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Police custody healthcare: The case for the AAAQ framework

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Abstract

Objectives: To apply the AAAQ (Available, Accessible, Acceptable and Good Quality) Framework for healthcare as an analytical lens for healthcare delivery in police custody suites in England and Wales.

Methods: We investigated two English police forces via three discrete work packages: an ethnography of four custody suites (two custody suites per police force); semi-structured interviews with professionals (Healthcare Professionals, Police Custody Sergeants and Detention Officers) and persons with Lived Experience of police custody detention (33 professional and 41 Lived Experience interviews); and documentary analysis of 3,200 police custody risk assessments (1,600 per force) and 40 case logs (20 per force). Collaborative qualitative thematic analysis was performed by the research team, but also included peer analysts from a Third Sector organisation.

Results: We identified that police custody healthcare in its current form does not meet many of the standards of the AAAQ Framework. Healthcare in police custody is not Available at the point of need due to a lack of embedded healthcare professionals; it is not Acceptable nor Accessible to all due to stigmatised assumptions about detained persons and scepticism about their reasons for requesting medication; and it is not Good Quality due to private providers having different Patient Group Directives resulting in a "Postcode Lottery" of treatments based on location of arrest. Insufficient resourcing of healthcare by private providers is the primary cause for these lapses, so we recommend police custody healthcare fall under the commissioning of NHS England Health and Justice to provide some oversight and governance for this domain.

Conclusions: The AAAQ Framework provides a basic set of healthcare standards that should be met in police custody suites. Beyond custody, as traditional forms of healthcare become increasingly carceral (especially maternity services), the AAAQ could also be fruitfully employed in other areas of healthcare nationally and internationally.

Keywords

police custody, healthcare professionals, AAAQ framework

Introduction

Healthcare in police custody suites in England and Wales is delivered in accordance with a combination of governance and practice standards: these include the practitioner's professional Nursing and Midwifery Council license[1]; the Police and Criminal Evidence Act[2] (the governance framework for the collection of police evidence); the Faculty of Forensic and Legal Medicine's guidance documents (although these do not officially constitute practice standards as forensic medicine is not a medical specialism); and policy directives from the healthcare provider company that employs the healthcare professional. Importantly, practice is also situated within police custody suites, necessitating collaboration with non-medical staff, who are often more focused on meeting criminal justice outcomes and ensuring the detained person is released without coming

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to further harm.[3] As a result, healthcare professionals are often required to negotiate the clinical assessment and treatment of detained persons in a vague and contradictory governance landscape.

Vague governance is not unknown in criminal justice healthcare with the prison "Equivalence Standard"[4,5] having been criticised for not providing details on what "equivalence" means in practice.[6,7] More recently, the AAAQ Framework has been proposed, which, offers a Human Rights Framework for a minimum standard of custodial healthcare, but again the authors have not provided a methodology for how it should be applied.[6,7] In this paper, based on a mixed methods study of the delivery of healthcare in two police forces in England, we apply the AAAQ Framework, albeit in police custody rather than in prisons (the context in which it was originally recommended), as an analytical lens in order to identify activities performed in police custody, which are at risk of breaching the human right to healthcare.

Problem formulation

Police custody can be a volatile space and can make a person's health worse, widening health inequalities. There were over 900,000 detentions recorded in police custody in England and Wales during 2023–24[8] and studies routinely identify detainees present with a range of health conditions, often chronic. For instance, Cranshaw et al.[9] in a sample of 144 detained persons identified 14% had asthma; 5% diabetes; 2% epilepsy; 12% cardiovascular complaints; 17% (non-head) injuries and 10% head injuries. More significantly, mental illness (including substance dependence) is very common amongst the detained population with Samele et al.[10] noting that out of 134 detained persons screened, 29% had a current diagnosis of mental illness, 40% had a lifetime diagnosis, and 8% met the diagnostic criteria for Post-Traumatic Stress Disorder. As a result, those regularly detained in police custody constitute some of the most vulnerable, while also having chronic and/or complex healthcare needs.

In England and Wales, healthcare in police custody was traditionally delivered by a police doctor but following an Audit Commission[11] review into the cost of their on-call service and a series of successful pilot studies employing nurses in the Kent and the Metropolitan Police Forces,[12] nurses (and more recently paramedics) serve as healthcare professionals, employed by private companies following a competitive tendering process. They are expected to be embedded for a 12-h shift within police station custody suites. They work alongside the police custody staff of Custody Sergeants (CS), and Detention Officers (DO). The CS refers a detained person to a healthcare professional should a medical concern be raised on a police risk assessment screening. Healthcare professionals can then attend to any immediate needs the detainee might have (managing medications, treating wounds), although non-urgent medical concerns are not treated and the detainee is advised to seek medical assistance after release. Healthcare professionals also assist the CS with medical support associated with criminal justice processing, for instance identifying if a person is fit to be detained, or fit to be interviewed, as well as collecting forensic evidence from detainees, for instance in sexual offence cases and following road traffic accidents.[3]

Close working relationships with criminal justice means healthcare professionals are not a traditional medical role. Criminal justice healthcare scholarship often refers to the ambivalence professionals feel working in custodial spaces having a "Dual Loyalty"[13] between criminal justice and healthcare, often expressing frustration given that medical objectives sometimes take secondary importance to criminal justice. For instance, Gorga[14] provides examples of healthcare professionals being denied entry to an attempted suicide by prison guards in order to preserve evidence, or to forcibly collect forensic evidence against the consent of the detainee. Alternatively, Rees[2] has shown that healthcare professionals coproduce criminal justice and healthcare objectives, finding activities that accomplish the goals of both institutions simultaneously. In such a way the "care v custody"[15] concerns are collapsed, but does such a co-production necessarily result in a lesser standard of healthcare?

As already mentioned, healthcare standards in criminal justice are ambiguous. The "Equivalence Standard"[4,5] was introduced with the aim of ensuring detained persons were afforded access to healthcare that is at least of the standard available to them at liberty. However, what exactly does equivalence mean in this context? Exworthy and colleagues[6,7] recommend a more structured approach: the AAAQ - Availability, Accessibility, Acceptability and Good Quality Framework developed from the Universal Declaration of Human Rights as a more practical solution that clearly articulates the basic standards for healthcare in custodial environments. Following the AAAQ, quality healthcare should be: AVAILABLE at the point of need; ACCESSIBLE in that the right forms of treatment are available to all; healthcare should be ACCEPTABLE to all and aware of the diverse needs and requirements of persons; and of GOOD QUALITY, including the materials and resources used.[6,7] However, while more detailed than the Equivalence Standard, Exworthy and colleagues are yet to provide a robust methodology that can be applied to evaluate when custodial healthcare is meeting or breaching its standards.

Aims

In this paper we apply the AAAQ Framework by employing its tenets as an analytical lens to ascertain where current practice is at risk of breaching detainees' human rights.

While the methodology of the AAAQ does not currently include a scoring system for ascertaining what constitutes being "Available", "Accessible", "Acceptable" and "Good Quality", one of the benefits of the framework is it is derived from our human right to healthcare and so the tenets can be understood in a non-technical way. As a result, we have reflected inductively on our collected data and have identified what we consider to be practices that do not meet AAAQ standards. In this paper we will unpack the three examples of potential breaches and provide recommendations to improve practice and governance.

Methods

A multi-method approach was taken across two police constabularies in England, using ethnography, semi-structured qualitative interviews, and documentary analysis of Police Custody Risk Assessments and Contemporaneous Case Logs. Social Constructivism[16] constituted the epistemology of the project with significant emphasis being placed on the meaning-making practices of respondents, especially the ways they described or recorded their practices and decisions in interviews and documents (for instance custody logs and risk assessment reports). As this study is predominantly qualitative, our reporting of methods and data has been informed by the Standards for Reporting Qualitative Research.[17]

Research setting

Two police forces in England were selected as the context for the study, one in the north (Northton) and one in the south (Sutherland), based on a "most similar" design.[18] The constabularies were similar in terms of: the number of persons they employed; the size of the area they covered; the size of the population they served; and the fact that they covered rural and urban and affluent and deprived areas. Moreover, both commissioned the same healthcare company, although one had recently changed to this provider and so the analysed documents and respondents' accounts of their practice referred to both the present and the previous company, providing an element of comparison. Ethical approval for the research was granted by a university ethics committee (reference number 13027) 29th October 2021.

Participants

Study participants were recruited from the two police forces and their geographical localities. Staff participants included custody sergeants, detention officers and healthcare professionals working within the custody environment. Persons with lived experience of police detention (hereafter 'LE') were also interviewed. For both participant categories, participation was through semi-structured interviews and presence during periods of ethnographic observation.

Sampling approach

Guided by the concept "Information Power,"[19] our sampling strategy was developed, taking into consideration the specificity of our research field and sample against the level of detail necessary to perform a rich analysis. As a result, we decided on two constabularies, as while one would have provided a detailed case study, a second case would ensure that the constabulary selected was not an outlier. Similarly, two custody suites within each constabulary were selected for ethnography, as one would run the risk of not being representative, while three would have been too complex and costly to manage. Two constabularies, with a focus on two police stations per force, provided an appropriate level of analytical detail while maintaining feasibility. Likewise, when considering our interview and risk assessment data we aimed to balance a range of diverse experiences and voices, while at the same time ensuring data collected was manageable and consistent with other studies in the area, for instance Skinns et al.[20]

Data collection

Ethnography. Ethnographic fieldwork was undertaken by MB. Ethnography involves being present within a field site and observing, interviewing and in other ways (for instance photography), recording the practices and behaviours enacted. Periods of observation occurred in four custody suites (130 h in total). Custody suite selection was based on discussion and agreement with a senior police officer in each force area. Observations occurred over a one-week period in each suite. Timing of attendances varied to observe a range of shifts. During observations, detailed notes were taken along with photographs of the space (for example, posters, suite layout), which were expanded on in successive visits. In addition to direct observation, note-taking, summarising, reflecting, analysing and producing summary reports were key methods used outside of the observational spaces. These provided rich accounts of practices and activities relating to routine, complex and traumatic cases observed in situ, and included direct quotations from individuals spoken to and photographs serving as visual representations of the suites.

Semi-structured interviews. Semi-structured interviews[21,22] were undertaken with professionals (CSs, DOs, and healthcare professionals), as well as retrospectively with LE participants. These were undertaken by GR and SM respectively. The interviews with staff were arranged with assistance from senior police officers and managers in the healthcare provider company, acting as gatekeepers facilitating access to participants whose details were not

publicly available. Upon receiving the contact details, GR e-mailed all on the lists provided, inviting them to take part in an online interview over the Microsoft Teams platform. GR interviewed all respondents who volunteered. Respondents were informed that all interviews would be anonymous and confidential and no identifiable information would be provided to employers.

Participants for the retrospective LE interviews were identified (by SM) through peer support groups and Third Sector organisations in the two constabulary areas. Where organisations responded positively, SM met with them to provide information regarding the project and to recruit interview participants. All potential participants were advised that the interviewer (SM) was independent of and not working with the police, to engender trust and openness, and facilitate recruitment. All participants who volunteered were interviewed. LE interviews were conducted in person, online (using Zoom video conferencing) or via telephone, as guided by the participant's preference.

For both professional and LE interviews, initial participant information sheets (PIS) were developed and provided to all potential respondents as part of the recruitment process. At the start of each interview, the interviewer asked if the respondent had read the PIS and answered any questions. They then asked if the respondent agreed to the interview being digitally recorded. As informed consent is only truly possibly following an interview (when the respondent knows what they have disclosed), a formal consent process was completed at the end of each interview.

Documentary analysis: Risk assessment and custody logs. In combination, these sources documented assessments and activities undertaken in the custody suites regarding individual detainees. The records included both structured/numerical data and contemporaneously made free-text comments. Guided by McKinnon and Finch,[23] stratified sampling of risk assessments (n = 1,600 per police force) was undertaken based on number of arrests. We requested the forces to collect the first 134 arrests each month stratified by each suite's proportion of known arrests within that police force (eg. *for Northton, Town 1 Custody Suite made up 22% of arrests, City 32%,* etc.) This data, contained in a Microsoft Excel spreadsheet, was anonymised prior to receipt by the research team, but further checked and cleaned to ensure removal of any identifiable information.

Custody logs document information, events and interactions during the detainee's stay in custody (for instance if a healthcare provider was required to clinically assess or treat the detained person, alongside procedural requirements relating to their detention, the reading of their rights for example). Based on the details from the risk assessments, the research team identified 40 cases of interest for more detailed exploration. These selected cases were chosen as they related to healthcare concerns most likely to present risks in police custody (for instance head injuries, alcohol withdrawal, epilepsy, diabetes and asthma), and cases where mental health complaints were recorded (such as low mood and anxiety, to diagnosed conditions such as psychosis). We also sought cases where risk assessments indicated complex health needs, for example where "suicide", "hospital" or "straight to cell", were mentioned. For balance, we also requested the case logs where the risk assessments contained little information. In addition, we tried to ensure that there was variation in the ages of selected cases but at the same time over-sampling female cases given the overall gender imbalance of the detained population in favour of men.

Data management. Interviews were digitally recorded, professionally transcribed, and checked and anonymised by the interviewer, prior to analysis. Interview data sets were input into NVivo software to assist data analysis. The case logs were received from the police forces as PDFs and these were uploaded to a secure Microsoft Teams site to make them available to all team members.

Data analysis

Our overall approach to data analysis for the project involved three phases. In the first phase, the team member responsible for their data set made a first attempt at identifying themes. For the ethnographic fieldwork, MB developed a large and detailed report based on their observations. Initial analysis of semi-structured interviews and the case logs involved initial familiarisation, coding and key theme identification by the respective researchers. Key to this analysis was a focus on the meaning-making practices of actors (be they staff or LE) in either their discourse or practice, consistent with our commitment to constructivism. Initial analysis of Risk Assessment data was undertaken descriptively by IM and TF. Cases were examined row by row recording physical and mental health conditions, along with the presence of neurodevelopmental conditions, declarations relating to self-injurious behaviours, issues relating to substances, and an analysis of items relating to mental vulnerability. Structured data was summarised and reported using descriptive statistics.

The second phase of analysis involved sharing data sets, summaries developed, and (for interview transcripts) team members' own codes and themes, with another member of the research team to enable reflection and discussion of the original analyst's themes. This phase further refined our themes for each dataset. Then, as the full research team, we shared and discussed all data sets collectively, specifically exploring the similarities and differences between data sets. Finally, we compared our findings to the AAAQ Framework. Our findings clearly identified routine experiences in police custody where healthcare was not available, accessible, acceptable, or of good quality. We double-checked

that the practices we highlighted were common in our data set (for instance, the lack of embedding of HCPs within suites), rather than actions that were uncommon or could easily be explained by a bad day or a rogue actor. We also checked with stakeholders (during Project Advisory Group meetings) the extent to which our findings exemplified common practice.

Stakeholder involvement. Alongside collaborative analysis amongst the team to reduce the potential of single-coder subjectivity, we also built in peer analysts to give us greater insight into our data sets, especially the LE data. SM organised a group of volunteers via the Third Sector organisation Waythrough (https://www.waythrough.org.uk/), an organisation that members of the research team had previously worked with. Each volunteer had their own lived experience of being detained in police custody during a mental health crisis and so could provide significant insight into the LE data (the volunteers all lived in a different constabulary from our case study areas). Acting as peer analysts, the volunteers read anonymised transcripts of LE data and provided insightful and experiential context for the data, helping us to fully appreciate the traumatic and difficult experiences of the people we interviewed. Significant care was taken to ensure that (as far as possible) interview samples provided to volunteers did not include data that could be retraumatising, but we also ensured that volunteers received the interview packs well in advance and that they had access to a counsellor ahead of peer analyst meetings, during the meetings themselves, as well as after the meetings in order to be supported throughout the process.

Similarly, we were supported throughout the project by an advisory panel comprising professional stakeholders from across the criminal justice and healthcare worlds, alongside academics studying within the field. It was from this group, that the importance of the AAAQ Framework was first identified, as Prof Andrew Forrester, one of the lead authors and proponents of the AAAQ Framework was part of the advisory panel and recommended we compare our findings against the framework (no other member of the research team nor the advisory panel was involved in the development of the AAAQ Framework, and Prof Forrester was not directly involved in the analysis). Oversight from the advisory panel concluded with the presentation of our results at an event for stakeholder organisations, which enabled further reflection, review and oversight of our findings and recommendations.

Results/findings

The overall data generated is presented in Table 1

In the following we will draw on examples from our data to highlight three ways contemporary police custody healthcare delivery could fail to meet the standards of the AAAQ Framework. While there are examples in our data set of healthcare performances that conform to the framework, due to space constraints, in this paper we will focus on what we considered the most common and most problematic lapses observed. All names presented are pseudonyms.

Table 1. Data collection.

Data source	Quantity
Ethnography	130 h
Interviews (LE)	41
Interviews (professionals)	33
Documents (risk assessment)	3200
Documents (custody logs)	40

Availability – Embedding

Part of the package of transitioning to commissioned services and away from on-call doctors, was the introduction of embedded healthcare professionals.[11] Data from interviews demonstrated that healthcare professional embedding was not common, either due to rota-related factors (for instance sickness, holidays, etc.), or due to a managerial decision to leave smaller or more remote custody suites without HCP coverage.

> So [Healthcare Company] statement was, "We're fully staffed," but at this present time, they don't have the funding for a HCP [healthcare professional] to be in every single station in the force. (Emily CS Northton)

Rota and cost pressures have led from an embedded healthcare model towards a telemedicine model where a manager or another healthcare professional is available virtually (via telephone or Microsoft Teams platform). Emily's quotation illuminates the concerns that CSs have with management's decision to transition towards a telemedicine model, they feel that they are being put at greater risk of an adverse healthcare encounter (including a potential death in custody) due to the absence of an embedded healthcare professional. Similarly, Derek said:

> "Oh, we're looking at your board from 50 miles away. We'll keep an eye on you." That doesn't help. I can do a better job than you bloody looking from 50 miles away. And it's noticeable. (Derek CS Sutherland)

In his interview, Derek went on to advise that when he was CS for a suite without a healthcare professional, he would be far more selective about the cases he would detain as he did not want to take the risk of a significant healthcare event without a healthcare professional on site and so detainees

would be transferred elsewhere. Our peer analysts were shocked that detainees would be transferred across a police force, and raised concerns about their wellbeing following release especially if they do not have any means to get home upon release.

Alongside offering a telemedicine model, another way the company attempted to maintain healthcare coverage across a force area without embedding was via on-shift healthcare professionals taking responsibility for multiple custody suites.

> I was at [Town 2], and it happened that somebody had rung in at short notice, sickness at [City]. So, the person from [Town 5] had gone through to [City] to cover, which, then, I'm based at [Town 1], I got a phone call to go through to [Town 2]. Wow, the board at [Town 2] was absolutely buzzing. My shift just went in like an instant. When I came out, it was the weirdest thing of being physically and emotionally exhausted. I ended up having to take a little nap, on my way back. But because it was my nightshift, by the time I'd driven home, I was then still tired and shattered and all these other things, with a bit of adrenalin still running through me, and I still couldn't sleep properly after. (Marie healthcare professional Northton)

Covering multiple stations had significant impacts on the healthcare professionals, requiring them to be aware of the healthcare needs and potential emergencies at multiple sites, but also to take into consideration the time necessary to travel between police stations, which could have an impact in emergency circumstances. The heightened risk of covering multiple stations effected healthcare professionals' wellbeing, which could lead to exactly the forms of burnout that necessitate this form of coverage in the first place.

The greatest impact of the lack of embedding was on detained persons themselves. Our analysis of custody logs demonstrated a wait time for a clinical assessment of two hours (on average) due to the absence of a healthcare professional. Similarly, non-healthcare professional custody staff are unable to provide medications to detained persons and as a result medications can only be provided when a healthcare professional is present. In the situation that a healthcare professional is covering multiple custody suites, they need to take into consideration when a person needs their medication and plan to be in the correct suite at the right time. This decision is enrolled within broader triage considerations with the result being that the planned time for a particular detained person might not be at a time when providing that medication is the highest priority (and of course, the triage decision itself takes into consideration distance travelled). As a result, many detained persons expressed that their medications were either delayed or denied altogether due to the absence of a healthcare professional.

> So, I told them, as soon as I got to the… as soon as they put me into the cells I told them, "I need to see a doctor because I need my medication for my arthritis." And they were like, "Okay, yeah, yeah, the doctor will come in five minutes." And anyway, to cut a long story short, nine hours later they still haven't given me my medication. (Keith LE Sutherland)

While telemedicine has values in other areas of healthcare, especially where patients are at liberty to access alternative healthcare provision, the detained population do not have autonomy and control over their access to medical treatments (for instance taking their own tablets) and so require access to onsite medical support. The lack of embedding of healthcare professionals in custody suites, produces delays or denials of clinical assessments as well as medications. Due to such absences and delays we understand the lack of embedding as failing to meet the Availability standard, as care is not present at the point of need.

Acceptable and accessible – Stigma and disbelief

The acceptable requirement recommends that respectful and equal healthcare treatment, including taking into consideration the particular needs of individual persons, is available and acceptable to all. Similarly, healthcare should be accessible to all, regardless of circumstances. Across all datasets, we found multiple circumstances where healthcare provided (or more commonly, not provided) did not meet these requirements. For instance, within the contemporaneous custody logs, the following was recorded:

> DP [Detained Person] stated she was pregnant, but it was 'not believed to be true'. (Northton, Female, Case Log 6)

> I have been through all the meals that are suitable for DP and she has managed to find an issue with all of them. (Northton, Male, Case Log 16)

Case log 16 specifically speaks to the ways that the dislike of detained persons demonstrated in the case logs conflicts with the acceptability requirement as the food available within police custody was not suitable to the specific requirements of that particular detainee, but here the team do not try and resolve the issue and provide acceptable support, rather they note their frustration within the case logs.

The generalised disdain for detained persons evident in the data impacted healthcare delivery in two key ways: the first relates to organising denials or delays of treatment; and the second concerns distrust of detained persons' medical histories. Taking denial of treatment first, we identified persons with healthcare needs not being assessed by healthcare professionals or not sent to hospital due to their behaviour. For instance, SM13 (Sutherland, Male, Case Log 13) had infected hand injuries that required hospital treatment, but the healthcare professional stated: "*due to*

[the detained person's] *abusive, aggressive behaviour, the medical treatment* can *wait.*" (Sutherland, Male, Case Log 13) Such notes were not uncommon in the case logs and were sometimes justified with regards to the risks posed by transporting an aggressive person to hospital, but, at the same time, also evidenced the ways that police custody staff came to label detained persons. Such labelling was at its worst in relation to expected "drug-seeking."

Custody teams' stigmatising beliefs resulted in them distrusting detainee accounts about their medical histories.

> And it's not that you want to call your patients liars, but some of them are, blatantly, because they will obviously look after their own end. And their way of thinking is they will say what they need to get the medication. (Kate healthcare professional Sutherland)

Staff interviewed explained that medicating, especially in cases of opioid dependency, could potentially lead to an overdose. While this risk derived from concerns with persons with opioid dependence, the belief that all detainees are drug-seeking had extended to the provision of all medication. For instance, a detained person would only be permitted their medication if it was adequately boxed and labelled, clearly showing what was in the box and the quantity and frequency of when it was to be taken. This is a standard of self-management many across the general population would not meet and so many people would be denied their medications in police custody. Similarly, healthcare professionals will not give any medication for the first six hours of detention (in order that anything consumed prior to arrest has metabolised), and in so doing interrupts traditional healthcare pathways (for instance the usual time to take a medicine).

Rather than healthcare being acceptable and accessible to all and healthcare professionals practising in an empathetic (or at least tolerant) manner, in police custody we identified dismissive attitudes and disbelief as the dominant approaches towards detained persons, and this had transitioned into practices that were potentially harmful. For instance, delays or denials of treatment based on either detainee behaviour or the belief that all detained within police custody are actively drug-seeking. These actions, in our opinion do not constitute Acceptable or Accessible healthcare.

Good quality – Postcode lottery

Should a person have managed to be clinically assessed in police custody and be deemed to require therapeutic treatment (a state, which, as we have shown is often unlikely) then a final hurdle (and potential breach of an AAAQ standard) is whether good quality materials and treatments are provided by the HCP. As previously outlined, police custody healthcare is provided based on for-profit tenders and there are a range of private companies who compete to deliver services. Each company has its own Patient Group Directive (PGD), a list of treatments healthcare professionals can provide and directions for when to provide them. Not all healthcare professionals have received prescriber training and so are reliant on the PGD for medications management. However, our data revealed that different companies have different treatments on their PGDs, with some choosing to omit certain treatments altogether.

> Yeah, it was done before, before we moved [Previous Company], and I get it, like they're very risk averse [Current Company] and we can't give [brand of analgesic], I think they're bringing that back now. (Eleanor, healthcare professional, Northton)

The AAAQ Framework articulates that quality healthcare includes provision of "Good Quality" resources and treatments. Given this we again consider the differentiation of PGDs as not meeting the standards of the AAAQ Framework. The diversity of PGDs, alongside lists of healthcare equipment maintained in police custody means that not all treatments are available and of high quality in all police suites. This could result in detained persons not having access to the treatments they require.

Discussion

The AAAQ Framework has been a useful lens for identifying the ways that current practice in police custody could be seen to potentially be breaching detainees' human rights. Providing accessible care at the point of need, ensuing that care is available to all, that it is appropriate and accessible to all as well as being good quality does not seem to us a particularly lofty ambition; however, the current staffing difficulties result in delays to service provision and stigmatising practices likely to further harm detainees. For instance, the triage decision when performed over an entire police force area (50+ miles between custody suites in some cases) can impact if a person will be clinically assessed and treated. Coupled with this is the focus on avoiding deaths in custody, especially from an overdose. These concerns combined result in healthcare professionals labelling detainees as drug-seeking and leaving them to suffer for long periods in states of withdrawal (if they are seen at all).

That the AAAQ is derived from human rights legislation and declares that access to healthcare is a human right, raises the stakes as to what these practices actually connote for detained persons. Being denied healthcare due to the understaffing of healthcare professionals (alongside medical resources), or due to stigmatised attitudes about detained persons means that their human rights are potentially being breached by these lapses of the framework. At the very least, the lack of compliance places additional costs

back on to the State with police custody teams needing to call out an ambulance in the case that a person has a medical incident within custody (although the private company has already been paid by the State to ostensibly provide healthcare for those detained) or the exacerbation of heath inequalities amongst sectors of the population given the close correlation between poor health and criminal justice involvement. Improving the quality of healthcare in police custody to at least conform with the AAAQ framework would therefore have benefits at the individual detainee level but also a broader public health level given the reduction on pressure on The Ambulance Service.

Implications for policy, practice and research

Alongside providing a tool for observing low quality healthcare, the AAAQ also provides remedies for the lapses. As a result, we would recommend that healthcare provider companies review their workforce strategies and rather than transitioning to more virtual or telemedicine services, instead, they should ensure that healthcare professionals are properly embedded within every custody suite (Table 2).

We strongly recommend that staff are trained to stop adhering to the six-hour timeframe for delaying medication (it is not the official policy of any governing body of forensic medical practice).[24] Similarly, we recommend that all custody staff demonstrate greater "Professional Curiosity"[25] when working with detained persons requesting medication. Exploring, for instance, when they usually access their medications, what they need them for, etc. Rather than assuming that the person has illegitimately appropriated them and is looking to "top up". More healthcare professionals practising with professional curiosity would enable empathetic healthcare practice that the AAAQ Framework is trying to ensure.

Finally, a standardised national PGD and equipment list that all provider companies employ, which provides clear instructions for a broad range of medical needs and ensures healthcare professionals can confidently address most routine care needs within custody.

In a larger context, the Angiolini[26] report into deaths in police custody recommended that healthcare provision should be brought under NHS England commissioning and while the NHS Health and Justice service, the chief commissioner for NHS services within criminal justice, currently liaises with the National Police Chiefs' Council to advise on standards, at the current time police custody healthcare is still not officially part of NHS commissioning.[27] Constabularies offer contracts by tender with advice from the National Police Chiefs' Council, but largely independently. We echo the recommendations of the Angiolini report, as full NHS commissioning (while not a panacea), would go some way to provide more informed healthcare governance and oversight, combating some of the lapses we observed related to the practices of private providers, for instance the understaffing of HCPs (which, due to compassion fatigue and other factors can result in stigmatised attitudes towards detainees), and the diversity of medications and equipment.

Limitations

While we stand by our analysis, it is important to recall that the AAAQ Framework is yet to have a detailed methodology. We based our use of the framework as a heuristic tool for describing the common experiences observed in police custody rather than a medical standard. As a result we do not have a quantitative basis on which to ascertain that the lack of embedding, for instance, constitutes a breach of availability, or police custody is no more stigmatised an environment than other healthcare institutions; however, until a more detailed methodology is described for the AAAQ Framework this will have to suffice. Nevertheless, as the framework is designed in relation to human rights legislation, taking a non-technical approach to the AAAQ's tenets seems to us a sensible approach.

Conclusion

The AAAQ Framework requires further development for use as an evaluation tool to measure breaches in standards for healthcare delivery in police custody, but in this paper

Table 2. AAAQ lapses and recommendations.

AAAQ framework	Lapse	Recommendation
AVAILABLE at the point of need	HCPs not embedded in all custody suites. Not available at point of need.	Review of workforce delivery to return to embedded provision
ACCEPTABLE and ACCESSIBLE to all and responsive to the diverse needs of persons	Stigmatised attitudes and practices evident rather than empathy (or at least tolerance)	Removal of six hour waiting period as well as "professional curiosity"
GOOD QUALITY materials and resources used	Commissioned services result in postcode lottery of medications. Not all PGDs conform to FFLM equipment and medication guidance	Standardised national medications list for police custody

we have attempted to show its value as a heuristic lens as applied to qualitative data by identifying examples of poor practice, but also using it to provide clear and feasible recommendations for improved healthcare. Poor healthcare practices in police custody have significant implications for public health and the human rights framework is a basic standard that should be adhered to. A more direct utilisation of the AAAQ Framework for evaluation of police custody environments would provide a helpful baseline for healthcare that healthcare professionals, their provider companies and the police could all apply to improve the practice and governance of healthcare within police custody.

Finally, as various scholars have recently noted, criminal justice operations are increasingly expanding into traditional healthcare environments (especially maternity wards, which have become a key site for policing migration).[28,29] It seems to us that such "carceral seepage"[30] necessitates the reaffirmation of a commitment to healthcare standards, which prioritise the right to healthcare over criminal justice need in traditional healthcare environs as much as in criminal justice spaces. In such ways, the AAAQ Framework could be seen to have salience in traditional healthcare spaces as much as within criminal justice, and this applies nationally, as we have shown with England and Wales, but also internationally.

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Ethical considerations

The research project received approval from the Newcastle University Humanities and Social Sciences Ethics Committee, approval number 13027.

Consent to participate

Respondents were directly requested as to whether they consented following both reading a participant information sheet at the beginning of the interview, and again at the end of each interview. Information was provided at the police custody suites observed for the ethnography of how to withdraw from the research.

Consent for publication

Consent to publish interview data was consented to as part of the informed consent procedures. Consent to publish documentary data was agreed as part of the data sharing agreement between Newcastle University and the two police forces.

Author contributions

Rees 25%, Mulrine 15%, Addison 15%, Blell 15%, Finch 15%, McKinnon 15%

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Data Availability Statement

Due to the data sharing agreements between the two police forces and Newcastle University, data cannot be shared beyond the research team. We have uploaded our data analysis tools, especially our conceptual mapping to the UK Data Service Archive.

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