Medical Care in Custody Procedure

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At the time of ratifying this procedure, the author is satisfied that this document complied with relevant legislation and Force requirements.

Sign and date

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(Author(s))
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1. Responsibilities

1.1 The Escorting Officer (designated police staff or police officer) is responsible for the handling and observation of detainees to ensure safer detention, working to the standards laid down in this procedure, Police and Criminal Evidence Act 1984 Codes of Practice and Safer Detention and Handling of Persons in Police Custody guidance.

1.2 Custody Sergeants are responsible for the supervision and welfare of custody staff and detainees and for the management of cell areas, working to the standards laid down in this procedure, Police and Criminal Evidence Act 1984 Codes of Practice and Safer Detention and Handling of Persons in Police Custody guidance.

1.3 Detention Officers are suitably trained and competent members of police staff, responsible for carrying out tasks to facilitate the day-to-day running of the suite. Cheshire Constabulary Detention Officers are designated under section 38 and 39 of the Police Reform Act 2002.

1.4 Health Care Professionals are responsible for addressing the medical and clinical needs of detainees. A Health Care Professional could either be a Forensic Physician or Nurse provided by the approved medical contractor.

1.5 The Duty Custody Inspector is responsible for the management of the custody suites and Police and Criminal Evidence Act and Safer Detention and Handling of Persons in Police Custody compliance.

1.6 The Chief Inspector, Custody Services is responsible for the overall operational management of custody services within Cheshire.

1.7 The Locum Superintendent has responsibilities set out in the Police and Criminal Evidence Act 1984.

1.8 Area Commanders are responsible for the transportation of detainees and for ensuring that their staff are suitably trained to comply with this procedure.

1.9 The Assistant Chief Constable Investigation holds the strategic portfolio for Custody.

2. Guidance

2.1 Introduction

2.1.1 This section provides guidance for all Custody Staff and Health Care Professionals involved in the physical and mental welfare of detained persons. It includes the processes and responsibilities for those involved, the agencies and contractors available and their agreed role in any treatment, examination, supervision or transport. It also includes the storage, administration and disposal of medication for
people held in police custody. It identifies good practice designed to prevent deaths and adverse incidents.

2.1.2 For the purpose of this procedure, the following apply:

- **In Custody** refers to the period from the point of arrest through to release and in the case of a death, 48 hours following release from custody;
- **Detainee** refers to a person whose detention has been authorised by a Custody Sergeant;
- **Arrested Person** refers to a person not yet in police detention but has been lawfully arrested;
- **Prisoner** refers to a person who has been sentenced or remanded by a court for example, a Safeguard prisoner held under the temporary provisions.

Unless specifically mentioned, this guidance is equally applicable to arrested persons, detainees and prisoners. However for ease of reading, they will all be referred to as detainees throughout this document.

2.2 Managed Medical Services

2.2.1 Cheshire Constabulary has chosen to provide clinical attention for detainees through a contracted managed medical service.

2.2.2 The Contractor shall provide comprehensive Medical Services on a 24 hours a day basis, 365 days a year (366 in a leap year). The key objectives are to provide:
- high quality Medical Services to Detainees;
- medical advice that is independent of the investigative process and that is in accordance with relevant Legislation, Guidance and identified Best Practice; and
- Health Care Professionals who meet the relevant professional and ethical standards and have the relevant training and qualifications to enable them to perform Medical Services lawfully and effectively.

2.2.3 The contractor shall provide the following services in relation to Detainees (this list is not intended to be exhaustive):
- Fitness for Detention
- Fitness for Interview
- Injury Assessment and Treatment
- Mental Health Assessment
- Forensic Examination – further details on this are contained within the Detention procedure (including intimate and non-intimate samples and samples for driving under the influence)
- Telephone Advice
- Post incident clinical attention and advice with regard to incapacitant spray, TASER (see Appendix A for Custody Sergeant Advice) and the use of attenuating energy projectiles
- Information regarding treatment prior an adverse incident and any relevant comments.

2.2.4 Comprehensive guidance with regards to response times and performance measurements are contained within the medical contract and is monitored by HQ Procurement and the Centralised Custody Management team.
2.2.5 The medical contractor is required to provide a doctor to act as the clinical lead who is the focal point for all contractual issues.

2.2.6 Any issues with regards to the performance of contract medical staff should be directed to the Centralised Custody Management Team who will liaise with the contracted clinical lead. In urgent cases, this will be the responsibility of the duty Custody Inspector.

2.3 Referral Agencies

2.3.1 Accredited referral staff are available at each Custody suite to provide advice, guidance and support to detainees in relation to alcohol and drug dependency. These staff are employed by external agencies.

2.4 Medical Facilities

2.4.1 Each suite has been built to Home Office design standards and contains a medical room which is in close proximity to the charge desk and equipped with discretely placed affray alarms.

2.4.2 Each medical room is equipped to the standards set out in the guidance on the Safer Detention and Handling of Persons in Police Custody, including two lockable cabinets (safes), one which contains controlled drugs and the other which contains other drugs. The security and contents of these cabinets is the responsibility of the medical contractor.

2.4.3 The medical contractor is responsible for procuring, storing, maintaining and replacing medical supplies and equipment and medicines necessary for the provision of medical services at custody suites. The medical supplies and equipment to be provided by the medical contractor includes, but is not limited to, the requirements set out in the National Policing Improvement Agency guidance on the Safer Detention and Handling of Persons in Police Custody 2006 and include the following:

• standard dressings and medical equipment required by the managed services staff;
• medicines used in Patient Group Directions, i.e. Dihydrocodeine and Diazepam;
• non prescription drugs and medicines e.g. aspirin, paracetamol;
• portable oxygen therapy equipment with an associated maintenance regime.

2.4.4 When the Health Care Professional is not on site, the medical room will be kept locked. The key will be kept in the secure key cabinet behind the charge desk. On arrival at the suite, the Health Care Professional will record their presence on the Medical whiteboard and obtain the key from the duty Custody staff. The Centralised Custody Station & Cell Key Register should be duly endorsed. Upon leaving the suite, it is the responsibility of the Health Care Professional to lock the medical room door and return the keys to the duty Custody staff and endorse the Station & Cell Key Register.
2.5 Management and Supervision

2.5.1 At the beginning of each shift the Custody Sergeants coming on duty will receive a verbal briefing and formal handover document from the outgoing staff, detailing each detainee and showing all known risks and any matters of relevance to their welfare, any treatment previously given, in hand, or reasonably envisaged during their time remaining in custody. Following this handover, each detainee will become the specific responsibility of an identified Custody Sergeant.

2.5.2 Detainees that come into police custody during a tour of duty will also become the specific responsibility of an identified Custody Sergeant.

2.5.3 Full details on the handover process are included in the Detention procedure (which will be located on the Force Information Centre database) but it is essential that medical information is included as part of the handover.

2.6 Emergency Equipment

2.6.1 Emergency equipment is available in all custody suites and Custody Sergeants and Detention Officers undergo regular training on its use as part of their first aid course. The equipment includes the following:

- Defibrillator;
- First aid kit;
- Crash bag – this contains vital basic life support equipment to deal with airway, breathing and circulation emergencies;
- Oxygen.

2.6.2 As part of the Custody Suite Minimum Standards checks required by the Safer Detention and Handling of Persons in Police Custody guidance, this equipment is checked on a daily basis to ensure it is suitable for use in an emergency. These checks are recorded and deficiencies reported.

2.6.3 There is also a maintenance regime in place for the defibrillator and oxygen.

2.7 First Aid Training

2.7.1 Custody Sergeants attending an initial National Police Improvement Agency custody course will undergo a one week accredited first aid course.

2.7.2 Detention Officers were initially trained to the four day Health and Safety at Work standard and will now receive annual appointed person first aid training.

2.7.3 Refresher training for both Custody Sergeants and Detention Officers will be completed at least every twelve months, and will include oxygen therapy and defibrillator training.

2.8 Medical Assessment

2.8.1 Following the initial risk assessment carried out as part of the booking in process, the Custody Sergeant will implement a care plan which must establish the levels of observation and engagement required for each detainee. (Further information on the four levels of observation can be found in Appendix B.)
2.8.2 This risk assessment is dynamic throughout the period of detention and as such the associated care plan will be subject to review at each handover or when the detainee’s circumstances change.

2.8.3 As a minimum, the Custody Sergeant must obtain satisfactory answers to the questions in the Detainee Risk Assessment section of the Atlas Custody Record. If the detainee is unwilling or unable to provide these answers, the Custody Sergeant will record their own observations in the Detainee Risk Assessment section, and any other relevant supplementary information is to be documented as a Detention Log entry under the ‘Medical’ category.

2.8.4 The Custody Sergeant is required to take a proactive approach to identifying medical issues, including recognising symptoms of detainees who may be at risk from self-harm. Particular attention must be paid to a detainee who appears drunk or behaves abnormally, as this may be attributable to an illness or medical condition i.e. diabetes, epilepsy, the effects of drugs, alcohol or an injury such as head injury. These matters are covered in Force First Aid training.

2.8.5 When the Custody Sergeant identifies that a detainee may be at risk from self-harm, they should refer the detainee to a Health Care Professional for assessment.

2.8.6 The Custody Sergeant has a duty to ensure that the detainee receives clinical attention as soon as reasonably practicable, if the detainee:
- appears to be suffering from physical illness;
- is injured;
- appears to be suffering from a mental disorder;
- appears to need clinical attention;
- is suffering the effects of alcohol or drugs (consider pre-existing conditions and dependence);
- provides a breath sample of 150µg or above in 100ml of breath;
- requires medication;
- is suffering from an infectious disease or condition;
- comes directly from hospital;
- requests a medical examination.

2.8.7 The above criteria apply even if the detainee makes no request for medical attention and whether or not they have received clinical attention elsewhere.

2.8.8 If the need for clinical attention is urgent, the Custody Sergeant must call the Health Care Professional (if on site) or ambulance immediately and make the detainee aware that they have done so.

For further information – see PACE Codes of Practice, Code C Paragraph 9.8

2.8.9 When a Custody Sergeant makes the decision to refer a detainee to a Health Care Professional, they should contact the medical contractor via the medical call centre. The Custody Sergeant will be required to provide the following information:
- Name of Custody Sergeant requesting the consultation;
- Collar number;
- Custody reference/incident number;
• Call out category;
• Reason for call;
• Medical history;
• Age of detainee;
• Sex of detainee;
• Ethnicity of detainee;
• Additional information.

In exceptional circumstances, a Detention Officer acting on the instructions of the Custody Sergeant can make this call; however they must be in a position to provide all of the above information to the call centre, clearly stating which Custody Sergeant has made the request.

2.8.10 On completion of the referral call, the Custody Sergeant will endorse the custody record with the URN provided by the medical call centre.

2.8.11 Notwithstanding the contractual obligations of the medical provider, a Health Care Professional may contact the Custody Sergeant by telephone as part of their medical assessment requesting additional information, such as:
• Time of arrest;
• Reason for arrest;
• Relevant information surrounding the arrest;
• Relevant information from the risk assessment;
• Reason assessment required;
• Anticipated time of interview;
• Possible time of release;
• Any immediate concerns etc.

2.8.12 Requests for healthcare assessments must be added to the Medical whiteboard in the charge desk area. Appendix C shows the process for the correct updating of this whiteboard.

2.8.13 On arrival at the Custody suite, the Health Care Professional will familiarise themselves with all the entries on the Medical whiteboard and when they are ready to see a detainee, they will be given a verbal briefing from the Custody Sergeant responsible for that detainee.

2.8.14 A Custody Sergeant, or Police / Detention Officer acting on the instructions of a Custody Sergeant, will bring the detainee from their cell to the medical room. A risk assessment or specific request by the Health Care Professional may require the Detention Officer to remain in the medical room whilst the detainee is being examined. If the risk assessment does not indicate this requirement, they will wait outside the medical room door and be in a position to respond immediately to any incident within the medical room. Under no circumstances should the Detention Officer escorting the detainee leave the immediate vicinity of the medical room.

2.8.15 The Custody Sergeant’s duty to seek medical attention does not automatically extend to minor ailments and/or injuries, although any doubts must be resolved in favour of calling the appropriate Health Care Professional. The Custody Sergeant must treat such ailments / injuries by providing basic first aid, e.g. plaster. They must also record all such ailments and injuries and subsequent treatment on the custody record.
2.8.16 The role of the Health Care Professional is to consider the risks and advise the Custody Sergeant of the outcome of that consideration. The Health Care Professional’s determination and any advice or recommendations should be made in writing and form part of the custody record. This does not preclude any other obligations specified in the medical contract.


2.8.17 The care plan is the responsibility of the Custody Sergeant. It should be completed in consultation with the Health Care Professional reflecting the findings of each clinical assessment. Although unlikely, should circumstances arise where the Custody Sergeant has to act contrary to the medical advice provided this should be recorded in the custody record along with the rationale for the decision and an explanation given to the Health Care Professional. The nature of the conflict must be referred to the duty Inspector for arbitration.

2.8.18 All medical examinations must be carried out by a Health Care Professional. The medical examination or treatment carried out on the detainee will result in a medical custody log entry which will form part of the detainee’s custody record. The Health Care Professional will indicate as part of this entry where the full medical notes made during the consultation are kept/stored.

For further information – see PACE Codes of Practice, Code C Paragraph 9

2.8.19 The Custody Sergeant must ensure that any actions taken in relation to injury, illness or medical requirement are endorsed on the custody record. If no action is taken, reasons for doing so must also be recorded on the custody record.

2.8.20 When a detainee wishes to call their own doctor they may do so at their own expense.

2.8.21 If a detainee has been seen by a Health Care Professional and is now requesting a second opinion or their own doctor, they are entitled to do so at their own expense.

2.8.22 The Health Care Professional must provide clear and precise oral and written clinical directions including advice on the appropriate levels of observations referring to the Cheshire Constabulary Detention procedure and the Safer Detention and Handling of Persons in Custody guidance regarding the care plan which would include standards required from and frequency of detainee visits. Written notes must be recorded within the custody record, medical notes and/or on the Prescription and Administration Form. The Custody Sergeant must ask for clarification if any clinical directions given by a Health Care Professional are unclear.
Refusal of Medical Treatment by the Detainee

2.8.23 In accordance with section 2.8.6, the Custody Sergeant should arrange a clinical assessment when they feel that a detainee requires clinical attention as they:
- appear to be suffering from physical illness;
- are injured;
- appear to be suffering from a mental disorder;
- requires medication;
- is suffering from an infectious disease or condition.

In urgent cases, the contract Health Care Professional must be called to the suite and an ambulance called.

2.8.24 Detainees will be subject to Level 4 (Close Proximity) observation until they are reviewed by the Health Care Professional and a care plan is agreed.

2.8.25 If the detainee refuses to go to hospital, and declines any medical assistance, the refusal should be noted on the custody record and the detainee requested to sign this. Their condition must be closely monitored for signs of deterioration.

2.8.26 If following the Health Care Professional’s assessment, they too are of the opinion that the detainee should be transferred to hospital and the detainee still refuses, another custody record entry must be made by the Custody Sergeant and the detainee asked to sign it.

2.8.27 The Health Care Professional may decide to call an ambulance despite the detainee’s refusal. If the detainee subsequently refuses following the advice from the ambulance staff, a copy of the ambulance record that the detainee signs that confirms their refusal for hospital treatment should be added to the detainee’s custody record.

2.8.28 The Custody Sergeant must follow the Health Care Professional’s advice indicating the level of observation and care plan for the detainee.

2.8.29 If the detainee’s level of consciousness or condition starts to deteriorate, the Custody Sergeant must act in the detainee’s best interest and call an ambulance. These decisions and actions must be clearly recorded on the custody record.

2.8.30 This process is shown in Appendix D.

2.9 Fitness for Process

2.9.1 Within a detainee’s period of detention, a Custody Sergeant may consult a Health Care Professional in relation to that person’s:
- Fitness to be detained;
- Fitness to be interviewed;
- Fitness to transport;
- Fitness for release from custody.

2.9.2 The Custody Sergeant must ensure that all relevant information is made available to the Health Care Professional, and that the Health Care Professional makes available all relevant information to the Custody Sergeant.
Fitness to be Detained

2.9.3 The Custody Sergeant may decide that clinical attention is needed before a decision can be made about a person’s fitness to be detained. Depending on the level of concern, the Custody Sergeant has the following options:
- Send them immediately to hospital;
- Seek urgent telephone advice;
- Request a Health Care Professional assessment through the medical call centre (see paragraph 2.8.9 for details of the information required for such a call).

2.9.4 Custody Sergeants should also be aware that the effects of alcohol or drugs may mask other illnesses or injuries.

2.9.5 A Custody Sergeant should bear in mind that during long periods of detention, a detainee’s condition may deteriorate, i.e. a detainee that was fit to be detained at the time of arrival at the custody suite may become unfit for detention. In such circumstances, the Custody Sergeant should repeat the process shown in paragraph 2.9.3.

Fitness to be Interviewed

2.9.6 Before any interview takes place, the Custody Sergeant must assess whether the detainee is fit to be interviewed. If doubts are raised about their fitness to be interviewed, the detainee must be assessed by a Health Care Professional before the interview takes place as failure to do this may prejudice subsequent proceedings.

2.9.7 The Custody Sergeant must record the reason for doubting a person’s fitness for interview. This must be clearly relayed to the Health Care Professional.

2.9.8 The result of the Health Care Professional’s assessment must be clearly documented on the custody record. The Health Care Professional must ensure that they make all relevant information available to the Custody Sergeant.

2.9.9 A Custody Sergeant should bear in mind that during long periods of detention, a detainee’s condition may change, i.e. a detainee that was fit to be interviewed six hours ago may no longer be fit for such an interview. In such circumstances, the Custody Sergeant should repeat the process as above.

2.9.10 The assessment should identify the risks to the detainee’s physical and mental well being, and determine safeguards that may be required during the interview process.

For further information – see PACE Codes of Practice, Code C, Annex G.

2.9.11 The Custody Sergeant cannot allow a detainee to be interviewed if they believe it would cause significant harm to the detainee’s physical or mental state. The matter must be referred to an officer of the rank of Superintendent or above in accordance with the Police and Criminal Evidence Act 1984, Code C, paragraphs 11.18 to 11.20.
**Fitness to be Transported**

2.9.12 **It is the Custody Sergeant’s responsibility** to determine whether a detainee is fit to be transported. If doubts are raised about their fitness to be transported, the Custody Sergeant should arrange for the detainee to be assessed by a Health Care Professional.

2.9.13 The Custody Sergeant must record the reason for doubting a person’s fitness to be transported. This must be clearly relayed to the Health Care Professional.

2.9.14 The result of the Health Care Professional’s assessment must be clearly documented on the custody record. The Health Care Professional must ensure that they make all relevant information available to the Custody Sergeant.

2.9.15 The assessment should identify the risks to the detainee’s physical and mental well being, and determine safeguards that may be required during the transportation.

2.9.16 This information should also be recorded in detail on the Prisoner Escort Record form for the benefit of the Prisoner Escort Contract Service provider. The Prisoner Escort Contract Service procedure found on the Force Information Centre database gives further details on this.

**Fitness for Release from Custody**

2.9.17 It is the Custody Sergeant’s responsibility to determine whether a detainee is fit to be released from Custody as part of the pre-release risk assessment process. If doubts are raised about their fitness to be released, the Custody Sergeant should arrange for the detainee to be assessed by a Health Care Professional.

2.9.18 The reason for this referral must be recorded on the custody record by the Custody Sergeant and clearly relayed to the Health Care Professional.

2.9.19 The result of the Health Care Professional’s assessment must be clearly documented on the custody record. The Health Care Professional must ensure that they make all relevant information available to the Custody Sergeant.

2.9.20 The assessment should identify the risks to the detainee’s physical and mental well being, and determine safeguards that may be required following release. Safeguards to be arranged by the Custody Sergeant could include referrals to mental health agencies for assistance or to other agencies such as, housing, benefits etc. for support.

2.9.21 As a minimum, the Custody Sergeant must arrange for vulnerable detainees to be handed a copy of the suite specific Support & Advice leaflet which provides contact details for a number of agencies which could provide support.

**2.10 Restraint or Cell Relocation**

2.10.1 Restraining or moving violent detainees from place to place, such as cell relocation carries a high risk of injury and should be avoided where possible. If, however, this becomes necessary the procedure must be carried out in line with the **ACPO/CENTREX Personal Safety Manual of Guidance**.
2.10.2 In line with the Detention procedure, the Custody Sergeant should take advice from a Health Care Professional where possible and request them to be present to monitor the detainee’s medical condition when restraining or moving violent detainees.

2.10.3 The unavailability of a Health Care Professional should not delay the urgent restraint or movement of a violent detainee.

2.10.4 The Custody Sergeant must document on the custody record the reasons for the Health Care Professional’s unavailability during this process.

2.10.5 If the Health Care Professional is present during the process, they will make contemporaneous medical notes detailing everything that has transpired. This assessment will include fitness for detention post relocation or restraint.

2.10.6 The Health Care Professional will then make a custody log entry detailing the outcome of their assessment. This could include observations on levels of force used and potential injuries suffered.

2.10.7 Should the Health Care Professional be unavailable, the Custody Sergeant should review the care plan based on:
   - The circumstances of the restraint or relocation;
   - Levels of violence offered by the detainee;
   - Levels of force required to control the detainee;
   - Any injuries suffered by the detainee;
   - The resulting demeanour of the detainee.

2.10.8 This review may result in a revised care plan:
   - Transfer to hospital;
   - Seeking medical advice telephonically (this may be urgent or non-urgent);
   - Requesting assessment by a Health Care Professional;
   - Administration of first aid.

2.11 Hospital Care

2.11.1 As part of the requirements of the Safer Detention and Handling of Persons in Police Custody, a regional healthcare protocol is being developed between the Constabulary, North West Ambulance Service and the various emergency departments which provide clinical treatment to arrested persons and detainees.

2.11.2 When this protocol is agreed it will provide structured guidance on the expectations and requirements of each organisation in obtaining clinical treatment for arrested persons and detainees.

   **Transfer to Hospital**

2.11.3 In medical emergencies the Custody Sergeant must ensure that all emergency equipment is taken to the detainee’s cell or point of collapse (defibrillator, oxygen, crash bag and first aid kit).
2.11.4 The Custody Sergeant must also ensure that an ambulance is called and the detainee taken to hospital as soon as possible. If there is a Health Care Professional available at the custody suite, they should be called to attend while awaiting the ambulance. If the Health Care Professional refers a detainee to hospital, they will complete the Emergency Department Referral form (see Appendix E).

2.11.5 Only in exceptional circumstances, e.g. if an ambulance is not available, should the Custody Sergeant authorise the transportation of the detainee to hospital by police vehicle. The detainee may require first aid, which should only be given by suitably qualified staff.

2.11.6 The Custody Sergeant must ensure that a Prisoner Escort Record form is completed to accompany the detainee to hospital. Attached to this should be blank copy of the Emergency Department Return to Custody form (see Appendix F). However in emergencies there may not be sufficient time to complete the Prisoner Escort Record form. In this case the Escorting Officers should be verbally informed and the Prisoner Escort Record form passed to them at the hospital as soon as practicable.

**Supervision and Security**

2.11.7 If a detainee is to be transported to hospital, the Custody Sergeant must request the provision of escort staff via the Resource Deployment Centre. They must provide the following information:

- Relative urgency;
- Number of staff required and specific gender (if appropriate).

2.11.8 It is the responsibility of the Area Operations Inspector to provide the relevant number of staff for such escorts and to ensure that they respond and attend the designated custody suite for briefing with due regard to the level of urgency.

2.11.9 Police officers and suitably designated police staff (not PCSOs) undertaking hospital supervision duties must be briefed by the Custody Sergeant about their role. This should include:

- The individual they are guarding;
- The known risks associated with the detainee and the risk management plan;
- Actions to be taken to prevent the detainee’s escape;
- Actions to be taken to preserve evidence;
- Actions to be taken to prevent the acquisition or retention of items that may cause harm to the detainee or others;
- Actions to be taken in the event of an incident involving the detainee or affecting the detainee;
- The requirement to fully brief staff who take over the role from them;
- The use of handcuffs;
- Relevant information should be recorded on Prisoner Escort Record form, to assist in subsequent briefings;
- Staff engaged on hospital supervision should be contacted by a supervisor at least once during each tour of duty to ensure:
  - The safety and welfare of the member of staff;
  - The safety and welfare of the detainee;
• Consultation with the hospital and medical staff;
• Compliance with instructions and guidance given on the detention and care of the detainee.

2.11.10 Inspectors completing PACE reviews on detainees who are at or being transported to hospital will need to be satisfied that the issues above have been addressed.

Discharge from Hospital back into Police Custody

2.11.11 Before a detainee is discharged from hospital to return to custody, the Escorting Officers must request that the doctor immediately in charge of the detainee provides a clear written clinical report detailing investigations carried out, medication given (time and dosage), diagnosis, and further treatment advised to assist in the detainee’s care plan whilst in custody. This information should be contained within the Emergency Department Return to Custody form (see Appendix F). The detainee must not be returned to custody without this information.

2.11.12 The Escorting Officers should return the suitably completed Prisoner Escort Record form to the Custody Sergeant and inform them of any additional risks identified.

2.11.13 The Custody Sergeant must review the risk assessment and update the custody record indicating any changes to the detainee’s care plan, in particular, stating the level of observation to be maintained.

2.11.14 The detainee must be re-examined by a Health Care Professional to determine their fitness for detention and/or interview.

2.11.15 Any case notes or items of information from hospital medical staff relevant to the continuing treatment of the detainee must be passed to the Health Care Professional at the Custody Suite.

2.11.16 The Custody Sergeant must be informed immediately if any changes to the detainee’s condition occur during the journey to the custody suite as they may be significant.

2.11.17 On arrival at the custody suite from hospital, the Custody Sergeant must ensure that the detainee is searched to ensure that they have not acquired items that could be used to cause harm to themselves or others, or to damage property.

2.11.18 If the Custody Sergeant has any doubt about a detainee’s fitness to be detained following the refusal of treatment by healthcare staff, they must seek immediate telephone advice from a Health Care Professional.

2.11.19 If the Escorting Officers do not agree with hospital staff that a detainee should be released from hospital, following telephone consultation with the Custody Sergeant, these options below must be considered in the following order:
• Request a second opinion from the hospital;
• Discuss options with the managed service Health Care Professional by telephone before leaving;
• Request that the managed service Health Care Professional discuss the issue with the Accident and Emergency doctor;
• In extreme cases, if the managed service Health Care Professional is not available, the detainee should be taken to another hospital for a second opinion.

2.11.20 The Custody Sergeant should refer such difficulties to the on-duty Police and Criminal Evidence Act Inspector for further advice.

2.11.21 Where it has been necessary to take the detainee to another hospital for a second opinion, the matter should be raised with the Chief Inspector, Centralised Custody, so that the issues can be discussed at strategic level between the organisations.

Refusal of Treatment by Healthcare Staff

2.11.22 The police retain a duty of care for detainees who are refused admission to hospital or treatment by ambulance staff. Efforts should be made to have the detainee examined and assessed but if healthcare services still refuse to accept the detainee, they should be taken to the Custody Suite. Escorting staff must obtain written documentation outlining the reasons for the refusal. Escorting staff must also request clear instructions about the detainee’s ongoing care, treatment and transportation from healthcare staff.

2.12 Sudden Collapse

2.12.1 Should a detainee be subject to a “sudden collapse”, the vital actions to be taken by Custody staff are:
• Basic Life Support;
• Call an ambulance;
• Ensure that all emergency equipment is taken to the detainee’s cell or point of collapse (defibrillator, oxygen, crash bag and first aid kit);
• If the detainee is breathing and does not require CPR, put them in the recovery position;
• Alert the Health Care Professional if available on site;
• Monitor breathing and pulse.

2.12.2 If the detainee comes from or is returning from hospital following a “sudden collapse”, a Health Care Professional must be called to examine the detainee for fitness for detention. The detainee must be subject to constant observation (Level 3) or close proximity (Level 4) until a Health Care Professional advises otherwise. Custody staff must:
• Observe the detainee, recording all events and changes in the custody record;
• Talk to the detainee so that they speak back and observe for mood, lucidity and slurred speech;
• Rouse the detainee at least every fifteen minutes unless a Health Care Professional advises otherwise (the Rousing Procedure Checklist is shown as Appendix G);
• Be aware that sealed packages can cause gut symptoms such as pain, nausea, vomiting or diarrhoea;
• Inform the Custody Sergeant immediately if any minor changes occur as they may be significant.
2.13 Common Medical Conditions Encountered in Custody

2.13.1 As part of the initial and ongoing risk assessment and to determine a suitable care plan, the Custody Sergeant must question the detainee about existing medical conditions. Items in a detainee’s possession should also be checked as they may indicate a medical condition, e.g. insulin syringes used by diabetics, inhalers used by asthmatics and GTN spray used by angina patients etc.

2.13.2 If it is believed that a detainee is suffering from a medical condition, other than a minor ailment, the Custody Sergeant must seek advice from a Health Care Professional.

For further information – see PACE, Code C, paragraph 9.5 and Notes for guidance, Note 9C.

2.13.3 When a detainee is violent and/or agitated and presents an increased risk to their safety and welfare and those dealing with them, the Custody Sergeant should treat them as a medical emergency. The following conditions may cause violent, or changing, behaviour:
- Diabetes (hypo or hyperglycaemia);
- Epilepsy;
- Head Injuries;
- Intoxication (alcohol or drugs);
- Strokes;
- Infections;
- Excited delirium;
- Dehydration;
- Mental Health problems.

2.13.4 Whenever possible, the detainee should be contained rather than restrained until medical assistance can be obtained. Restraint in a prone position must be minimised. Prolonged restraint, in particular in the prone position, and struggling may result in exhaustion and ultimately death. Pressure must be avoided on the trunk, remembering the amount of time that restraint is applied is very significant.

For further information regarding the Police Management of Acute Behavioural Disturbance, please access the document “Policing Acute Behavioural Disturbance” (pages 7 onwards), via the following web link:

Intoxicated Detainees

2.13.5 When dealing with detainees believed to be intoxicated, staff should be aware that:
- Alcohol is a poison in its own right and detainees can die of alcohol poisoning;
- If an alcoholic is withdrawing from alcohol, there is a high risk of alcoholic fits / death;
- Head injury victims and persons with diabetes may appear to be drunk;
- Drug misusers may appear to be drunk when they have overdosed;
• Detainees must be capable of walking unaided to the cell and say a few appropriate words. If not, they should be treated as Drunk and Incapable and the Custody Sergeant should arrange to transfer them to hospital;
• Severely intoxicated juveniles should always be transferred to hospital;
• The Police National Computer may show that other serious medical conditions are present;
• Detainees who are intoxicated, are problematic users, or who are withdrawing from alcohol, are at an elevated risk of suicide or self-harm;
• If there is a need to consult with a Health Care Professional, then this should be done as soon as practicable;
• Snoring is a sign of airway obstruction and the detainee should be roused at the time of snoring as per his/her care plan.

2.13.6 The Custody Sergeant must treat detainees who are under the influence of drink or drugs as “intoxicated” until they are declared as being “not intoxicated”. This decision must be fully documented and evidenced in the custody log. Detainees will be subject to a minimum of Level 2 (Intermittent Observation) or as per instructions given by a Health Care Professional. Any person visited as “intoxicated” will be roused and spoken to and a full detention log entry made detailing their behaviour, actions and demeanour. If the detainee is extremely drunk then the Custody Sergeant must consider medical examination and/or removal of the detainee to hospital for treatment. All decisions must be recorded in full on the custody record.

2.13.7 Descriptive language will be used to describe the visit and the condition of the detainee. The acronym "AIO" (All in Order) or other similar entries must not be used.

2.13.8 The detainee’s Observations list in Code C will be followed by all staff visiting this category of detainee (see 2.13.9). If Custody Staff have any concerns about the welfare of a person influenced by drink or drugs they must inform the Custody Sergeant immediately.

2.13.9 There are particular conditions to look for when rousing and checking intoxicated detainees. If any detainee fails to meet any of the following criteria, an appropriate health care professional or an ambulance must be called:
• When assessing the level of rousability, consider the three Rs:
  o **Rousability** – can they be woken?
    ▪ go into the cell
    ▪ call their name
    ▪ shake gently
  o **Response to questions** – can they give appropriate answers to questions such as:
    ▪ What’s your name?
    ▪ Where do you live?
    ▪ Where do you think you are?
  o **Response to commands** – can they respond appropriately to commands such as:
    ▪ Open your eyes!
    ▪ Lift one arm, now the other arm!
• Remember to take into account the possibility or presence of other illnesses, injury, or mental condition. A person who is drowsy and smells of alcohol may also have the following:
- Diabetes
- Epilepsy
- Head injury
- Drug intoxication or overdose
- Stroke

Where a person becomes more difficult to rouse, the change may be due to a serious unidentified medical condition. Unless a Health Care Professional is on site and able to see the detainee immediately, the detainee must be sent to hospital as soon as possible by ambulance. **REMEMBER** that urgent medical advice can be obtained via telephone at all times from a Health Care Professional under the medical contract;

Where detainees are quiet, which can also be a significant indicator of risk, they should be roused and checked in accordance with their care plan and at least every thirty minutes until they are talking coherently. General guidance is given above.

2.13.10 A Health Care Professional must always be consulted if:
- The risk assessment indicates that constant observation (Level 3) or within close proximity (Level 4) is required;  
  *For further information see the Cheshire Constabulary Detention procedure and guidance on the Safer Detention and Handling of Person in Police Custody section 7.6.1 Observation and Engagement.*
- A detainee registers more than 150 micrograms of alcohol on the evidential breath-test machine. There is no power to test a detainee for alcohol other than in cases of suspected drink/driving;
- A Custody Sergeant has particular concerns about any intoxicated person, for example those with visible head injuries;
- The detainee shows symptoms of alcohol withdrawal.

2.13.11 In the event of a seizure occurring or a detainee showing signs of delirium tremors (DTs), an ambulance **must** be called and the detainee taken to hospital.

2.13.12 If the Custody Sergeant is concerned and a Health Care Professional is not readily available, they must consider removing the detainee to hospital urgently by ambulance.

2.13.13 Custody Staff will have to carry out health care related activities in the Custody Suite when a Health Care Professional is not available. This may include the following conditions:
- Hypothermia – remove wet clothing and supply suitable replacement dry clothing. Place the detainee on a mattress on the floor and cover with blankets. If conscious, provide the detainee with hot drinks;
- Vomiting – if unconscious, place the detainee in the recovery position and call for an ambulance;
- Hypoglycaemia (low blood sugar) – may result in brain damage. Conscious adults should be encouraged to take sweet drinks and food with water. In these circumstances the Custody Sergeant should consider either transferring the detainees directly to hospital, or arranging for advice to be provided over phone from a Health Care Professional (which may subsequently result in removal to hospital).

2.13.14 If an intoxicated person appears to have collapsed, their airway, breathing and circulation (ABC) should be checked. They should then be rolled into the
recovery position if safe to do so. Any debris should be removed from the mouth and throat before attempting further resuscitation. An ambulance should be called and where available, the immediate assistance of a Health Care Professional should be sought.

In the event of a collapse, First Aid procedures as taught in Force First Aid Training should be followed, an ambulance should be called and the Force Incident Manager informed. Staff will follow procedures as laid down in Adverse Incidents and Deaths in Police Custody procedure.

2.13.15 If there is a decline in the condition of the detainee or their level of consciousness, for example, if speech becomes incoherent, a Health Care Professional should be informed and consideration given to sending the detainee directly to hospital.

2.13.16 Where arrangements are being made to secure clinical attention for a detainee, the Custody Sergeant must make sure that all relevant information which might assist in the treatment of a detainee’s condition is made available to the responsible Health Care Professional either in person. This applies whether the Health Care Professional asks for the information or not. Any officer or member of police staff with relevant information must inform the Custody Sergeant as soon as practicable. All relevant information and actions must be fully documented on the custody record.

2.13.17 Whenever the Health Care Professional is called to examine or treat a detainee who is believed to be intoxicated, the Custody Sergeant shall ask for their opinion about:

- Any risks or problems which police need to take into account when making decisions about a detainee’s continued detention;
- The appropriate level of observation and the need for safeguards to be added to the existing care plan.

2.13.18 When clinical directions are given by the Health Care Professional, whether orally or in writing, and the Custody Sergeant has any doubts or is in any way uncertain about any aspect of the directions, the Custody Sergeant must ask for clarification. It is particularly important that the directions concerning the established care plan and in particular the levels of observation are clear, precise and capable of being implemented.

2.13.19 Equally, if any member of staff working in the custody suite has any concerns they should seek clarification from the Custody Sergeant.

2.13.20 Special risks related to Intoxicated Drug Users include:

- Snoring is indicative of airway obstruction. Silent breathing could be indicative of respiratory depression and may well represent an early stage in the overdose process;
- Any suspected ‘package swallowing’ must be treated as a medical emergency that requires urgent hospitalisation (for further information, see Police and Criminal Evidence Act Code of Practice C, Annex K);
- ‘Withdrawal’ is a high risk factor.
Head Injuries

2.13.21 Custody Staff must be aware of the risks associated with head injuries. They should also be aware of the fact that there may be an underlying head injury that is not obviously apparent, for example, when dealing with detainees who may have been involved in a fight or a road traffic collision. A head injury may result in a rapid deterioration in the health of the detainee.

2.13.22 If the detainee has sustained a head injury, the Custody Sergeant must immediately call an ambulance if any of the following symptoms have occurred:
- Unconsciousness, or lack of full consciousness (for example, problems keeping their eyes open);
- Problems understanding, speaking, reading or writing;
- Loss of feeling in part of the body;
- Problems balancing or walking;
- General weakness;
- Any changes in eyesight, e.g. double vision;
- Any clear fluid running from ears or nose;
- Blood running from ears;
- A black eye with no associated damage around the eye;
- New deafness in one or both ears;
- Bruising behind one or both ears;
- Any evidence of scalp or skull damage, especially when the skull has been penetrated;
- Vomiting;
- Severe headaches that do not respond to analgesia;
- Any convulsions or fits.

2.13.23 If the detainee does not fit the above criteria and the Custody Sergeant is unsure whether to transfer the detainee to hospital, they should seek urgent telephone advice from a Health Care Professional.

Diabetes

2.13.24 Diabetics are often identifiable by bracelets or necklaces, or may carry a medical card detailing their medical condition.

2.13.25 If the detainee claims that they suffer from diabetes, the Custody Sergeant should ascertain what method it is controlled by, i.e. insulin or tablet controlled, whether they have medication with them or whether arrangements can be made to collect it, e.g. from their home address. Doses and times should be recorded on the custody record and the Custody Sergeant should establish when the next dose is due. If the detainee’s detention extends beyond their next medication time, the Custody Sergeant should arrange for a Health Care Professional to attend. Following assessment the Health Care Professional will advise on the further management of the detainee whilst in custody, i.e. fitness for detention, fitness for interview, collection of medication, administration of medication, diet etc.

2.13.26 Information about any possible complications as a result of taking or not taking their medication should be obtained from the detainee and the Health Care Professional.
2.13.27 Once insulin has been prescribed, persons with diabetes may, subject to the Custody Sergeant’s risk assessment and a Health Care Professional’s medical assessment, inject themselves. This must be after having food and under the supervision of the Custody Sergeant. The benefit of the meal, followed by insulin to avoid hypoglycaemia, should be explained to the detainee.

2.13.28 The detainee should be given regular meals in accordance with healthcare advice.

2.13.29 If the detainee complains of becoming hypoglycaemic, they should be supplied with glucose tablets or a cold still drink with two teaspoons of sugar. The Custody Sergeant should then seek urgent telephone advice.

2.13.30 Detainees will be subject to a minimum of Level 2 (Intermittent Observation) or as per instructions given by a Health Care Professional.

2.13.31 If the detainee REFUSES insulin, the Custody Sergeant should inform the Health Care Professional immediately. However, insulin refusal per se is not a medical emergency, as deterioration in health will take hours or days.

2.13.32 Signs, symptoms and treatment of hypoglycaemia may include sweating, aggression, stubbornness, anxiety, pallor, trembling, confusion, hunger, sleepiness and lack of co-ordination.
   • Immediate action – for a conscious detainee, give the individual a sweet drink or three tablets of glucose or chocolate immediately. When recovered, a meal or bowl of cereal should be offered;
   • The advice of a Health Care Professional should be sought immediately, or the detainee removed to hospital for assessment by Ambulance;
   • If the detainee is slipping into unconsciousness an ambulance must be called immediately and first aid administered as per section 2.4.31.

2.13.33 Signs, symptoms and treatment of hyperglycaemia may include:
   • Unconsciousness or a reduced level of consciousness, dry skin, deep breathing, and/or a smell of acetone (similar to pear drops) on the breath;
   Immediate action – transfer to hospital.

**Epilepsy**

2.13.34 People with epilepsy are often identifiable by bracelets or necklaces, or may carry a medical card detailing their medical condition.

2.13.35 Signs and symptoms of epilepsy include
   • The detainee may tell you of their condition;
   • The detainee may tell you that they can feel a fit about to start (known as an aura);
   • The detainee may cry out, become rigid, fall to the ground and then start to shake violently all over or an isolated part of the body e.g. just one leg;
   • Following a fit there will be a period of unconsciousness (length variable);
   • Staring into space, nodding of the head and lip smacking often characterise the partial type of seizures;
• Behaving in a drunken manner, undressing and performing repetitive tasks with no apparent purpose, again characterise partial seizures;
• The detainee may well become incontinent of urine and/or faeces.

2.13.36 If the detainee claims that they suffer from epilepsy the Custody Sergeant should ascertain the following:
• The type of fit they experience;
• Any medication prescribed (whether taken regularly and when next due);
• The frequency of the fits;
• When the last fit occurred.

2.13.37 The Custody Sergeant should arrange for a referral to a Health Care Professional by contacting the medical contractor via the medical call centre.

2.13.38 Detainees will be subject to a minimum of Level 2 (Intermittent Observation) with the visit frequency set at 15 minutes until they are reviewed by the Health Care Professional and a management plan is agreed.

2.13.39 If a person with epilepsy says that they ‘feel a fit coming on’, they should be placed in a cell with a second mattress on the floor and the care plan amended to Level 4 – Close Proximity. A Health Care Professional must be informed.

2.13.40 **During an epileptic fit**, the Custody Sergeant **MUST** ensure that:
• An ambulance is called;
• If possible during the fit, place the detainee in the recovery position;
• Oxygen is given during the fit;
• The airway is kept open at all times;
• Nothing is placed between the teeth; jaw spasms can easily bite through pens, rulers etc. and cause airway obstruction;
• Alert the Health Care Professional if available on site.

2.13.41 During the fit, it is important that the person remains unrestrained and that movement of their limbs is guided by holding onto their clothing.

2.13.42 If there is sufficient time, the Custody Sergeant should ensure that:
• The person is guided to the ground and made comfortable lying down - preferably in the recovery position;
• Tight clothing is loosened and glasses are removed;
• The head is supported on a folded blanket or pillow;
• Any potential objects of danger are removed from around the person such as chairs, tables, etc.

2.13.43 **Following a fit**, the person must be placed in the recovery position whilst awaiting the ambulance or Health Care Professional,

2.13.44 Custody Staff should be prepared for the person to have another fit after the first fit. If this does occur this is regarded as a dire medical emergency. Following an epileptic fit there is often a period, during which a person feels tired and confused, speaks incoherently and may act in a strange way. This normally lasts no more than a few hours, but in rare cases can persist for up to twenty-four hours.
2.13.45 As the detainee recovers, Custody Staff should talk to the detainee to reassure them and stay with them until full recovery.

**Excited Delirium**

2.13.46 This is a life threatening condition that can be caused by heavy use of certain drugs, typically stimulants of which cocaine is the most common. Symptoms include a fever, rapid pulse, acute behavioural disturbance (perceiving others as frightening and dangerous) and breathing problems. People who appear to have this condition should only be restrained in an emergency. They should be taken by ambulance to hospital immediately the diagnosis is considered and the Health Care Professional alerted if available on site.

**Heart Disease**

2.13.47 People with heart disease are often distinguishable by bracelets or necklaces, or may carry a medical card detailing their medical condition.

2.13.48 All Custody Staff must be aware that people with heart disease pose a significant risk of sudden death in custody. The stress of detention and custody procedures presents significant risks for detainees suffering from heart complaints.

2.13.49 A detainee with heart disease should not be allowed to retain their angina spray whilst unsupervised, however the need for ready access to the angina spray must be considered as part of the risk assessment and the most suitable location fully documented on the care plan, e.g. in the medication cabinet, in the prisoner’s property cupboard, in the cell shoe locker, carried by custody staff (on medical instructions) or retained by the detainee during interview (on medical instructions) etc. The Custody Sergeant should be guided by the Health Care Professional in these circumstances. If the angina spray is to be kept in the cell shoe locker, this must be recorded on the cell hatch whiteboard.

2.13.50 A Health Care Professional should also be consulted in the following circumstances:

- Known heart disease but with no current problems. A Health Care Professional’s attendance must be arranged if the detainee is staying overnight or in excess of six hours;
- If any medication is required before interview;
- Chest pains but no known heart disease;
- Unsubstantiated claims of heart disease.

2.13.51 If the Custody Sergeant has any concerns about the detainee irrespective of his/her potential duration in custody, a consultation by a Health Care Professional must be arranged. The Custody Sergeant must clearly state to the Health Care Professional their cause for concern.

2.13.52 The Custody Sergeant must always call an ambulance for detainees known to have heart disease who:

- Have pain persisting for more than fifteen minutes despite using medication;
- Appears unwell with symptoms listed in 2.13.53;
- Feel sick or are vomiting;
- Are not fully conscious;
• Are requesting their medication excessively.

2.13.53 The Custody Sergeant must also call an ambulance for any detainee who they suspect is having a heart attack. Symptoms to look out for are:
• chest pain or clutching at their chest;
• detainee appears cold, sweaty, grey or pale;
• detainee complains of pain down their left arm or up their left jaw etc.

Asthma

2.13.54 People with asthma may be identifiable by bracelets or necklaces, may carry a medical card detailing their medical condition, or have in their possession an inhaler.

2.13.55 An asthmatic detainee should not be allowed to retain their inhaler whilst unsupervised, however the need for ready access to an inhaler must be considered as part of the risk assessment and the most suitable location fully documented on the care plan, e.g. in the medication cabinet, in the prisoner’s property cupboard, in the cell shoe locker, carried by custody staff (on medical instructions) or retained by the detainee during interview (on medical instructions) etc. The Custody Sergeant should be guided by the Health Care Professional in these circumstances. If the inhaler is to be kept in the cell shoe locker, this must be recorded on the cell hatch whiteboard.

2.13.56 The Custody Sergeant should also examine the inhaler to ensure that, as far as is possible, it has not been tampered with or used to conceal other substances. All actions must be fully documented in the custody record.

2.13.57 When dealing with an asthmatic detainee, consider the following:
• Signs and symptoms – the individual has difficulty in talking, there is an obvious state of anxiety and stress (not always present) and/or a wheezing sound from the chest (not always present);
• In severe attacks the individual may be unable to speak and may have pale or grey/blue coloured (cyanosed) skin; This may be less apparent in a black or dark skinned person but there may be some discolouration of the lips and tongue; The wheezing sound may worsen to a point where the wheezing stops and may be accompanied by reduced consciousness or marked exhaustion;
• Treatment – reassure the detainee (who may be very frightened), place them in a position where they feel most comfortable (usually sitting), instruct them to breathe slowly and deeply, and allow them to use their inhaler, i.e. two puffs.
• Having allowed the detainee to self administer medication, seek urgent telephone advice from a Health Care Professional;
• In all cases of severe asthma attacks or where the attack worsens or is prolonged, an ambulance must be called. Whilst awaiting the arrival of the ambulance, oxygen should be administered;
• In non-severe cases, Custody Staff should still seek the advice of a Health Care Professional.

Drugs – Including Packers and Swallowers

2.13.58 All detainees believed to be under the influence of drugs must be seen by a Health Care Professional as a matter of course.
2.13.59 If it is known or suspected that a detainee has swallowed or packed drugs, they must be treated as being in need of urgent medical attention and an ambulance and a contract Health Care Professional called immediately.

2.13.60 If the detainee refuses to go to hospital, and declines any medical assistance, the refusal should be noted on the custody record and the detainee requested to sign this. Their condition must be closely monitored for signs of deterioration.

2.13.61 Detainees will be subject to a minimum of Level 4 (Close Proximity) until they are reviewed by the Health Care Professional and a care plan is agreed.

2.13.62 If following the Health Care Professional’s assessment, they too are of the opinion that the detainee should be transferred to hospital and the detainee still refuses, another custody record entry must be made by the Custody Sergeant and the detainee asked to sign it.

2.13.63 The Health Care Professional may decide to call an ambulance despite the detainee’s refusal. If the detainee subsequently refuses following the advice from the ambulance staff, a copy of the ambulance record that the detainee signs that confirms their refusal for hospital treatment should be added to the detainee’s custody record.

2.13.64 The Custody Sergeant must follow the Health Care Professional’s advice indicating the level of observation for the detainee. This should either be constant observation (level 3) or close proximity (level 4).

2.13.65 If the detainee’s level of consciousness or condition starts to deteriorate, the Custody Sergeant must act in the detainee’s best interest and call an ambulance. These decisions and actions must be clearly recorded on the custody record.

2.13.66 If after 12 hours, the detainee’s condition has not deteriorated, the Custody Sergeant must arrange for a reassessment by the Health Care Professional and be guided by the Health Care Professional’s recommendation for future levels of observation.

2.13.67 Section 55A of the Police and Criminal Evidence Act 1984 allows, subject to certain conditions, a person who has been arrested and is in police detention to have an x-ray taken of them or an ultrasound to be carried out. This can only be carried out if:

- authorised by an officer of Inspector rank or above who has reasonable grounds for believing that the detainee:
  - may have swallowed a Class A drug; and
  - was in possession of that Class A drug with the intention of supplying it to another or to export; and
- the detainee’s appropriate consent has been given in writing and is recorded on the custody record.

For further information – see Police and Criminal Evidence Act, Code C, Annex K.
Drugs Swallowers - Discharge from Hospital back into Police Custody

2.13.68 Before a detainee who it is believed has swallowed drugs is discharged from hospital to return to custody, the Escorting Officers must request that the doctor immediately in charge of the detainee provides a clear written clinical report detailing investigations carried out, medication given (time and dosage), diagnosis, and further treatment advised to assist in the detainee’s care plan whilst in custody. The detainee must not be returned to custody without this information:
- Detainees may still have drug packages in their bodies and hospital tests and observation will not always detect them;
- The detainee will continue to be at risk of deterioration, which may be either slow or sudden;
- The detainee should be re-examined by a Health Care Professional to determine their fitness for detention and/or interview.

2.13.69 Prior to examination by the Health Care Professional for fitness to be detained, the detainee’s care plan must either be subject to constant observation (Level 3) or close proximity (Level 4).

2.13.70 If a Health Care Professional is not immediately available i.e. at another suite, telephone advice could be sought as soon as possible, pending their arrival.

2.13.71 The Custody Sergeant must be informed immediately if any minor changes to the detainee’s condition occur as they may be significant.

**Sickle Cell Anaemia**

2.13.72 People with sickle cell anaemia are often identifiable by bracelets or necklaces, or may carry a medical card detailing their medical condition.

2.13.73 Detainees with sickle cell anaemia must be seen by a Health Care Professional.

2.13.74 Custody Sergeants must call an ambulance for detainees with sickle cell anaemia who appear unwell.

2.13.75 Normally sickle cell anaemia is symptomless, but exposure to cold, infection or bodily water shortage (dehydration) may trigger episodes of sickle cell disease called ‘sickling crises’.

2.13.76 When ‘sickling crises’ occur, the main symptoms are:
- Gradually worsening pain in bones and joints;
- Severe pain in the abdomen with rigidity of the muscular wall;
- Fever;
- Stabbing chest pain on breathing, with breathing difficulty;
- If the brain is affected, seizures and possible weakness on one side of the body;
- Pain in the upper abdomen from the liver and the spleen;
- Blood in the urine from kidney damage;
- Persistent and painful erections in men.
**Claustrophobia**

2.13.77 Whenever a detainee claims to be claustrophobic, the Custody Sergeant should ensure that as part of their risk assessment and associated care plan, they consider the most suitable location and suitable control measures for the detainee during their period of detention.

2.13.78 As part of the care plan, the Custody Sergeant should consider the following options for accommodating the detainee:
- General observation (Level 1) with:
  - increased frequency of visits,
  - periods in the exercise yard;
- On constant observation (Level 3);
- Within close proximity (Level 4);

2.13.79 Custody Sergeants should be aware that:
- Claustrophobia is a difficult condition to deal with in the custody environment - detainees may say they are claustrophobic when they are not;
- There are generally no suitable areas within a Custody Suite to keep detainees who do suffer from claustrophobia.

2.13.80 When dealing with a claustrophobic attack, Custody Staff should:
- Remain calm;
- Reassure the detainee;
- Take the detainee to a cool, quiet place e.g. exercise yard;
- Encourage the detainee to breathe more slowly;
- If hyperventilating, encourage the detainee to breathe into and out of a paper bag;
- Remain with them until they have recovered;
- Call a Health Care Professional.

**Communicable Diseases**

2.13.81 Custody staff should treat all detainees with universal precautions irrespective of whether they have a communicable disease or not.

2.13.82 Whenever a detainee is known or suspected to have a communicable disease, advice should be sought from a Health Care Professional.

2.13.83 Some detainees will give information readily about a disease or infection, others will not. Information may be available on the Police National Computer or Atlas, and there may be visible signs such as discolouration of the skin or weeping sores.

2.13.84 It is essential that information about communicable diseases is passed on to all staff likely to come into contact with the detainee but this needs to be balanced with protecting the detainee’s privacy. Information should be recorded on the risk assessment within the custody record.

2.13.85 The whiteboard should clearly indicate that the detainee has a contagious or communicable disease but the disease should not be specified. This should be
done by writing the standard Police National Computer marker CO in red. The actual diagnosis should be included in the custody record.

2.13.86 The Police and Criminal Evidence Act, Code C, paragraph 9.7 permits the custody of a detainee and their property in isolation until clinical directions have been obtained.

2.13.87 Where a person with a communicable disease has occupied a cell, arrangements must be made in accordance with the force cleaning contract for the cell to be cleaned before another detainee uses it. In most circumstances, this will require standard cleaning with approved disinfectants. However, Custody Sergeants may need to consider the deep cleaning of the cell.

2.13.88 Relevant information about communicable diseases must be included on the Prisoner Escort Record form.

2.13.89 Common communicable diseases include the following and further details on each are shown in Appendix H:
- Hepatitis;
- Tuberculosis (TB);
- HIV and AIDS;
- Scabies;
- Methicillin-resistant staphylococcus aureus (MRSA);
- Norwalk virus (Norovirus);
- Fleas.

For further information see http://www.nhsdirect.nhs.uk

2.13.90 Pending the completion of the Force procedure on Infectious Diseases, staff who are concerned that they have come into contact with a communicable disease, other than for immediate first aid, should not seek advice from the contract medical staff. They must be referred to the occupational health provider. If the occupational health provider is not available for immediate advice, staff should contact the local emergency department.

Nicotine Withdrawal

2.13.91 Nicotine withdrawal may also have an adverse effect on the detainee and should be considered as part of the risk assessment. Cheshire Constabulary Custody Suites are subject to a no smoking policy. Any concerns relating to nicotine withdrawal must be referred to a Health Care Professional for clinical advice.

2.14 Mental Health

2.14.1 Being in a police cell may aggravate a person’s condition if they are already suffering from mental illness. In particular, isolation and the noise in a busy custody suite can be aggravating factors. Mental health problems and alcohol/drug misuse often coincide and a person’s mental health problem can make it more likely that they will self-harm or commit suicide.

2.14.2 People with mental health problems can experience an adverse reaction to being touched and this can sometimes escalate a threatening situation into a violent one.
The individual is more likely to respond positively to being talked to, with restraint only being used in situations where this approach is not possible or a very real danger of harm is present to the individual or another.

**Mental Health Assessment**

2.14.3 Should a Custody Sergeant have concerns and it appears that the detainee may be suffering from a mental disorder in line with the Police and Criminal Evidence Act, they must call a Health Care Professional to examine and assess the detainee.

2.14.4 The process to be followed is:

- The Custody Sergeant will request that a Health Care Professional examines a detainee to determine fitness to be detained and/or fitness to be interviewed;
- The Health Care Professional will examine the detainee and decide if they require a mental health assessment under the Mental Health Act;
- If a mental health assessment under the Mental Health Act is required, the Health Care Professional will notify the Custody Sergeant who will arrange this assessment. The Health Care Professional will contact the Approved Mental Health Practitioner as a matter of courtesy;
- The Approved Mental Health Practitioner may request that the detainee first be seen by the Forensic Physician;
- If the Forensic Physician feels that the detainee is sectionable under the Mental Health Act, they will complete the Form 11 – Mental Health Referral form and leave it with the Custody Sergeant in an envelope marked confidential for the attention of the Approved Mental Health Practitioner. The Forensic Physician will discuss the case with the Approved Mental Health Practitioner as a matter of courtesy;
- The Custody Sergeant should also consider using the Criminal Justice Mental Health Liaison Team in line with the local protocols for their Area (see Appendix I which is the recommended flowchart detailing this referral system).

**Mental Health Act 1983 Section 136 Detainees**

2.14.5 When a person is detained under section 136 of the Mental Health Act 1983, they must be taken to a place of safety for an assessment. This will not normally be a police station or Custody Suite, unless the person is extremely violent or otherwise out of control. Non-violent section 136 detainees who have not committed an offence must be dealt with in accordance with the Section 136 multi-agency protocols and taken directly to the designated place of safety (available on the Force Information Centre database).

2.14.6 If a section 136 detainee is brought into a custody suite who is not violent or not otherwise out of control, the Custody Sergeant must make arrangements for the detainee to be transferred to the designated place of safety. If possible, the Custody Sergeant should inform the designated place of safety of their impending arrival. This must not delay the transfer.

2.14.7 If a section 136 detainee is brought into a custody suite who is violent or otherwise out of control, the Custody Sergeant must request an assessment by a Health Care Professional for a fitness for detention, clearly stating that the patient has been brought in under s136 and all other relevant information, such as whether they are...
intoxicated, violent etc. The Custody Sergeant will clearly document on the custody record the reason why the custody suite is being used as the place of safety.

2.14.8 A police custody suite is not the ideal place of safety for a section 136 detainee, the Health Care Professional should, as per 2.14.6, ensure that non-violent section 136 detainees are transferred to the designated place of safety.

2.14.9 Should the demeanour of a previously violent or out of control section 136 detainee change and they are considered by a Health Care Professional to be fit to be transported, they can be transferred to the designated place of safety. This should be arranged in accordance with the Detention and Transportation of Arrested Persons, Detainees and Prisoners procedures.

2.14.10 Any section 136 detainee being transferred from police custody to the designated place of safety following an assessment by the Health Care Professional must first be accepted by the designated place of safety before the journey starts.

2.14.11 If a mental health assessment under the Mental Health Act is required, the Health Care Professional will notify the Custody Sergeant who will arrange this assessment. The Health Care Professional will contact the Approved Mental Health Practitioner as a matter of courtesy.

2.14.12 If a detainee is sectioned under the Mental Health Act, they should be transported as per the Section 6(1) Mental Health Act 1983 Conveying to Hospital protocol which is available on the Force Information Centre database.

2.14.13 If a detainee is not sectioned under the Mental Health Act, they must be released from custody. The Custody Sergeant must complete a pre-release risk assessment, taking into account any advice given by the Approved Mental Health Practitioner, section 12 doctor (as defined by the Mental Health Act 1983) and/or Forensic Physician.

2.15 Medication

2.15.1 As part of the medical contract, a Patient Group Direction has been agreed which sets out the guidelines for the use of prescription only medication by Health Care Professionals employed by the managed service provider.

Responsibilities of a Custody Sergeant

2.15.2 Following the initial risk assessment by the Custody Sergeant, where it is known that a detainee requires medication, the Custody Sergeant is responsible for the safekeeping of their medication together with the Prescription and Administration Form (see Appendix J) indicating dose and times to be administered. These will be held in a numbered locked cabinet corresponding to the detainee’s allocated cell located in the custody office.

2.15.3 The access key for each medical cabinet will be kept secure in the key cabinet located in the custody office.
Medication in Possession on Arrival at the Custody Suite

2.15.4 The Custody Sergeant must record any medication that a detainee has in their possession on arrival at the custody suite, together with an explanation from the detainee as to why they have the medication and if they need to take it whilst detained.

2.15.5 A note shall also be made of medication they claim to need but do not have with them. In these circumstances, the detainee must be referred to a Health Care Professional. The Health Care Professional will subsequently determine whether the detainee requires this medication whilst in custody.

2.15.6 Where a detainee is in possession of lawfully prescribed medicines for personal use, including drugs other than controlled drugs, the Custody Sergeant will retain these with the detainee’s personal property and record on the custody record. If the medication is to be administered whilst in police custody, this must be retained in the detainee’s secure medical cabinet.

Possession of a Controlled Drug as Prescribed Medication

2.15.7 Where a detainee is in lawful possession of a controlled drug, no Custody Staff may administer or supervise the self-administration of controlled drugs of the types and forms listed in the Misuse of Drugs Regulations 2001, Schedules 1, 2 and 3 (see Appendix K). A detainee may only self-administer such drugs under the personal supervision of the Forensic Physician authorising their use.

2.15.8 The common controlled drugs encountered in Custody that will be administered by a Forensic Physician only are:

- Ritalin;
- Oromorph;
- Diamorphine;
- Morphgesic;
- Zomorph;
- Cyclimorph;
- MST;
- Subutex / Buprenorphine;
- Methadone;
- Temgesic;
- Fentanyl;
- Durogesic;
- Suboxone;
- Oxycodone;
- Oxycontin;
- Oxynorm;
- Pentazocine;
- Pethidine.

2.15.9 Methadone and subutex are the more common controlled drugs prescribed to detainees coming into police custody. In general, withdrawal symptoms from methadone are not likely to be present for at least 24 hours. (Appendix L provides
an overview of how Health Care Professionals would wish to treat a detainee who uses methadone for opiate withdrawal whilst in police custody.)

2.15.10 Notwithstanding contractual obligations there may be occasions when, following consultation with and approval from the Forensic Physician, drugs listed in Schedule 4 or 5 (see Appendix K) may be distributed by the Custody Sergeant for self-administration by the detainee. This consultation can be done by telephone and the Forensic Physician must be satisfied that self-administration will not expose the detainee, Custody Staff or anyone else to any risk.

2.15.11 The consultation with the Forensic Physician should be noted in the custody record. The Forensic Physician must also ensure that a custody record entry is made with regards to the advice given.

2.15.12 Once the medication is administered, the Prescription and Administration Form must be endorsed by the Custody Sergeant.

For further information – see PACE Codes of Practice, Code C paragraph 9.9-9.13

Detainee Requiring Medication

2.15.13 If a detainee is required to take or apply any medication in compliance with clinical directions prescribed before their detention, the Custody Sergeant must consult with the appropriate Health Care Professionals before use of the medication.

2.15.14 If the medication is in secure blister packs and a correctly labelled box, i.e. has the detainee’s name, is in date and clearly states the name and dosage of the medication, this medication can be authorised for administration by a Health Care Professional. Such authorisation can be obtained by the Custody Sergeant speaking in person to a Health Care Professional by telephone. The Custody Sergeant should provide the Health Care Professional with the following information:

- Name of the detainee;
- Age of the detainee;
- Time of arrest;
- Reason for arrest;
- Relevant information from the risk assessment;
- Name and dose of medication to be administered;
- Time medication last taken;
- Time medication next due;
- Plan of action for the detainee i.e. anticipated time for interview or release etc.

2.15.15 Where a detainee requires prescribed medication and is not in possession of it, the Custody Sergeant should obtain advice and guidance from a Health Care Professional before making arrangements for the medication to be obtained. This can be done telephonically.

2.15.16 If the medication cannot be obtained, a Health Care Professional consultation should be requested. The Health Care Professional may attempt to obtain a NHS prescription from the detainee’s GP, drugs team etc. Collection of the prescription and medication is the responsibility of the Force.
2.15.17 If it is necessary for a Forensic Physician to attend to issue a prescription, only private prescriptions may be issued, with the cost being met by the Force.

2.15.18 Where a detainee requests non-prescribed medication, e.g. paracetamol for a headache, this medication can be authorised for administration by a Health Care Professional. Such authorisation can be obtained by the Custody Sergeant speaking in person to a Health Care Professional by telephone having logged a request with the call centre. The Custody Sergeant should provide the Health Care Professional with the following information:
- Name of the detainee;
- Age of the detainee;
- Gender of the detainee;
- Time of arrest;
- Reason for arrest;
- Circumstances surrounding the arrest;
- Relevant information from the risk assessment, in particular, medical conditions and prescribed medication/treatment;
- Any known allergies;
- Reason for the request;
- Details of any medication taken in the last six hours;
- Plan of action for the detainee i.e. anticipated time for interview or release etc.

The medical advice, including any instruction to provide medication, given by the Health Care Professional must be recorded in the Custody record.

2.15.19 If the Custody Sergeant is in any way uncertain of any instructions or procedures given by the Health Care Professional, they must notify the Health Care Professional of this uncertainty and be satisfied by the clarity of the advice before proceeding.

2.15.20 Following the advice given by the Health Care Professional, a Custody Sergeant should obtain the relevant medication and dose from the Non-Prescription Medicine Safe. This safe contains the following general sales list medication:
- Paracetamol;
- Ibuprofen;
- Gaviscon;
- Glucose tablets;
- Aspirin.

Medication removed from this safe must be endorsed in the Medication Register (see Appendix M).

2.15.21 In the presence of another Custody Sergeant or Detention Officer, the Custody Sergeant will check the medication against the telephone instructions provided by the Health Care Professional and if correct, place the medication in a dispensing cup. It will then be handed to the detainee to self-administer. The purpose of the second member of staff being present is to ensure that the medication provided to the detainee is administered correctly, i.e. the correct detainee, the correct medication, the correct dose, the correct date and the correct time.
2.15.22 The Custody Sergeant must be satisfied that the medication has been swallowed by the detainee and will endorse the custody record with details of the provision of the medication.

2.15.23 Once the medication is administered, the Custody Sergeant must complete a Prescription and Administration Form (see Appendix J) detailing the medication taken. This form must be placed in the detainee’s medication cabinet.

**Medication Dispensed by a Forensic Physician**

2.15.24 If, after examination, a Forensic Physician prescribes medication to a detainee, the Forensic Physician will place one medication type into one bag (Henley) e.g. Diazepam in one bag and Dihydrocodeine in another bag.

2.15.25 The following information will appear on the medication bag:
- Name of the detainee;
- Name of the doctor;
- Doctor’s contact details;
- Contents of the bag e.g. white tablets or yellow capsules etc.;
- Name of the medication;
- Strength of the medication;
- The number of tablets / capsules to be given;
- Time(s) to be given;
- Date to be given;
- Special instructions e.g. with food, when detainee awakes, before sleep, etc.

2.15.26 If it is a one off dose, all the medication can be placed in one bag.

2.15.27 In certain circumstances, the Health Care Professional may administer one off medication and not leave bagged medication.

2.15.28 All medication administered, prescribed and bagged will be clearly documented on the custody record by the Health Care Professional.

2.15.29 Medication that has been bagged for administering later will be handed to the Custody Sergeant responsible for the detainee concerned. The Custody Sergeant must satisfy themselves that they fully understand the instructions for the administration of the medication, which will be written clearly by the Health Care Professional, on the Henley bag and the Prescription and Administration Form. If there is any doubt, they must seek clarification from the Forensic Physician. The medication will be held in the secure medicine cabinet relating to the detainee until the time to be taken.

2.15.30 The Forensic Physician will fill out a Prescription and Administration Record (see Appendix J) which should be given to the Custody Sergeant. The Custody Sergeant will place it with the medication in the secure medical cabinet.

2.15.31 At the allotted time and in the presence of another Custody Sergeant or Detention Officer, the Custody Sergeant will check the bag against the dispensing instructions provided by the Forensic Physician (Prescription and Administration Form) and if correct, open the bag and place the medication in a dispensing cup. It will then be handed to the detainee to self-administer. The purpose of the second
member of staff being present is to ensure that the medication provided to the detainee is administered correctly, i.e. the correct detainee, the correct medication, the correct dose, the correct date and the correct time.

2.15.32 Detention Officers are not authorised to administer medication however they may be used as the second officer to witness the Custody Sergeant administering medication to detainees. In this role, they are expected to assist the Custody Sergeant in determining that the correct medication is given in the correct dose at the correct time.

2.15.33 Once the medication is administered, the Prescription and Administration Form (see Appendix J) must be endorsed by the Custody Sergeant.

2.15.34 The Custody Sergeant must be satisfied that the medication has been swallowed by the detainee and will endorse the custody record with details of the provision of the medication.

2.15.35 If the Custody Sergeant is in any way uncertain of any instructions or procedures given by medical staff, they must speak to a Health Care Professional before allowing a detainee to take any medicine.

2.15.36 No medication is to be kept by the detainee in their cell.

Recording of the Health Care Professional’s Instructions

2.15.37 The Health Care Professional must provide clear instructions for Custody Sergeants relating to the care and treatment of a detainee. This will be done in two ways.

- A custody record entry which is signed by the Health Care Professional. This will contain all non-confidential information that the detainee has consented to the disclosure of. An example of the medical contract provider’s standard custody log entry is shown at Appendix N.
- A verbal report directly to the Custody Sergeant responsible for that detainee. This will correspond to the custody log entry made by the Health Care Professional.

2.15.38 The Custody Sergeant will be responsible for amending the care plan accordingly in the light of guidance and advice provided by the Health Care Professional.

Drugs for Heart Conditions, Diabetes and Asthma

2.15.39 Where a detainee demands immediate access to medication, e.g. for angina, diabetes or asthma and that demand occurs before a Health Care Professional can be consulted, then the Custody Sergeant must consider authorising use of the medication, i.e. prior to consultation with the Health Care Professional. However, every attempt must be made to contact a Health Care Professional for urgent telephone advice before administration of the medication.

2.15.40 It is important that the Custody Sergeant has sufficient knowledge to make an informed decision.
2.15.41 The emergency medication available for use in the custody suites are:
- Ventolin inhalers;
- GTN spray.

2.15.42 Emergency medication could be accessible in two ways:
- The detainee has brought their own medication with them to custody;
- Is kept as emergency medication within the Non-Prescription Medicine Safe in the custody office.

2.15.43 If emergency medication is used from the Non-Prescription Medicine Safe, it must be endorsed in the Medication Register (see Appendix M).

2.15.44 The Sergeant must satisfy themselves that the medication has been taken as directed by the detainee and endorse the custody record with details of the provision of the medication.

2.15.45 Once the medication is administered, the Custody Sergeant must complete a Prescription and Administration Form detailing the medication taken (see Appendix J). This form must be placed in the detainee’s medication cabinet.

**Safe Disposal of Medication**

2.15.46 If a detainee has come into custody with their own medication, they must, in principle, be permitted to leave custody with their prescribed medication, unless the pre-release risk assessment completed by the Custody Sergeant in consultation with the Health Care Professional indicates the potential for risk to the detainee, e.g. a detainee that has been given methadone by the Forensic Physician an hour or two prior to release and the detainee still has more methadone in his property which they could potentially take immediately after release.

2.15.47 Medication prescribed during the period of detention may be:
- Given to the detainee on release (only on the authority of the prescribing Forensic Physician);
- Given to the escort service (travel with detainee) and correctly recorded in the Prisoner Escort Record form;
- Returned to an appropriate Health Care Professional;
- Disposed of as unused medication in the appropriate designated receptacle.

2.15.48 The custody record should be updated to show how the excess medication has been disposed of.

2.15.49 The suite Inspector will be responsible for emptying the contents of the unused medication receptacle on a regular basis and arranging for suitable disposal as per local instructions.

*For further information – see PACE Codes of Practice, Code C, paragraphs 9.9 to 9.12.*

2.16 Disclosure of Medical Documentation

2.16.1 Medical notes made by a Health Care Professional during their consultation with a detainee are considered confidential. These notes may only be disclosed following
written informed consent from the detainee. Failing which the notes may only be disclosed under a direct order from a court.

2.16.2 In circumstances where a detainee has provided written consent to undergo a medical examination e.g. an intimate search, this consent does not extend beyond the extent of the examination, i.e. to disclose confidential medical notes.

2.16.3 If a detainee requests a copy of their medical notes, they will need to do so in writing to the medical contractor. It will be the decision of the medical contractor as to whether or not the detainee can be furnished with a copy of these notes. The notes are the property of the Health Care Professional, hence the medical contractor.

2.16.4 If a police officer requires a copy of medical notes for investigative purposes, they can only be disclosed following written consent from the detainee or as at section 2.16.1, under a direct order from a court.

2.16.5 The Health Care Professional must state on the custody record who has possession of the original notes.

2.16.6 This section should not preclude the lawful provision of a custody record to those people who are entitled to a copy.

3. Procedure Aim

3.1 This procedure aims to give clear direction in all matters regarding the medical welfare of persons in Police Custody at any of Cheshire’s Custody Suites, or elsewhere having been arrested or in detention, for example when at hospital having been taken there for medical attention after detention is authorised at a custody suite.

3.2 This procedure is to be applied in conjunction with, and not in substitution for, any instructions contained in Code C of the Codes of Practice on the detention and treatment of detained persons made under the Police and Criminal Evidence Act 1984 which remains the definitive legislation in respect of any such policy or procedure.

3.3 This procedure has been written with reference to both the National Policing Improvement Agency document ‘Guidance on the Safer Handling & Detention of Persons in Police Custody’ and the guidelines for forensic physicians and custodians entitled, “The Safety and Security of Administration of Medication in Police Custody” prepared by the Association of Forensic Physicians in consultation with the Association of Chief Police Officers (see Appendix O).
4. Appeals

4.1 Persons affected by the exercise of powers, directives or action under this procedure have the right to make representations and/or challenges and/or appeals to the decisions involved, via judicial processes (e.g. Civil Law) and or non-judicial processes (e.g. internal management, grievance and complaints procedures). They may wish to consult with their legal advisor and/or their respective staff association representative when considering such processes or procedures.

5. Review

5.1 This procedure will be formally reviewed in two years to consider:
- Its effectiveness in the business area concerned
- Any changes to legislation
- Challenges to the procedure
- Any identified inefficiencies in relation to implementation
- Impact on diversity and equality (Medium on the Race Diversity Impact Assessment Template)

6. Appendices

Appendix A – Custody Sergeant Advice Regarding TASER

Appendix B – Levels of Observation

Appendix C – Medical Whiteboard Operating Rules

Appendix D – Refusal of Medical Treatment by a Detainee
Appendix E – Emergency Department Referral Form

Appendix F – Emergency Department Return to Custody Form

Appendix G – Rousing Checklist

Appendix H – Common Communicable Diseases

Appendix I – Criminal Justice Mental Health Liaison Team Contact Pathway

Appendix J – Prescription and Administration Record

Appendix K – Misuse of Drugs Regulations 2001 – Schedules 1 to 5

Appendix L – Opioids, Methadone and Buprenorphine (Subutex) in Custody

Appendix M – Medication Register
Appendix N – Medical Contractor Assessment: Standard Custody Log Entry

Appendix O – The Safety and Security of Administration of Medication in Police Custody
## Procedure Review Form

**Title:** Medical Care in Custody  
**Procedure Author:** Insp C Jones/Chief Insp Edgar  
**Tel. Ext.:** 6343  
**Procedure approved by:** C/Supt Tim Jackson  
**Linked to Policy:** Custody  
**Date Approved:** 6/5/2010

### Procedure Review

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was the procedure last reviewed?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is this procedure still required?</td>
<td>Yes</td>
</tr>
<tr>
<td>If No, contact Business Management to archive the document</td>
<td></td>
</tr>
<tr>
<td>Could this procedure be consolidated with another?</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, contact Business Management to arrange a joint review</td>
<td></td>
</tr>
<tr>
<td>Does this procedure involve significant change to working practices that will have a resultant impact on service delivery, budget or operational risk?</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, inform Business Management</td>
<td></td>
</tr>
<tr>
<td>What forms are linked to this procedure?</td>
<td></td>
</tr>
<tr>
<td>Ensure all forms included in the procedure are reviewed. If amendments are required to any forms contact the Force Forms Administrator within Design and Print.</td>
<td></td>
</tr>
<tr>
<td>Has the procedure considered the following?</td>
<td></td>
</tr>
<tr>
<td>What evidence is in the procedure to support this?</td>
<td></td>
</tr>
<tr>
<td>Resource implications</td>
<td>Yes</td>
</tr>
<tr>
<td>Finance implications</td>
<td>Yes</td>
</tr>
<tr>
<td>IT Service implications</td>
<td>Yes</td>
</tr>
<tr>
<td>There are no implications as the procedure formalises current working practices</td>
<td></td>
</tr>
</tbody>
</table>

### Policy Owner Sign Off

I authorise this procedure for publication  
*Delete as appropriate*

**Policy Owner:** Chief Superintendent Tim Jackson  
**Signed:** T R D Jackson  
**Date:** 6/5/2010

### ACPO Member Sign Off

I authorise this procedure for publication / I do not authorise this procedure for publication  
*Delete as appropriate*

**ACPO Member:**  
**Signed:**  
**Date:**
# Procedure – Human Rights Review

## Human Rights Compliance Assessment

| List legislation relevant to the procedure: | PACE Act  
| Other: Imprisonment (Temporary Provisions) Act 1980, SOCAP |
| Has any of the legislation / case law changed since the last review? | N/A  
| If **No** to both questions then previous compliance test stands |
| Has procedure changed since last review? | N/A |

As a result of the application of the procedure, which Articles are likely to be infringed?

<table>
<thead>
<tr>
<th>Article</th>
<th>Infringed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Respect for private and family life</td>
</tr>
<tr>
<td>9</td>
<td>Freedom of thought, conscience and religion</td>
</tr>
<tr>
<td>10</td>
<td>Freedom of expression</td>
</tr>
<tr>
<td>11</td>
<td>Freedom of assembly and association</td>
</tr>
</tbody>
</table>

For each Article infringed, identify the legitimate aim(s) that justify the infringement:

<table>
<thead>
<tr>
<th>Legitimate Aim</th>
<th>Article 8</th>
<th>Article 9</th>
<th>Article 10</th>
<th>Article 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Security</td>
<td>X</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public safety</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic wellbeing of country</td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Prevention of crime and disorder</td>
<td>X</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>Protection of public order</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Territorial integrity</td>
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<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Protection of reputation and rights of others</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Preventing disclosure of information received in confidence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Maintaining authority and impartiality of judiciary</td>
<td>n/a</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>Protection of health or morals</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protection of rights and freedoms of others</td>
<td>X</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Is the interference the least intrusive option to achieve the identified legitimate aim?  
Yes

Is the interference justified and proportionate with regard to the identified legitimate aim?  
Yes

Is the interference identified applied in a non-discriminatory manner?  
Yes

Are decision making processes and outcomes of actions documented?  
Yes

---

**Article 8 – Right to Respect for Private and Family Life** – Everyone has the right to respect for his private and family life, his home and his correspondence.

**Article 9 – Freedom of Thought, Conscience and Religion** – Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

**Article 10 – Freedom of Expression** – Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.

**Article 11 – Freedom of Assembly** – Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests.
Section A

Title of Procedure: Medical Care in Custody

Has a Diversity Impact Assessment been previously completed? No

If Yes, when and was it H/M/L? If No, go to Section B

Has the procedure changed sufficiently to require a further impact assessment? Yes / No

If Yes, go to Section B. If No, go to Section C

If no impact assessment has been completed or a further assessment is required, complete the following flowchart to identify whether the procedure has a potentially Low / Medium / High impact and bear in mind the recognised ‘6 strands’ of diversity:

- Minority Ethnic communities including asylum seekers and Gypsies
- Gay, Lesbian, Bisexual and Transgendered members of the community
- Age
- Religion
- Gender
- Disability

Section B

Please complete the following flowchart and put an X in the box next to the score you have assigned the procedure:

Does the procedure only relate to an internal process?

YES

NO

Does the procedure affect staff employment / development?

YES

NO

Is data with minority indicators collected?

YES

NO

Ensure monitoring procedures are in place and then re-answer the question

Could the procedure be applied with discretion that might discriminate against a minority group?

YES

NO

Does the procedure show the potential for discrimination?

YES

NO

Are all reasonable safeguards and processes in place to ensure any potential discrimination is minimised?

YES

NO

MEDIUM

HIGH

Could application of the procedure affect community relations?

YES

NO

MEDIUM

Are all reasonable safeguards and processes in place to ensure any potential discrimination is minimised?

YES

NO

MEDIUM

X

LOW

Does the procedure show the potential for discrimination?

YES

NO

Does the procedure only relate to an internal process?

YES

NO

Does the procedure affect staff employment / development?

YES

NO

Is data with minority indicators collected?

YES

NO

Ensure monitoring procedures are in place and then re-answer the question

Could the procedure be applied with discretion that might discriminate against a minority group?

YES

NO

Does the procedure show the potential for discrimination?

YES

NO

Are all reasonable safeguards and processes in place to ensure any potential discrimination is minimised?

YES

NO

MEDIUM

HIGH

Could application of the procedure affect community relations?

YES

NO

MEDIUM

Are all reasonable safeguards and processes in place to ensure any potential discrimination is minimised?

YES

NO

MEDIUM

X

LOW
If on completion of the flowchart you consider that the initial impact assessment should be raised then please re-grade the impact as High or Medium.

| Initial Impact Assessment raised? | Yes / No | If Yes then, was it raised to Medium / High |

<table>
<thead>
<tr>
<th>Section C - Race and Diversity Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does this activity present an opportunity for improving race/community/disability/age/gender or sexual orientation relations? If so, how?</td>
</tr>
<tr>
<td>2. Is there public/political concern in relation to race/disability/age/gender/sexual orientation/community issues attached to this activity? If so, what are those concerns?</td>
</tr>
<tr>
<td>3. What other sources of information have been used in the development of this procedure i.e. HMIC Inspection Reports, Home Office Circulars?</td>
</tr>
<tr>
<td>4. Does the procedure relate to the use of a statutory power? If so, under what circumstance could discrimination be acceptable?</td>
</tr>
<tr>
<td>5. What data collection process exists for this procedure? How is the data monitored to ensure that the impact is not discriminatory or disproportionate? e.g. use of community intelligence. If reviewing the procedure what are the results of the monitoring?</td>
</tr>
<tr>
<td>6. What evidence is there that actions to address any negative effects in one area may affect other areas of equality?</td>
</tr>
<tr>
<td>7. When the Race and Diversity impact assessment has included consultation, who was consulted? (Include a summary of the key points)</td>
</tr>
<tr>
<td>8. Has the procedure been altered following the consultation? (Include a summary of the key changes)</td>
</tr>
<tr>
<td>9. Has feedback been given to the groups involved in the consultation?</td>
</tr>
<tr>
<td>I confirm that this procedure is compliant with the Constabulary’s commitment to Equality and Diversity.</td>
</tr>
<tr>
<td>Approved by Diversity Advisory Unit</td>
</tr>
<tr>
<td>Name: D Ardern</td>
</tr>
</tbody>
</table>
Medical Procedure May 2010

NOT PROTECTIVELY MARKED

Procedure – Health and Safety

<table>
<thead>
<tr>
<th>Health and Safety Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>If required, guidance for this section should be sought from the Force Health and Safety Advisor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who will be affected by this Procedure?</th>
<th>Police Employees / Public / Contractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are any of the existing generic risk assessments affected by this Procedure?</td>
<td>No</td>
</tr>
<tr>
<td>Is a new risk assessment required by this procedure?</td>
<td>No</td>
</tr>
<tr>
<td>Does this procedure require revised Health and Safety training for Staff?</td>
<td>No</td>
</tr>
<tr>
<td>Does this procedure require revised equipment for Staff?</td>
<td>No</td>
</tr>
</tbody>
</table>

I confirm that this procedure is compliant with Health and Safety legislation and regulations.

Approved by the Force Health and Safety Department

Name: Sent 30/04/09, no response

Date: |

Procedure – Quality of Service Commitment

<table>
<thead>
<tr>
<th>Quality of Service Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National Quality of Service Commitment sets out the standards and services the public can expect when they make contact with the police. Further information is available on Looking Glass by clicking here</td>
</tr>
</tbody>
</table>

Is it possible that this procedure may impinge upon quality of service and specifically a National Quality of Service Commitment? No

If YES answer the following questions, for each commitment affected state whether it is in a positive or negative way and give details

<table>
<thead>
<tr>
<th>Making it easy to contact us</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing a professional and high quality service</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Dealing with your initial contact</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Keeping you informed</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Ensuring your voice counts</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Victims of Crime</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Other service commitments</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Complaints</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

What changes, if any, have been made to the procedure to reduce an adverse impact on quality of service? |

If the procedure adversely affects quality of service, can it be justified because of the overall objectives? Yes / No If Yes, give details
Procedure – Victims Code of Practice

**Victims Code of Practice**

The Code of Practice for Victims is a statutory requirement and establishes the minimum service levels to be given to any person who has made an allegation to be the victim of a crime to the police or has had such an allegation made on their behalf. Further information is available on Looking Glass by clicking here.

Is it possible that this procedure may impinge upon the service provided to victims of crime and, specifically, compliance with the Victims Code? No

If YES answer the following questions, for each commitment affected state whether it is in a positive or negative way and give details

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Positive / Negative</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons entitled to receive services under the Code</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Vulnerable or Intimidated victims</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Crime Reporting, Assessment and Victim Support</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Investigation</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Family Liaison Officers</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Arrest and Bail</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Decisions to bring Criminal proceedings</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Bailing of Persons to Court</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Other disposal methods</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Youth Offending Teams</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Requests from the Criminal Injuries Compensation Authority and/or the Criminal Injuries Compensation Appeals Panel</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Information about the Criminal Cases Review Commission</td>
<td>Yes / No</td>
<td></td>
</tr>
</tbody>
</table>

What changes, if any, have been made to the procedure to reduce an adverse impact on the service given to victims of crime and to maintain compliance with the Code?

If the procedure adversely affects the service given to victims of crime and compliance with the Code, can it be justified because of the overall objectives? Yes / No

If Yes, give details

Procedure – Data Protection

**Data Protection**

The Data Protection Act applies to personal data. This is defined as information relating to a “living” individual, who can be identified either from the information itself or indirectly by combining the information with other data available. All personal data must be dealt with in accordance with eight Data Protection Principles.

I confirm that this procedure is compliant with the Data Protection Act 1998.

Approved by Data Protection Officer

Name: P O’Brien  Date: 21/05/09
Procedure – Freedom of Information

Freedom of Information

The Freedom of Information Act 2000 requires that all public authorities develop and maintain a publication scheme. Cheshire has adopted the ACPO publication scheme model. This requires that force policies and procedures are routinely made available to the public on the force website.

Approved by Procedure Author (please complete one of the following statements)

This document is considered by the Author to be suitable for publication

Name: C Jones Date: 29/04/09

Approved by Freedom of Information Officer

I confirm that this procedure is compliant with the Freedom of Information Act 2000.

Name: Sent 30/04/09, no response Date:

Procedure – Management of Police Information

Management of Police Information (MoPI)

The “Management of Police Information” (MoPI) Guidance follows the publication in July 2005 of a Code of Practice on the management of police information developed by the Home Secretary under the Police Act 1996. This Statutory Code was part of the government's response to the recommendations of the Bichard Inquiry into the circumstances surrounding the tragic murders in Soham and was designed to provide a common national framework for the management of police information, highlighting the importance of common standards in high risk areas of activity.

The Force has a duty to be MoPI compliant in all business areas by 2010 and will be subject to HMIC inspection thereafter.

To support this, the procedure has been developed in accordance with the Force Information Management Strategy, MoPI Guidance and Codes of Practice. Further information is available on the Force Information Centre by clicking the above links.

Does the procedure deal with the collecting, recording, evaluating, sharing, retaining or disposal of police information? If so, does it contain documented guidance covering roles and responsibilities?

Not applicable

I confirm that this procedure is compliant with the Management of Police Information Guidance 2006

Approved by MoPI Officer

Name: M Caulfield Date: 06/05/09

Procedure – Force Solicitor’s Office Vetting

Force Solicitor’s Office Procedure Vetting

I am also satisfied that this procedure does not disadvantage the Force or place it in a position of legal vulnerability. I have reviewed this procedure and can confirm that in my opinion all engagement of articles from Human Rights Act are lawful, proportionate and necessary.

Approved by the Force Solicitor’s Office

Name: Sent 30/04/09, no response Date:
Procedure – Risk Management

<table>
<thead>
<tr>
<th>Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the procedure have any impact on organisational risk? Organisational risk includes anything that has the potential to impact upon the Constabulary’s assets, earnings, reputation, performance or personnel. An example of this could be where the Constabulary decides not to adopt national guidance in the application of its procedure.</td>
</tr>
<tr>
<td>Yes, this procedure, if followed correctly, will reduce corporate risk.</td>
</tr>
</tbody>
</table>

Procedure – Values Check

<table>
<thead>
<tr>
<th>Values Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>The force has developed a set of core values which should be reflected in all our policies and procedures so the values can be systematically embedded in our daily tasks and processes.</td>
</tr>
<tr>
<td>A Values Checklist has been developed to assist staff who are writing a new or updating an old procedure to provoke ideas that may not have been previously considered.</td>
</tr>
<tr>
<td>I confirm that this procedure is compliant with the Force Values.</td>
</tr>
<tr>
<td>Name: C Jones</td>
</tr>
</tbody>
</table>

Procedure – Promotion and Distribution

<table>
<thead>
<tr>
<th>Promotion and Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will staff be made aware of the procedure?</td>
</tr>
<tr>
<td>This procedure will be published in Weekly Orders and a copy placed on the Force Information Centre database and Looking Glass.</td>
</tr>
<tr>
<td>Training to Centralised Custody Unit staff will also be provided.</td>
</tr>
</tbody>
</table>