disciplinary medical provision in custody centres

50. Following a comprehensive review of its FME service, Lothian and Borders Police entered into a three-year contract with NHS Lothian to bring in a revised FME service and forensic (custody) nursing. The terms of the revised contract, which came into force in April 2006, allowed for two full-time FMEs covering the hours 0700 – 1700, Monday to Friday, and a number of part-time on-call FMEs for out-of-hours service. The aim was to provide a comprehensive and *identical* integrated service across the entire Lothian and Borders area. Forensically trained nurses were brought in to support the FMEs in their dealings with prisoners held at the force's custody facilities. The contract provided for two forensic nurses on duty between 1900 – 0700 hours, seven days a week, and 24 hour forensic nurse cover over the weekend. Though primarily based in the custody suite at St Leonard's police station in Edinburgh, as part of the service and where circumstances demand, a nurse would travel to other stations in the force area.

51. The Lothian and Borders Police model therefore provides continuous out-of-hours nursing coverage. The contract requires all nursing staff to be qualified independent nurse prescribers, consistent with the Scottish legislative framework, to be vetted and have professional experience of an A&E department, mental health or substance misuse service. All healthcare and some forensic services are covered by means of a one-off payment.

52. The initiative is viewed positively by many across the police service in Scotland, and a number of forces are actively considering introducing a similar scheme. Certainly Lothian and Borders Police personnel believed that it had allowed them to become much more professional in caring for people in custody and to establish a safer environment for them. The force also felt that the new contract had brought about cost efficiencies, particularly in the area of FME call-outs. And while some drawbacks around de-skilling and isolation of nurses had been encountered, these had been acknowledged and steps were being taken to resolve these matters.

53. In considering what the optimum scope of nursing activity in this area might be, we observed that staff in England and Wales were able to perform almost all the functions traditionally carried out by FMEs. The only exceptions were assessing the fitness of those to be detained/interviewed, carrying out mental health assessments and granting death certificates.

54. In addition, the Health Directorate and Crown Office have urged caution around any proposal to extend nurses' powers further. Not only are there some legislative restrictions on the use of nurses, there is also some concern that without the in-depth knowledge and experience of doctors they may be badly exposed should they subsequently be required to provide evidence in court proceedings. Interestingly, the ACPOS health/medical services reference group acknowledged this concern and was represented on the National Skills for Health – National Occupational Standards for Healthcare Professionals Working in Police Custody Settings group. At the time of our inspection, this group was reviewing the protocols associated with police custody settings and the people who should be carrying them out within a Scottish context.

55. Notwithstanding these developments, we believe that there is much to commend the nursing/multi-disciplinary approach in Lothian and Borders. We also feel that there may be merit in the other forces in Scotland seeking to replicate a similar approach suited to their own particular situations.

Recommendation 3: That, whilst the long-term approach could be to transfer responsibility for medical services to the NHS, forces in the meantime collaborate with the NHS to introduce multi-disciplinary clinical personnel into their custody facilities.

Mental health issues

56. Many of the arguments rehearsed previously in this document regarding the arrangements for people who are drunk and incapable are equally applicable to arrangements for people with mental health problems, accepting of course that the latter are not personally responsible for their condition. The main similarity lies in our belief that significant numbers of people falling into both categories are being detained on police premises despite the inappropriateness of doing so. Inappropriate police detention of people suffering from mental health problems is partly due to the fact that it can often be difficult for police officers to differentiate between sufferers exhibiting distress or lack of self control and offenders acting in a disorderly fashion. The other factor leading to inappropriate police detention is interpretation of the legal restraint which dictates that behaviour has to be a real danger to the individual and/or others before health practitioners can invoke powers of detention.

57. At the present time, if the police believe that mental illness may be a contributory factor in the behaviour of someone they are dealing with in a public place, and that he or she requires immediate care, then they have the power under the Mental Health (Care and Treatment) (Scotland) Act, 2003 *"to*

remove that person to a place of safety". Only if there is no place of safety immediately available should a police station be considered. In other words, the police station should be used solely as a last resort. In reality, because of the 24-hour, immediate response nature of the police service, it does often act as a 'gatekeeper' agency to the psychiatric system.

58. That said, a number of forces spoke of their difficulties in getting mental health agencies to accept people who they believed to be mentally ill. The situation is compounded by the fact that no psychiatric assessment will be carried out on a person who is under the influence of alcohol or other substances. While we appreciate the challenges faced by psychiatric professionals, the Act clearly states that holding such people within a police facility should be the last resort. In practice, it would seem that incarceration in police custody is the only option available. We are pleased to note that this area is one that is being considered by Audit Scotland in their proposed 'Overview of mental health services in Scotland'. It is perhaps worth remembering at this point that only a small proportion of people with mental health problems encountered by the police in public places have actually committed a criminal offence.

59. Tayside Police, the Crown Office, the Procurator Fiscal service and NHS Tayside have established a protocol: *Joint Operational Procedure for 24-hour Police Referrals for Psychiatric Assessment in Tayside*. Under its terms psychiatric services attend to all police referrals for assessment, where possible without delay. Should individuals then not be admitted to hospital a reason is given and advice on more appropriate support/services may be offered. Tayside Police believes that this protocol is working well in terms of providing a better service to people suffering from mental illness, and is resulting in fewer people being held inappropriately in a police cell.

Recommendation 4: That the Tayside Psychiatric Assessment Protocol be viewed as good practice, and that other police forces in Scotland pursue a similar approach.

Performance Management

60. ACPOS has agreed a national IT system for the retention of all data on people detained in police custody. The first force to use the system was Dumfries and Galloway Constabulary in 2006, the intention being that it be rolled out across the remainder of the Scottish police forces over a period of time. However, a number of practical issues arose which seriously delayed its implementation, as a result of which it had not been introduced to the next force on the roll-out at the time of writing. We are concerned at the lack of progress achieved so far and would wish to see this national process introduced to all forces as soon as possible.

61. It was our intention to provide detailed national statistics, we believe for the first time, on various aspects of custody operations as an appendix to this report. Police forces and their boards/authorities cannot hope to make reasoned decisions about the efficiency and effectiveness of custody processes, or indeed much more importantly, the proper implementation or appropriateness of their arrest and detention policies, without quantitative information on the through flow of custodies and without comparing that between areas within their forces as well as between forces. Local criminal justice boards and the national criminal justice board should also be interested in these comparisons. The Scottish custody recording system would have been the ideal tool for capturing nationally uniform data. However, for the reasons cited above and despite the efforts of individual forces it proved very difficult, if not impossible, to obtain the relevant data without an excessive

amount of manual effort being expended. Therefore we are unable to present any statistical data in a meaningful way.

62. In a number of forces the provision of medical services lacks a coherent management framework. These forces, and particularly their boards or authorities, clearly lack the information necessary to ensure that they are securing best value. Performance information is essential for quality assurance and the dearth of accurate information on patterns of demand and the nature of the work undertaken by FMEs is, in our view, the single biggest obstacle to achieving a planned, rationally managed service. Though still in various stages of development and enhancement, the solution may be found in the national IT based custody system, and to a lesser extent the common policing performance platform, a police management information system currently being developed.

63. Our review also found no standard approaches in forces to recruitment, contractual arrangements, training or quality assurance in relation to medical services. Indeed it appeared to us that some forces employed FMEs on what can be described as little more than a 'handshake agreement'. Given the requirement for a consistent service across the whole of Scotland, there may be a role for the SPSA in standardising or co-ordinating procurement processes.

Recommendation 5: That the Association of Chief Police Officers in Scotland (ACPOS), via its National Custody Forum, create and incorporate common performance management information within the developing national custody system. This would give forces, police authorities/boards, and the health service a shared understanding of what should be expected and delivered across Scotland.

Conclusion

64. The difficulties currently faced by police forces in Scotland in maintaining viable medical services have brought about the need for a review of such services to take place. Throughout this inspection we were mindful that the primary driver for change should not be to save money – although efficient use of public funds is clearly vital – but to provide the best and most appropriate service possible to people who find themselves in police custody. A compelling catalyst for change was the Scottish Government's desire to achieve a 'whole of life' medical service for the population, as were the challenges to the aim of reducing health inequalities that the current system presented. We were also struck by the arguments of a number of contributors, who saw the issue as being one of providing medical services not to the police per se, but to the individuals in police custody.

65. The main thrust of this report, then, has been to examine the current state of these services and to establish how best to provide them now and in the future. We appreciate that, given the nature of our recommendations, few can be implemented easily. But we believe that the time is right to initiate a national debate, under the direction of the Scottish Government, in order that people in Scotland who find themselves in police custody receive the best medical service possible. We are confident that our recommendations can both stimulate such debate and make a valid contribution to the way forward.

Annex A

The following provides a summary of the responses we received from forces to the eight questions we posed as part of this inspection.

1. In addition to any information you may have already supplied to the ACPOS health/medical services reference group relative to this area – has your force carried out any evaluations of the medical services provided to people in police custody? If so, what were the results of these evaluations?

1.a. About half of all police forces in Scotland had not carried out any formal evaluations of the medical services provided to people in police custody. Nevertheless a number had developed option appraisals for the future delivery of such services, mostly as a result of struggling to recruit and retain sufficient FMEs to provide coverage.

1.b. Grampian Police had conducted a review as part of its wider best value review of custody provision in May 2006.

1.c. Strathclyde Police had conducted a number of reviews into particular aspects of medical services, including both a best value review of police surgeon services in January 2002 and a thematic review of police casualty surgeons in August 2003.

1.d. Tayside Police had carried out a review of its provision of medical services by a private provider in February 2005. Northern Constabulary had completed a similar review with its private provider during 2006.

2. Did you seek independent advice when selecting partner agencies to work with the force in this area? Is there independent assessment of the services provided by partner organisations and the performance of the staff concerned?

2.a. Most forces managed their medical provision through the appointment of senior or principal FMEs who provided guidance and direction on clinical governance matters. Fife Constabulary was the only force to employ a full-time FME, attached to its Criminal Justice Department.

2.b. Though some benchmarking was evident in forces, few if any had used any external consultants to advise on service provision. This was seen as a result of the somewhat piecemeal way in which services had developed. The lack of a performance management regime in many forces is commented upon in the main report.

2.c. A number of forces had developed their provision through a competitive tendering process which had resulted in private companies operating in two forces (Northern Constabulary & Tayside Police) and the NHS operating under contract in another (Lothian & Borders Police).

2.d. Central Scotland Police was about to begin a multi-agency led review of its service provision. Some informal discussions, mainly with local health boards, were also evident in the responses.

3. What are your current processes for issuing prescribed medication to persons held in police custody?

3.a. All forces had processes and procedures in place for issuing and administering all medication to people held in custody. This was normally incorporated into forces' care and custody manuals or standard operating procedures. It came as no surprise to learn that FMEs played a central role in this process.

3.b. There was some divergence between and even within certain forces in the practice of issuing methadone. Medical advice appeared to vary in this respect, with clinical guidance and the length of time a person would remain in custody being the key factors in determining whether methadone was or was not issued. In view of the national prominence given to methadone and the high incidence of poly-drug use amongst many people in custody, we were somewhat surprised at the lack of consistent guidelines here.

4. Are any changes currently taking place in the infrastructure of your custody provision (building projects, centralisation of custody, etc.) or are any envisaged, which may have relevance to this thematic inspection?

4.a. Nearly all forces had or were planning to rationalise their custody facilities, the majority having no more than three main custody holding centres. This matter was explored in more depth in our recently published thematic inspection of custody facilities of March 2008.

4.b. The rationalisation of such facilities would undoubtedly make it easier to deliver medical services in a standardised fashion.

5. Are there any force processes, practices or procedures that you believe should be identified as good practice?

5.a. A number of areas of best practice were identified as a result of this review, and those that we felt would be most pertinent and have most impact on forces are contained within the main body of the report. These include:

- Drunk & Incapable Protocol (Fife Constabulary)
- Introduction of multi-disciplinary teams (Lothian and Borders Police)
- Mental Health Protocol (Tayside Police)

5.b. In addition, the following areas were highlighted by forces:

Fife Constabulary	The full-time position of a police NHS liaison officer in Fife is unique in Scotland, allowing greater interaction with NHS Fife.
Grampian Police	The use of life signs monitoring equipment in cells in Elgin police station. This was commented upon in our custody facilities thematic report.
Northern Constabulary	A protocol with NHS Highland to provide, in certain circumstances, specific medical services to persons in custody.
Strathclyde Police	Job descriptions for FMEs, and regular themed training days organised by the force.
	The recently established Glasgow Archway project, providing a centre of excellence for adult victims of sexual crime. This was funded by the Scottish Government, with running costs jointly funded by Strathclyde Police and Greater Glasgow and Clyde Health Board.

5.c. A number of forces also commented on the benefits of having a dedicated custody manager or non-clinical manager, responsible for all matters pertaining to custody including the provision of health care. This had generally led to improvements in efficiency, productivity and the achievement of best value through, for example, the innovative use of relief police custody support officers.

5.d. In addition, a number of forces hosted regular 'end user' and/or technical fora. Discussion and dissemination of learning points at these events ensured that best practice was promulgated throughout all force custody suites.

6. Does your force believe that the police service should still be responsible for the provision of this particular service or do you feel that efforts should be made to pass such responsibility on to the Health Service? Please supply additional comments, if possible.

6.a. Forces were unanimous in their desire to see the National Health Service assume ownership of this service, allowing partnerships to be created between the police, the National Health Service and other associated agencies.

6.b. Views and opinions expressed by individual forces have been incorporated into the arguments expounded within the main body of our report. These include difficulties in recruiting medical personnel, competing demands on such personnel, inefficient use of public resources, irregular geographical coverage, significant cost implications, and lack of consistency in service provision.

6.c. A resounding view expressed was that, whilst the police do make a positive contribution to the care and welfare of persons in custody, it must be recognised that the core business of custody suites is not to provide health care and that indeed health care is outwith the primary functions of the police service.

7. Do you have any other comments to offer which may be relevant to this particular thematic inspection?

7.a. All forces welcomed this thematic inspection, with a number expressing concern at the difficulty of securing adequate medical provision across their entire force area. Whilst the term 'crisis' was not used, it was clear that many were facing acute shortages in cover and all expressed fears for future provision.

7.b. This is a particular though not exclusive problem for rural areas within forces and, partly as a result of these difficulties, three Scottish forces had already entered into contracts with medical service providers. The difficulty of securing coverage was also the primary driver in at least two further forces which were actively discussing the possibility of achieving this through private providers. The pros and cons of such an approach are discussed in the main body of the report.

7.c. Ever rising costs was another issue, with around £8m to £9m being spent by all Scottish forces combined, annually. One force reported a 740% increase in costs over the last five years alone. Projected costs for all forces are expected to be even higher. To put this in some context, ACPOS reported that between 01 April 2007 and 31 March 2008 (the latest reporting period available), 215,711 individuals passed through police custody.

7.d. The important role of the ACPOS health/medical services reference group was also highlighted. Though we hope that this report will act as a platform for debate and reform, the role of the ACPOS group will be central in ensuring that any agenda for change is driven forward.

8. For EVERY individual who was taken into custody or detention (i.e. those who are under arrest or detained, or otherwise in custody, who are taken to a police station/office), during the month of February 2008, please could you provide the following information: (there followed a list of basic factual information requests such as reason for detention, age group, length of time in custody etc)

8.a. This question perhaps more than most highlighted the difficulties many forces have in accessing accurate management information in this area. With no national standardised performance management system in place as yet, many forces struggled to provide even a limited response. Systems in place at the time of our inspection offered only very limited search functionality and to provide comprehensive statistical analyses would have been very labour-intensive. Because of this, we asked forces to provide statistics only where this required reasonable effort on their part. This matter is explored further in the main report.