



# Health care of detainees in police stations

Guidance from the BMA Medical Ethics Department and the Faculty of Forensic and Legal Medicine

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## Standards of care

### ■ The legal framework

- Human Rights Act
- Police and Criminal Evidence Act 1984 (PACE) and Police and Criminal Evidence (Northern Ireland) Order 1989
- The care of prisoners in Scotland
- Mental health legislation in England, Wales and Northern Ireland
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Police Reform Act 2002
- Data Protection Act 1998

### ■ General ethical considerations

### ■ Particular needs of people held in police stations

### ■ The changing face of forensic medical services

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# 1. Introduction

## 1.1 Aim and focus

This third edition of *Health care of detainees in police stations* has been updated and expanded to take account of developments in the law and in practice. Its primary aim is the same as the original report, to draw attention to the entitlement of detainees in police stations to standards of health care equal to those in the NHS and to summarise the rules and guidelines within which care must be provided. In order to deliver standards of care that are in line with the best NHS models of practice, forensic physicians need to be familiar with good ethical practice, and with the particular clinical needs of this patient population. In addition, they need a good understanding of the requirements of vulnerable detainees including mentally disturbed offenders and those under the influence of, or dependent on, alcohol or other drugs, who make up a high proportion of detainees. A further aim of this report is to protect detainees against human rights abuses and inhuman or degrading treatment or punishment.

Since the second edition, The Royal College of Physicians has established a Faculty of Forensic and Legal Medicine (FFLM) in 2005 with the following objectives.

- *To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine in all its classes ('Forensic and Legal Medicine').*
- *To develop and maintain for the public benefit the good practice of Forensic and Legal Medicine by ensuring the highest professional standards of competence and ethical integrity.*

The faculty represents forensic physicians, medico-legal advisers and medically-qualified coroners.

## 1.2 Definitions relating to the care and treatment of detainees

### Care

Defined loosely as the provision of both paid and unpaid, formal and informal, services by health professionals, commercial enterprises, families and others, to people who are unable to look after themselves adequately. Care is different from medical treatment and includes meeting the basic requirements for food, drink, human contact, warmth, sleep, exercise, personal hygiene, clothing and protection from injury.

### Custody officer

A police officer appointed to ensure that detainees are treated in accordance with the Police and Criminal Evidence Act (PACE) and its codes of practice in England, Wales and Northern Ireland.<sup>1</sup> In Scotland, where PACE does not apply, the Scottish Police Service still has a statutory duty to look after and guarantee the safety of persons in custody. Provisions relating to the detention of suspects and potential witnesses are contained within the Criminal Procedure (Scotland) Act, 1995. Section 76 of the Criminal Justice (Scotland) Act 2003 amends the Police (Scotland) Act 1967 to give statutory powers to certain civilian support staff employed or appointed by police authorities. The section also enables suitably skilled and trained Police Custody and Security Officers, (PCSOs) under the direction and control of chief constables, to exercise powers and undertake duties in carrying out specified functions. PCSOs can perform functions in three broad categories: police custody; court security; and prisoner escorting. A PCSO is therefore also responsible for ensuring that detainees are treated fairly and according to the relevant laws and guidelines. In this report, 'custody officer' is used to refer to those undertaking this role throughout the United Kingdom.

**Detainee**

A person in custody in a police station (categories are listed in para 1.3 below).

**Designated detention officer**

Designated detention officers were introduced in England, Wales and Northern Ireland under the Police Reform Act 2002. Their main function is to conduct drug testing on detainees arrested for trigger offences,<sup>2</sup> but they also assist custody officers in many aspects of their work.

**Forensic medical examination**

A medical examination of a person in relation to the investigation of a crime, during which records are kept by the examiner for possible use in later court proceedings. A significant part of the forensic physician's responsibility is to undertake a forensic examination of a victim or suspect at the request of the police. This could include assessing the nature and possible cause of injuries, taking samples or assessing fitness to be detained or interviewed.

**Forensic physicians**

Registered medical practitioners who are contracted to police authorities to provide independent and impartial medical services. In the past those occupying this role have been referred to as police surgeons or forensic medical examiners but the term 'forensic physician' is now more commonly used. Historically, forensic physicians were general practitioners (GPs) who were contracted to the police on a part-time basis but increasing numbers of practitioners are specialising in forensic work and work as full-time forensic physicians. Many forensic physicians have legal and forensic qualifications, such as Membership of the FFLM.

The forensic physician's work falls into two main categories: clinical assessment and treatment, and more complex medical and forensic examination of victims and suspects of crime, frequently leading to giving evidence in court.

**Medical treatment**

Includes all forms of medical intervention. Most examinations by forensic physicians involve elements of clinical assessment, medical treatment and forensic examination.

**Prisoner**

A person in a prison service establishment who is untried or convicted but not sentenced (remanded custody), or is sentenced. This report focuses on prisoners in all of these categories who are held in police stations.

### **1.3 Categories of those in police stations who may require medical examination**

#### **Detainees**

- those detained for a period including overnight stay
- those detained for a short period for interview
- those detained but released without charge
- juveniles
- immigration cases
- prisoners – remand and sentenced
- Complainants

- of robbery, making statements
- of physical assault, with injuries
- of serious crime against the person

### **Children**

- accompanying prisoners being detained
- needing assessment

(These two groups may occasionally be seen in police stations but are more frequently seen at referral centres.)

### **Persons requiring a 'place of safety'**

- people with no fixed abode needing general care
- mentally ill, needing psychiatric assessment
- those who are drunk or on drugs requiring a place of safety

## **1.4 Types of medical attention required in police stations**

### **Fitness for detention**

- assessment of illness (physical or mental)/injuries/drug and alcohol problems
- advice to custody officer on general care while in custody
- provision of necessary medication
- referral to hospital
- admission under mental health legislation

### **Fitness for interview**

- assessment of competence to understand and answer questions
- where the patient is mentally ill or mentally vulnerable, advising on the need for an appropriate adult
- advising on any special provisions required during interview
- reassessment after interview

### **Forensic examination**

- assessment and recording of injuries (including injured police officers)
- interpretation of injuries
- collecting samples, eg blood to test for toxicology and intimate samples (eg in murder or rape cases)
- Road Traffic Act 1988 and Road Traffic (Northern Ireland) Order 1995 cases

### **Therapeutic assessment and treatment**

- for illness
- for injuries sustained
- advice to custody officers on general care while in custody
- provision of necessary medication
- provision of a report of any illness or injuries requiring attention to be passed to other health professionals when the detainee is transferred

### **Transfer and care**

- from one custody suite to another
- from police stations to court
- custody in court
- transfer from court to prison

## 2. Standards of care

The rules covering the detention, treatment and questioning of persons by police officers are set out in the law and in guidance (see section 3). This includes the standards of medical care and treatment to be provided to detainees.<sup>3</sup> As a general principle, the standard of care for detainees should be equal to that provided by the NHS. In view of the situation in which care is provided, forensic physicians need to be continually aware of the obligation to respect detainees' human rights and to be sensitive to the ways in which those rights can be compromised. All doctors have a duty to speak out when services are inadequate or pose a potential threat to health.

### 2.1 Conditions

There are many areas where the care of detainees in police cells may be unsatisfactory. Police cells are less than ideal for the management of those who are experiencing alcohol or drug withdrawal, or those who are on medication, eg people with diabetes, who need special diets and regular measurement of blood glucose levels. For certain categories of patients, conditions in police stations may be inappropriate.

The forensic physician must be mindful of the conditions in which detainees are kept. The following are of particular concern:

- people showing symptoms of alcohol or drug withdrawal
- people showing symptoms of benzodiazepine withdrawal
- mentally ill
- diabetics
- epileptics
- people with head injuries
- prisoners on special diets
- people held for long periods under immigration procedures
- people detained under terrorism legislation

Police cells are not designed to hold people for extended periods. Despite the efforts of police officers to make conditions tolerable in difficult circumstances, facilities for exercise, washing, bathing and visits are frequently inadequate. Many police cells have insufficient lighting, heating, and ventilation. Showers may be available in some police stations, but not in others.

The procedure for administering medication to detainees in police stations may fall below the usual standards expected in UK hospitals despite FFLM guidelines on the subject. All pills and medication are accounted for and entered onto a chart. In police cells, doctors are required to leave the medicine with the custody officer for the detainee to take later. This leads to a risk that medication can be wrongly dispensed, or misplaced. The use of hospital-type medication charts may improve this situation as long as their implementation is accompanied by appropriate training for custody staff.

### 2.2 Facilities for examination<sup>4</sup>

The forensic physician's room must provide an efficient working area matching the facilities of an examination room used in general practice. Its clinical appearance should help reassure the detainee that he or she may expect impartiality. Its construction should ensure that nothing said within the room can be heard from outside it. Although CCTV is commonly installed in police stations for security reasons, it should not be placed in rooms used for medical purposes. The forensic physician's room should not be used for non-medical purposes and, ideally, the forensic physician should have the keys to all the

cupboards. In reality, it is likely that these will be kept by the station officer, who is responsible for ensuring that no one other than authorised doctors has access.

There must also be security precautions, which may include bars on the windows to prevent escape and alarm buttons; such features are acceptable in the circumstances in which the forensic physician has to work. All doors must be equipped with locks that can be operated from the outside to lessen the danger of the doctor being taken hostage. A telephone is essential, but (like other easily seized objects) has the potential to be used as a weapon. Privacy is available elsewhere in most police stations for the doctor to make confidential telephone calls. Police officers must be within calling distance, as detainees' reactions are often unpredictable. Doctors are well advised to heed the warning if a police officer suggests that a police presence in the room is warranted although due account must be taken of confidentiality.

The room should be adequately heated and ventilated. Good lighting and an examination light are also necessary.

## **2.3 Independent custody visitor scheme**

The independent custody visitor scheme, which operates in England, Wales and Northern Ireland, represents an important safeguard for detainees as it involves unannounced visits and private consultations by impartial members of the public. Custody visitors should be encouraged to look at medical facilities and resources and report deficiencies to a senior police officer and the Police Authority. Independent custody visiting was introduced into Scotland on a non-statutory basis in 2000.



## 3. The legal framework

### 3.1 Human Rights Act

The Human Rights Act 1998, which came fully into force in October 2000, incorporated into UK law the bulk of the substantive rights set out in the European Convention on Human Rights.<sup>5</sup> It is important for doctors to be aware of this piece of legislation because doctors are required to observe the Convention rights in reaching decisions and must be able to demonstrate that they have done so. This should not, however, represent a major change in practice for health professionals since the requirements of the Human Rights Act reflect, very closely, existing good practice. Decisions taken by doctors on the basis of current ethical standards are likely to be compliant with the Act. Issues such as human dignity, communication and consultation, and best interests, which are central to good clinical practice, are also pivotal to the Convention rights.

The Convention rights with particular relevance to the practice of medicine are:

- Article 2 – right to life
- Article 3 – right to freedom from torture or inhuman or degrading treatment or punishment
- Article 5 – right to liberty and security
- Article 6 – right to a fair trial
- Article 8 – right to respect for private and family life
- Article 9 – freedom of thought, conscience and religion
- Article 10 – freedom of expression
- Article 12 – right to marry and found a family
- Article 14 – enjoyment of these rights to be secured without discrimination.

In making medical decisions, doctors must consider whether an individual's human rights are affected and, if so, whether it is legitimate to interfere with those rights. Any interference with a Convention right must be proportionate to the intended objective. This means that even if there is a legitimate reason for interfering with a particular right, the desired outcome must be sufficient to justify the level of interference proposed. Where different rights come into conflict, doctors must be able to justify choosing one over the other in a particular case. The British Medical Association (BMA) has issued specific guidance on the impact of the Human Rights Act on medical decision making.<sup>6</sup>

### 3.2 Police and Criminal Evidence Act 1984 (PACE) and Police and Criminal Evidence (Northern Ireland) Order 1989

The Police and Criminal Evidence Act 1984 (PACE) applies in England and Wales and very similar provisions are contained in the Police and Criminal Evidence (Northern Ireland) Order 1989, as amended. Both pieces of legislation are wide-ranging, concerned with the powers and limitations of the police during criminal investigations and with the rights of suspects and those who are arrested. References in this document to PACE and its codes of practice (see below) should also be taken to apply to Northern Ireland.

A series of codes of practice are issued covering England and Wales<sup>7</sup> and Northern Ireland.<sup>8</sup> Each is divided into codes A, B, C, D and E. Code C is concerned with the detention, treatment and questioning of people by police officers and includes the provision of medical care. Code D refers to the identification of persons by police officers including identification by body samples. Those aspects of Codes C and D that are relevant to forensic physicians are briefly discussed below. It should be noted that the codes of practice have been amended to include scope for some tasks, previously undertaken by forensic physicians, to be undertaken by a registered nurse or other registered health care professional (see section 6.1).

### 3.2.1 Attendance at police stations

Where a person in detention appears to the custody officer to be:

- suffering from physical illness; or
- injured; or
- suffering from a mental disorder; or
- in need of medical attention

the custody officer must immediately call an appropriate health care professional or, where appropriate, send the person to hospital. This excludes 'minor ailments or injuries, which do not need attention' which are not defined but the codes state that any doubt must be resolved in favour of calling a health care professional. The requirement to call a health care professional applies even if the detainee makes no request for medical attention and whether or not the individual has already received clinical attention elsewhere.

Whenever a forensic physician is called it is advisable for him or her to speak to the custody staff to assess the urgency of the call. There may, however, be circumstances where the forensic physician will advise that the detainee be conveyed immediately to hospital.

The BMA has been concerned by some cases where referral to hospital for investigation or diagnosis has been delayed because the detainee is intoxicated or smelling of alcohol. A person who appears to be drunk or behaving abnormally may be suffering from an illness, or may have sustained an injury (particularly a head injury) and need urgent medical attention. The PACE codes of practice advise that where there is doubt, an appropriate health care professional or an ambulance should be called urgently.

If a detainee requests medical attention, even if the above criteria are not apparent to the custody officer, a health care professional must be called. Detainees have the right also to request an examination by their own doctor, at their own expense. The BMA General Practitioners Committee advises that if the patient has a routine complaint that would ordinarily justify a home visit and the station is within the area of the GP's practice, the GP should attend. If the police initiate a medical assessment or if the patient has been injured, or claims to have been injured while in custody, then the examination should be carried out by a forensic physician or other appropriate health care professional. General practitioners attending police stations at the request of their patients should be made aware of the special procedures that apply to treating patients in custody and, where time permits, should be given a copy of the PACE code of practice C (which is available in all police stations). Advice may also be sought from a forensic physician who will be familiar with the terms of the legislation and guidance. Once convicted and sentenced prisoners in detention lose their right of access to a doctor of their choice.

If it appears to the custody officer that a person is suffering from an infectious disease, reasonable steps must be taken to safeguard the health of the detainee and others in the police station. Advice should be sought from an appropriate health care professional about the steps to be taken, which might include isolating the detainee and his or her property until a decision is made about how to proceed.

### 3.2.2 Medication

If detainees claim to need any medication in compliance with clinical directions prescribed before their detention, or if they claim to suffer from a serious chronic disease, such as diabetes or a heart ailment, the advice of an appropriate health care professional must be sought.

The custody officer is responsible for the safe keeping of drugs and for ensuring that detainees are given the opportunity to take or apply medication that has been approved by an appropriate health care professional. In England and Wales and Northern Ireland, however, detainees may administer schedule 2 or 3 controlled drugs, as listed in the Misuse of Drugs Regulations 2001, to themselves only under the personal supervision of a registered medical practitioner authorising their use. Drugs listed in schedules 4 and 5 may be distributed by the custody officer for self-administration if he or she has consulted the registered medical practitioner authorising their use (this may be done by telephone) and both parties are satisfied that this will not expose the detainee, police officers or anyone else to risk of harm or injury.

Guidance on the safety and security of administration of medication in police custody<sup>9</sup> is available from the FFLM.

### 3.2.3 Taking samples

Forensic physicians may be called upon to take samples from those detained or from victims of crime for identification purposes. A distinction is made, in the legislation and in the codes of practice, between intimate and non-intimate samples. In England and Wales, the definition of 'intimate' samples was amended by section 58 of the Criminal Justice and Public Order Act 1994 so that mouth swabs were classed as 'non-intimate samples' which could be taken by a police officer rather than a health professional. This followed the lead of Northern Ireland, where mouth swabs had been categorised as non-intimate samples since 1988.<sup>10</sup>

Intimate samples now comprise:

- any swab from a body orifice (other than the mouth)
- blood, semen, urine and any other body fluid except saliva
- pubic hair
- dental impressions.

Only a registered dentist may take dental impressions. Other intimate samples (with the exception of urine) may only be taken by medical practitioners or other registered health care professionals. These samples may only be taken with the authorisation of an officer of at least the rank of inspector and with the written consent of the detainee. The authorising police officer must consider that the taking of the sample will tend to confirm or disprove the detainee's involvement in a recordable offence.

If consent to the taking of an intimate sample is refused without good cause, a court may draw inferences from the fact of that refusal and the refusal may 'be treated as, or as capable of amounting to, corroboration of any evidence against the person in relation to which the refusal is material'.<sup>11</sup>

Non-intimate samples comprise:

- hair other than pubic hair, which includes hair plucked with the root
- a sample taken from a nail or from under a nail
- a swab taken from any part of a persons body including the mouth but not any other body orifice
- saliva
- a skin impression, other than a fingerprint, including foot impressions.

It is usual for police officers to take non-intimate samples although forensic physicians may also take them. These may lawfully be taken with the written consent of the detainee or, without consent, if authorisation has been provided by an inspector (in England and Wales) or superintendent (in Northern Ireland) or more senior officer. In giving his or her authorisation, the police officer must consider that the sample will tend to confirm or disprove the suspect's involvement in a recordable offence.

### 3.2.4 Intimate body searches

Another medically related aspect of PACE concerns intimate body searches, which consists of the physical examination of a person's body orifices other than the mouth. The code of practice for England and Wales points out that the intrusive nature of such searches means the actual and potential risks associated with intimate searches must never be underestimated.

Intimate body searches can only be authorised by an officer of the rank of inspector or above, who has reasonable grounds to believe that the person may have concealed on him or herself:

- (a) anything which he or she could and might use to cause physical injury to the person or others; or
- (b) a Class A drug which he or she intends to supply to another or to export;

and that an intimate search is the only means of removing the items.

An intimate search of a body orifice other than the mouth may generally only be performed by a medical practitioner, or a registered nurse. Where, however, a police officer with the rank of inspector or above, having considered the risks involved decides that this is not practicable, he or she may authorise a search for weapons (but **not** drugs) to be undertaken by a police officer of the same sex as the detainee. Searches for drugs may only be undertaken in a hospital, surgery, or other medical premises (with facilities for full resuscitation), but one for weapons may also be undertaken in a police station.

Consent is not legally required for an authorised intimate search for anything that might be used to cause physical injury and forcible restraint may be used if necessary. Although any doctor carrying out an authorised intimate search without consent would not be acting unlawfully, he or she would be acting contrary to the policy of both the BMA and the FFLM. Under the Drugs Act 2005, written consent is required to carry out an intimate body search for Class A drugs. Detailed guidance for those asked to perform intimate body searches is available from the BMA and FFLM<sup>12</sup> which advises that forensic physicians should always be called **and attend** when an intimate body search is proposed. This does not commit the doctor to carrying out the search but allows the doctor to talk to the detainee to ascertain his or her wishes about the search and to establish whether the patient gives consent to the search being undertaken. It also allows a discussion to take place about possible risks to the patient's health, and about alternative methods of identification or retrieval of concealed material. If consent is not given, the doctor should refuse to participate and have no further involvement in the search.

### 3.2.5 Appropriate adults

If the detainee is a juvenile, is mentally vulnerable or appears to be suffering from a mental disorder, an appropriate adult should be called. The responsibility for initiating this action falls to the custody officer but if the forensic physician becomes aware of the need for an appropriate adult this information should be passed to the custody officer.

### 3.3 The care of prisoners in Scotland

The Police and Criminal Evidence Act does not apply in Scotland and doctors working as forensic physicians in Scotland act under rules partly derived from the common law and professional guidance and partly under the Criminal Procedure (Scotland) Act 1995: section 13 – Suspects & Witnesses, section 14 – Detention at Police Stations, section 15 – Rights on Arrest & Detention. Sections 18 to 19B of the 1995 Act also provide powers for obtaining prints and samples from arrested or detained persons.

#### 3.3.1 Providing medical care for detainees

The attendance of medical practitioners to examine prisoners is governed by advice contained in local force orders/procedures and covers matters such as the management of dependence (on alcohol or other drugs), prescribing, administering and disposal of medication and assessing fitness for interview and detention. Every person in police custody has the right to see a doctor if they request it and in any instance where there is doubt about the fitness of a prisoner to be detained or about the prescription of medication, a forensic physician must be contacted.

The professional care and custody of prisoners is routinely assessed during force inspections carried out by Her Majesty's Inspectorate of Constabulary for Scotland (HMIC).

#### 3.3.2 Taking samples

Section 18 of the Criminal Procedure (Scotland) Act 1995 provides that where a person has been arrested and is in custody a constable may, with the authority of an officer of the rank of inspector or above, take the following samples:

- from the hair of an external part of the body other than pubic hair, by means of cutting, combing or plucking, a sample of hair or other materials
- from a fingernail or toenail or from under any such nail, a sample of nail or other material
- from an external part of the body, by means of swabbing or rubbing, a sample of blood or other body fluid, of body tissue or of other material.

In addition, a constable, or at a constable's direction a police custody and security officer, may take from the inside of the person's mouth, by means of swabbing, a sample of saliva or other material. Mouth swabs do not require the authorisation of an inspector.

Intimate samples in Scotland are defined in the Immigration and Asylum Act 1999 as:

- a sample of blood, semen or any other tissue fluid, urine or pubic hair
- a dental impression
- a swab taken from a person's body orifice other than the mouth.

Intimate samples may lawfully be taken, without the individual's consent, under the authority of a sheriff's warrant.<sup>13</sup>

#### 3.3.3 Intimate body searches

Where an intimate body search is considered necessary in Scotland, in the interests of justice and in order to obtain evidence, this may lawfully be carried out under the authority of a sheriff's warrant. As with searches authorised under other legal provisions however (see section 3.2.5) the BMA and FFLM consider that such searches should be carried out by a doctor only when the individual has given consent. If consent is not given, the doctor should refuse to participate and have no further involvement in the search.

### 3.3.4 Appropriate adults

The appropriate adult scheme in Scotland is on a non-statutory basis. In June 1998 the then Scottish Office issued guidance to promote the development of appropriate adult schemes in Scotland.<sup>14</sup> This guidance recommended that a medical assessment should be undertaken, by a psychiatrist or a forensic physician, to determine whether an appropriate adult is required, in any case where the interviewee appears to be suffering from:

- excessive anxiety
- unusual mood level, eg tearfulness or euphoria
- incoherence (not solely drug or alcohol induced)
- inability to understand or answer questions
- unusual behaviour traits
- agitation leading to physical activity which is not in keeping with the current situation; or
- other signs of mental disorder.

In September 2002 the Scottish Executive commissioned research to evaluate the appropriate adult scheme in Scotland including issues such as utilisation and effectiveness.

## 3.4 Mental health legislation in England, Wales and Northern Ireland

In England and Wales, the compulsory treatment of people suffering from mental disorder is regulated by the Mental Health Act 2007 which amends the Mental Health Act 1983. In Northern Ireland it is regulated by the Mental Health (Northern Ireland) Order 1986 as amended by Mental Health (Amendment) (Northern Ireland) Order 2004. Legislation in Northern Ireland is currently the subject of review, although new legislation is not imminently expected. All forensic physicians should be familiar with the terms of the relevant mental health legislation and their codes of practice.

Mental health legislation permits, in certain clearly defined circumstances, compulsory admission to a psychiatric hospital for a patient's own health and safety or for the protection of other people. Most forensic physicians are not expected to give an expert opinion on the psychiatric state of detainees, but some have received additional training to undertake formal mental health assessments. All forensic physicians must be prepared to give on-the-spot assessment in relation to the detainee's capacity to participate in an interview. They may be asked to advise about detainees who have been arrested and charged, often with a trivial offence, where it seemed that the prisoner may be suffering from a mental disorder.

### 3.4.1 Compulsory admission to hospital in England and Wales

Where compulsory admission to hospital for assessment or treatment is deemed appropriate this should, wherever possible, be made under Sections 2 or 3 of the Mental Health Act 2007. This requires written recommendations from two registered medical practitioners, one of whom is approved under Section 12 of the Act to carry out mental health assessments. One of these may be a forensic physician. Before a patient can be compulsorily admitted, it must be shown that the patient:

- is suffering from a mental disorder of a nature or degree which warrants his detention in hospital for assessment or treatment
- ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons
- in the case of admission for treatment, appropriate medical treatment is available to him.

Section 4 of the Act provides for the urgent admission of a patient, on the application of either an approved mental health professional or the patient's nearest relative. Only one doctor needs to examine the patient, but he or she must have seen the patient within the last 24 hours. Ideally the doctor should have previous knowledge of the patient. The duration of urgent admission is 72 hours. An application for detention in an emergency can only be made when:

- the criteria for detention for assessment under Section 2 are met
- the patient's detention is required as a matter of urgency; and
- obtaining a second medical recommendation would cause undesirable delay.

This power must not be used as a convenience or to rid the police of a problem detainee. Where an offence has been committed and the detainee is charged, it is necessary for the receiving psychiatrist to be informed of all the circumstances.

### **3.4.2 Compulsory admission to hospital in Northern Ireland**

Article 4 of the Mental Health (Northern Ireland) Order 1986 permits a patient to be compulsorily admitted to hospital for assessment and detained on the application of the nearest relative or an approved social worker (who must have personally seen the patient within the two days preceding the application). This application must be supported by the recommendation of one medical practitioner who has seen the patient within the two days preceding the application and ideally knows the patient personally. If it is not possible to obtain a recommendation from a doctor who knows the patient personally, another medical practitioner, including a forensic physician can provide this. All patients who are compulsorily admitted to hospital in Northern Ireland are held initially for a period of assessment of up to 14 days. For compulsory admission it must be shown that:

- the patient is suffering from mental disorder of a nature or degree which warrants detention for assessment or for assessment followed by treatment; and
- failure to detain the patient would create a substantial likelihood of serious physical harm to him or herself or to others.

### **3.4.3 Place of safety**

In England, Wales and Northern Ireland legislation permits a police officer to remove from a public place an individual who appears to be suffering from mental disorder and to be in immediate need of care or control. The purpose of removing the individual to a place of safety is to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for the person's care and treatment. Police stations should only be used as places of safety on an exceptional basis. If a police station is used, health and social care agencies should work with the police in arranging, where appropriate, the transfer of the person to a more suitable place of safety. Where an individual is removed to a police station under this section, contact should be quickly made with the local social services authority, or with its approved mental health practitioner service and with an appropriate doctor. A person can only be detained under this section for a maximum of 72 hours.

## **3.5 Mental Health (Care and Treatment) (Scotland) Act 2003**

The Mental Health (Care and Treatment) (Scotland) Act 2003, regulates the treatment of persons suffering from a mental disorder. This section summarises the provisions of the Act in relation to compulsory admission to hospital and removal to a place of safety.

Where an individual has been charged with an offence and appears to be suffering from a mental disorder, an application may be made to a court, by the prosecutor or by Scottish Ministers (where the person is on remand), for an 'assessment order' allowing the individual to be detained for a period of up to 28 days so that he or she can be fully assessed and receive treatment if necessary.<sup>15</sup>

In making such an order the court is required to consider a written or oral statement from a medical practitioner, who could be a forensic physician. Before making the order the court must be satisfied, based on the report of the medical practitioner, that there are reasonable grounds for believing that:

- the person has a mental disorder
- it is necessary to detain the person in hospital to assess whether medical treatment would be likely to prevent the disorder worsening or alleviate any of the symptoms, or effects, of the disorder; and
- if the assessment order were not made there would be a significant risk to the health, safety or welfare of the person or a significant risk to the safety of any other person.

Section 36 of the Act provides for any registered medical practitioner, which could include a forensic physician, to issue 'an emergency detention certificate' authorising the removal of the patient to a hospital within 72 hours and his or her detention there for up to 72 hours. Section 243 of the Act allows for urgent treatment to be administered to a patient subject to an emergency detention certificate where the purpose of the treatment is to save the patient's life or to prevent serious deterioration in the patient's condition. In order to issue such a certificate, there must be no conflict of interest in relation to the medical examination.

Secondly, the doctor must also consider it likely that the patient has a mental disorder and, because of that mental disorder, his or her ability to make decisions about the provision of medical treatment is likely to be significantly impaired.

Thirdly, the doctor must be satisfied:

- that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be provided to the patient
- that if the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or to the safety of another person
- that making arrangements with a view to the grant of a short-term detention certificate (see below) would involve undesirable delay.

Finally, the doctor must, where practicable, consult and seek the consent of a mental health officer (appointed for each area by the local authority) before granting the emergency detention certificate.

Where the forensic physician is an 'approved medical practitioner' under section 22 of the Act, and the required agreement of a mental health officer has been obtained, the issuing of a 'short-term detention certificate' (under section 44 of the Act) would be preferable to an emergency detention certificate. This is because short-term detention certificates confer on the patient an array of rights and safeguards which they do not have when subject to an emergency detention certificate.



The 2003 Act also contains provisions under sections 292-8 for those with a mental disorder to be taken to a place of safety from their home or a public place. This may, in very exceptional cases, be a police station where the forensic physician would be required to provide medical care and assessment until alternative arrangements can be made for the patient to be admitted to hospital. In some circumstances where patients are removed from their home or from a public place, it may be necessary for the forensic physician to issue an emergency detention certificate (or a short-term detention certificate) or to take steps for an application to be made for an assessment order.

### 3.6 Police Reform Act 2002

Forensic physicians may be asked by the police to take a blood sample, for later testing for alcohol or other drugs, from a person who lacks capacity, under the terms of the Police Reform Act 2002 and the Criminal Justice (Northern Ireland) Order 2003. Such samples will usually be taken in hospital. The BMA and FFLM have joint guidance on the legislation<sup>16</sup> the main points of which are summarised below.

A blood sample may be taken for future testing from a person who lacks capacity who has been involved in an accident and is unable to give consent where:

- a police constable has assessed the person's capacity and found the person to be incapable of giving valid consent due to medical reasons
- the forensic physician taking the specimen is satisfied, at the time the sample is requested, that the person is not able to give valid consent (for whatever reason)
- the person does not object to or resist the specimen being taken and has not refused consent to the sample being taken before losing competence; and
- in the view of the doctor in immediate charge of the patient's care, taking the specimen would not be prejudicial to the proper care and treatment of the patient.

The specimen is not tested until the person regains competence and gives valid consent for it to be tested. If a sample is to be taken in a police station, and the purpose of taking the sample was to test for drugs, the forensic physician must be satisfied that the condition of the person might be due to some drug. The police cannot require a doctor to take a sample, it is merely lawful for a doctor to agree to do so.

### 3.7 Data Protection Act 1998

Patients in the United Kingdom have a statutory right of access to information about themselves, enshrined in the Data Protection Act 1998, and this extends to information held by a forensic physician. Competent patients, including young people, may apply for access to, and copies of, their own records, or may authorise a third party, such as their solicitor, to do so on their behalf. Detailed advice about access under the Data Protection Act is available from the BMA.<sup>17</sup>

The law exempts some categories of data from its subject access provisions including the following.

No information that identifies any other person can be revealed to the patient without the consent of the person so identified (unless that person is a health professional who has been involved in the patient's care, or it is reasonable to release the information without consent).

Information may be withheld if the doctor believes the information would be harmful to the patient or another person, although this should be extremely rare.

Access may not be given to records that are subject to legal professional privilege or, in Scotland, to confidentiality as between client and professional legal adviser.

In addition to the statutory right of access, the codes of practice issued under the Police and Criminal Evidence Act 1984 and Police and Criminal Evidence (Northern Ireland) Order 1989 (see section 3) states that:

'The detainee, appropriate adult or legal representative shall be permitted to inspect the original custody record after the detainee has left police detention provided they give reasonable notice of their request.'<sup>18</sup>

### 3.8 Examination in support of a complaint

Forensic physicians sometimes undertake examinations in support of a complaint against the police. Following a 1981 Appeal Court ruling,<sup>19</sup> it was generally held that written disclosure of such findings to anyone (including the subject of the report) other than representatives of the Police Complaints Authority could not be made except by leave of a court. This was because all police complaints documents were held to be subject to public interest immunity. This judgement was, however, overruled by a House of Lords ruling in 1994.<sup>20</sup> The House of Lords held that 'in the absence of any clear and compelling evidence that it was necessary, there was no justification for imposing a general class public interest immunity on all documents generated by an investigation into a complaint against the police'. Unless a specific application is made for particular documents to be withheld, on public interest grounds, therefore such reports should be disclosed, on request, in the usual way.

### 3.9 UK National DNA database

In 1995 the Government set up the UK National DNA Database. This initially recorded, as numerical representations, the DNA profiles of individuals who had been charged with, informed they would be reported for or convicted of a recordable offence. With the appropriate authorisation, samples could also be taken from those suspected of being involved in a recordable offence where it was believed that this would tend to confirm or disprove the individual's involvement by comparison with samples left at the crime scene. Police powers were extended in England and Wales by the Criminal Justice Act 2003 so that DNA may be taken without consent from anyone arrested for a recordable offence, including those where there was no crime scene sample.<sup>21</sup> The profiles will then be added to the DNA database and used for speculative searches against samples found at both past and future crime scenes. The process of taking samples uses mouth swabs that are taken by police officers. Forensic physicians may, however, be involved with assessing or providing treatment to the person from whom a sample is being taken. The BMA believes that doctors should object if any part of the process of taking the sample would be detrimental to the patient's care. It is not, however, the role of the doctor to assess whether the patient is competent to give consent.

When the database was first set up, the sample and profile had to be destroyed if someone was acquitted of a crime, or it was decided not to proceed with the case. This was amended, for England, Wales and Northern Ireland, by the Criminal Justice and Police Act 2001, to allow the profiles and samples to be retained even if the individuals are acquitted of the crimes for which they were taken, or if the case is dropped. Under these changes, those who volunteer samples for elimination purposes may be asked to sign a consent form for their profile to be added to the database. This consent cannot

subsequently be revoked and any stored profile may subsequently be used for speculative searches against samples left at scenes of crime (including both serious and more minor offences). These two forms of consent – consent for immediate use for a particular crime and consent for inclusion on the database for future comparisons – should be clearly separated.

It is possible that those volunteering samples for elimination – who may be the victim of, or witness to, a crime – may be under the influence of drugs or alcohol, or because of his or her experience might be very nervous or distressed. In such cases, although a sample may be needed quickly in order to expedite the investigation, there are good arguments – because of the irrevocable nature of the decision – for delaying seeking consent for the retention of the sample until the individual is able to make a more objective and informed decision. In deciding about future retention and use, individuals need to be given sufficient information to make an informed decision. In order for the consent to the retention and future use of the sample to be valid, the individual would need to know:

- that they have the option to refuse
- that it is possible to consent to the taking and use of a sample in relation to the crime currently being investigated, but to refuse consent for retention and subsequent use
- that, once given, the consent to retention can never be revoked
- what the sample may be used for in the future, including comparison with samples obtained in connection with any other crime, not just serious crime.

## 4. General ethical considerations

Individuals held in custody have the same rights and expectations to medical care as any other patient, which include the right to privacy, dignity and confidentiality. Nevertheless, the relationship between a forensic physician and his or her patients is rather different from the usual doctor-patient encounters. The forensic physician has dual obligations in that he or she is contracted to the police to provide forensic and therapeutic services but, as a doctor, retains a duty of care to the person being examined or treated. These two roles can come into conflict. In any situation where doctors have dual obligations, the following principles should inform their actions.

- Doctors acting for a third party must ensure that the patient understands that fact, and its implications.
- Doctors appointed and paid by a third party still have a duty of care to the patient whom they examine or treat, and must abide by professional guidance on ethics and law.
- Medical reports must be objective and impartial.
- Consent is as important as it is in other areas of medical practice.
- Doctors have a duty of confidentiality and information should not normally be disclosed without the patient's knowledge and consent.
- Doctors have a duty to monitor and speak out when services with which they are concerned are inadequate, hazardous or otherwise pose a potential threat to health.

### 4.1 Consent to examination

In any case where patients are conscious and competent, their consent to examination must be sought. Written consent is recommended, although verbal consent, freely given on the basis of information, is adequate; where oral consent is given this may be witnessed and recorded in the forensic physician's notes. (The FFLM have produced a number of model consent forms that are available on its website.) In some cases, the individual also has a choice of whether the examination is carried out by the forensic physician or by another doctor of the patient's choice (see section 3.2.1). Patients should be advised, in advance, that if they choose to see their own doctor, they will be required to meet the doctor's private fee.

In all cases forensic physicians should identify themselves to the person to be examined. In seeking the person's consent to examination, doctors should clearly explain their role and their contractual relationship with the police, as well as explaining the reason for the examination and any specimens requested. Forensic physicians should state explicitly, before any information is volunteered, that part of their role is to collect evidence for the police. Therefore, any information volunteered might be used in evidence in the case and no assurances can be given that confidentiality will be maintained (see section 4.3). This is an intrinsic part of the consent procedure and forensic physicians should ensure that the patient has understood and agreed to this before any information is collected or any examination takes place.

Detailed procedures are in place for obtaining consent for intimate samples (see section 3.2.4) and forensic physicians should ensure that these procedures have been followed, and obtain separate consent, before proceeding.

#### 4.1.1 Consent for examination of victims of crime

An important part of the role of the forensic physician is to examine victims of crime both in order to provide evidence and to provide any necessary medical care and attention. Evidential examination is different in aim and in procedure from clinical examination. Its purpose is to elicit material evidence regarding a possible criminal charge. Although the

police sometimes ask GPs or hospital doctors to provide a report of injuries sustained in an alleged criminal act, documenting injuries for forensic purposes is a specialised task requiring specific training. When a serious crime, such as rape or assault, has occurred there is inevitable pressure to act quickly to protect others. The time limits for obtaining supporting evidence and full information of the alleged crime dictate that examinations must be carried out promptly. This should be explained to the victim. The police have done much admirable work to address sensitive issues surrounding sexual crimes and generally have specially trained officers to provide counselling and support. Nevertheless, the forensic physician cannot assume that the subject's presence implies consent. In order to consent validly, the individual needs to know what is entailed by the examination and understand that forensic information, and any other information that might affect the outcome of the case, will be passed to the police. Everyone involved should be sensitive to patients' preferences regarding the gender of the examining doctor.

#### **4.1.2 Consent for examination of a person held in custody**

The purpose of examining a person held in custody may be to look for evidence of involvement in a crime, to assess fitness for detention or interview, or to deal with any illness or injury. In all of these cases the individual has the right to refuse to be examined, treated or to provide intimate samples. (It is lawful for some intimate body searches to be undertaken without consent, although the BMA and FFLM consider that doctors should only participate with the individual's consent – see section 3.2.5.) In order for consent to be valid, the detainee should be competent, informed of the purpose of the examination or specimens and not subject to coercion. The ability of detainees to give consent can be compromised by factors such as illness, distress or the effects of alcohol or drugs and their very situation is likely to make them feel somewhat pressured. Nevertheless, most people can make valid choices even in difficult situations.

If the patient refuses consent, the examination should not proceed and this fact should be recorded in the forensic physician's notes. The forensic physician must, however, be mindful of any possible underlying pathology that may be making the detainee uncooperative. If there is sufficient information available from observing the patient to make a judgement about, for example, fitness to be detained, this should be stated and recorded. If the forensic physician considers there to be insufficient information on which to make a judgement, the police should be informed of this and it is for them to make a decision about how to proceed.

Problems sometimes arise when the doctor begins an examination with one purpose in view, which is duly explained to the individual, but the information obtained is required for another purpose at a later date which has not been previously mentioned to the person in custody. A patient with minor injuries, for example, may be examined to see if he or she is fit to be held in custody but it may later be established that the individual sustained the injuries in a serious assault on another person. The patient consented to the examination but may not have done so if the examination had been explicitly for forensic purposes. The detained person, therefore, should be advised before giving consent to the examination that there is no absolute privilege and that information obtained during an examination may later be sought by the police or lawyers (see section 4.3). Where the forensic physician is aware that the circumstances have changed and is concerned about the validity of the consent provided at the time of the examination he or she should go back to the patient to seek renewed consent.

#### 4.1.3 Consent for examination of minors

Where the detainee is a minor, relatives may be present at the examination if the young person agrees. For people under 16, no forensic examination or samples should be undertaken without the consent of the young person **and** wherever possible someone with parental responsibility.<sup>22</sup> In addition to ensuring that valid consent has been obtained, the forensic physician also needs to ensure that any legal considerations are met regarding the admissibility in court of any forensic evidence obtained. For example in relation to consent to obtain intimate samples, 'appropriate consent' is defined in the legislation as meaning:

- the consent of a person who has attained the age of 17 years
- the consent of the individual and his or her parent or guardian if the person is between 14 and 16 years old; or
- for someone under the age of 14, the consent of a parent or guardian.<sup>23</sup>

It is important, in cases of suspected child sexual abuse that children are not subject to repeated examination and these assessments should **not** be carried out in police stations. It is good practice for one examination to be carried out jointly by a forensic physician and a paediatrician.

#### 4.1.4 Incapacitated detainees

Decision-making in relation to adults who lack the capacity to consent on their own behalf is governed in England and Wales by the Mental Capacity Act 2005, and in Scotland by the Adults With Incapacity (Scotland) Act 2000. This legislation applies equally to detainees as to other citizens. A decision relating to the treatment of an incapacitated adult detainee would need to be comply with the relevant legislation. In Northern Ireland, decisions are covered by the common law and are governed by best interests. Decisions about treatment, or medical procedures, for mentally incompetent adults must be made on the basis of an assessment of their best interests, following the guidelines laid out in the code of practice of the relevant legislation. Further guidance on both Acts is available from the ethics section of the BMA's website.

Decisions relating to patients experiencing temporary incapacity, for example due to intoxication, should, wherever possible be deferred until the patient has regained decision-making capacity. In an emergency, where lack of capacity is temporary, treatment should be administered in the patient's best interests in a way which is minimally restrictive to that individual's freedoms and any decisions which can be deferred until the patient has regained capacity, should be.

Specimens can be taken for diagnostic purposes if doing so is deemed to be in the patient's best interests. They should not, however, be taken or used for forensic tests except where a blood sample is taken from an incompetent driver under the terms of the Police Reform Act 2002 or the Criminal Justice (Northern Ireland) Order 2003 (see section 3.6).

## 4.2 Privacy

The duty to respect the individual's privacy to the greatest extent possible is not only a professional obligation but is also a requirement of the Human Rights Act (see section 3.1). Any infringement of that right must be legitimate and proportionate. In a police station setting, however, the need to preserve the patient's privacy and dignity during examination or treatment must be balanced against the risk of danger to the forensic physician. Some detainees have a history of violence or may become violent in the setting of the police

station. In some cases the police may advise the doctor to exercise caution. The normal practice is to examine a prisoner with protection – normally a police officer within discreet proximity. Ideally the police officer should be out of immediate earshot although this is not always attainable and depends on the circumstances. This practice compromises privacy, but the safety of the doctor must be ensured.

The safety of the doctor extends beyond issues of physical risk of assault, to the medico-legal consequences of examinations being undertaken without a chaperone present. When examining a prisoner, victim, or police officer of the opposite sex to the doctor, a chaperone should be present. In addition, a detainee, victim or police officer may request a chaperone in other situations. The presence of a person employed by the police, however, could present problems of confidentiality. The Codes of Practice issued under the Criminal Procedure and Investigations Act specifically states that any police officer, or any other police employee, involved in a case has a duty to record events and to pass this information to the prosecutor. This duty extends to the chaperone. Doctors must therefore weigh up considerations of safety and confidentiality with this in mind.

### 4.3 Confidentiality

The primary purpose of most examinations conducted by forensic physicians is to obtain evidence for a possible prosecution; evidence obtained may, of course, also be of assistance to the defence. Confidentiality is a difficult issue and people who are examined – both victims and suspects – should be clear about the use that will be made of their information. Forensic physicians should say explicitly at the outset that part of their job is to collect evidence for the police and so no assurances about confidentiality can be given. They should also explain that they are required to disclose information obtained during the examination that might affect the outcome of the case.

In the mid-1990s some confusion arose about the conflict between forensic physicians' duty to disclose information to the police and their duty of confidentiality. On one side, it was argued that forensic physicians are part of the 'prosecution team' and are obliged to provide the police with all notes of their examinations, including medical history or any purely therapeutic (as opposed to forensic) information. On the other, a distinction was drawn between the two categories of information on the basis that forensic physicians have a duty of confidentiality to the people they examine and are bound by the guidance of the General Medical Council (GMC). Any breach of confidentiality, without sufficient justification, could result in a finding of serious professional misconduct and ultimately, the doctor could be removed from the medical register. The situation was clarified for England, Wales and Northern Ireland in Parliamentary debate on the Criminal Procedure and Investigations Act 1996. It was made clear that the reports forensic physicians prepare for criminal proceedings must be given to the police, but any information obtained for therapeutic purposes would be subject to the usual rules of confidentiality.<sup>24</sup>

The GMC's guidance on confidentiality<sup>25</sup> states that:

'Patients have a right to expect that information about them will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care.' (para 1)

Information which is neither forensic evidence nor germane to the case, will fall into this category. Forensic physicians, therefore have a duty to keep this part of the examination

confidential unless the patient consents to disclosure or there are exceptional reasons to justify disclosure. The GMC says that:

'When seeking express consent you must make sure that patients are given enough information on which to base their decision, the reasons for the disclosure and the likely consequences of the disclosure. You should also explain how much information will be disclosed and to whom it will be given. If the patient withholds consent, or consent cannot be obtained, disclosures may be made only where they can be justified in the public interest, usually where disclosure is essential to protect the patient, or someone else, from risk of death or serious harm.' (para 14)

Information gained by the forensic physician from previous consultations with the detainee should not be disclosed without consent, nor should it form part of the forensic examination.

Only forensic information and other information likely to affect the outcome of the case should be included in the statement prepared for the police. If the police or the Crown Prosecution Service request access to the therapeutic information, the individual's written consent should be sought. If the individual refuses or only consents to partial disclosure, that decision must be respected unless a judge orders full disclosure. Disclosure may relate to hand-written contemporaneous notes made at the time the detainee was seen. In court, forensic physicians should state why the information should not be disclosed or why they think it would not affect the outcome of the case. If, however, a court order is issued, the patient should be told of this and the information must be disclosed. The BMA and FFLM have issued joint guidance on confidentiality for forensic physicians in England, Wales and Northern Ireland.<sup>26</sup> Doctors in Scotland should take advice from their defence body.

#### 4.4 Custody records and confidentiality

Concerns are sometimes expressed that forensic physicians record details such as the HIV status of detainees on custody records without the patient's consent. This contravenes the duty of confidentiality. Where information needs to be passed to the police, concerning the individual's health and his or her need to be given medication or kept under observation (see section 4.5), only the information necessary to fulfil this requirement should be disclosed. Where such information is provided, however, clear and unambiguous instructions should be given. All other information should be recorded in private notes.

The doctor should keep private records of all medical examinations (including medical history) and any advice about a patient given to the police or other health professionals, either in person, on the telephone or through other means of communication. These notes may form the basis of a written statement or report if requested by the police, the Crown Prosecution Service or the defence. Reports may also be requested for the purpose of civil litigation. These reports should contain relevant material only, and should omit hearsay (second-hand information obtained). If the doctor is not confident that consent obtained at the original examination is adequate to cover the production of a report, then consent should be obtained for this purpose. This is particularly important in relation to reports that may be requested in relation to civil proceedings, which may occur many years after the original examination.

The same standards of confidentiality apply to computerised records, which are being increasingly implemented throughout the UK.



#### 4.5 Sharing information with the police

Forensic physicians should provide custody officers with clear and detailed instructions about any medical supervision required, including the frequency of visits needed. In providing this information, they should bear in mind that police officers are not medically qualified and cannot be expected to interpret complicated medical terminology. Due account should also be taken of confidentiality (see section 4.2) and information about detainees' health should only be provided when it is necessary to protect their health or that of others who come into contact with them. The codes of practice for England and Wales state that information about the cause of any injury, ailment or condition is not required to be recorded on the custody record if it appears capable of providing evidence of an offence.

#### 4.6 Sharing information with other health care providers

As with other areas of medical practice, it is important for forensic physicians to share information with other providers of health care. This includes ensuring that a confidential record of any medical treatment provided, or requested, by the forensic physician while the individual is in police custody, accompanies the individual when transferred elsewhere. Where another doctor, such as a psychiatrist, has been consulted about, or has seen, the patient, this should be included in the notes. This should include information about suspected mental disorders, physical illness, substance abuse or suicidal tendencies. Medical information should be in a sealed envelope marked 'confidential' and should be attached to the Prisoner Escort Record (PER) form (see section 4.7).

Forensic physicians, GPs and prison medical officers are encouraged to communicate with each other, with the detainee's consent, to obtain confirmation of the detainee's medical history. Forensic physicians working in a group or rota situation should ensure that appropriate procedures are in place for exchanging information when handing over the care of detainees.

#### 4.7 Assessing risk and Prisoner Escort Record forms

In 2000 the Home Office issued guidance for the police in England and Wales, about procedures for assessing detainees' level of risk and about the revised PER form.<sup>27</sup> Risk assessment should be undertaken in relation to all detainees entering police custody. Responsibility for ensuring that such an assessment is undertaken rests with the custody officer but, on the following issues, the forensic physician is likely to be asked to contribute:

- medical/mental conditions
- medication issues
- drug/alcohol issues
- suicide/self-harm.

As part of the risk-assessment, every person entering police custody must be asked a series of questions such as:

- do you have any illness or injury?
- have you seen a doctor or been to a hospital for this illness/injury?
- are you taking or supposed to be taking any tablets/medication?
- what are they? What are they for?
- are you suffering from any mental health problems or depression?
- have you ever tried to harm yourself?

Based on the answers to these questions it is for the custody officer to determine whether a health care professional or a forensic physician needs to be called or whether the detainee should be given additional monitoring or observation.

In addition to recording risk-assessment information in the custody record, it is a requirement that similar information is included on a PER form, which must accompany every detainee who is moved from a police station to another location, such as to court or prison. It is not normal practice to record medical information on the face of the PER form, unless that is essential to ensure the health and safety of the detainee or others. It is not, for example, appropriate to record a prisoner's HIV status on the form itself but communicable diseases that are transmissible through normal contact should be recorded on the form to safeguard those who come into contact with the detainee. Information about a prisoner's ongoing need for medical care, observation, examination or medication should be included on the PER form or in open attachments. Confidential medical information, however, should be attached to the PER form in a sealed envelope and marked 'confidential'. In this way confidentiality will be maintained but the information will be available in an emergency situation or for those taking over the medical care of the detainee. Similar procedures are in place in Scotland and Northern Ireland.

#### **Summary of patient confidentiality in the police station setting**

- Careful attention must be given to ensuring that people being examined understand the role of the forensic doctor.
- Before any information is volunteered, doctors should state explicitly that part of their role is to collect evidence for the prosecution. They should make clear that any information given may be so used and that confidentiality cannot be guaranteed. The patient should understand and agree to this prior to examination or to the collection of information.
- Doctors should explain that, in addition to providing forensic evidence, they are required to provide to the police any information obtained during the examination that might affect the outcome of the case.
- Before an examination takes place doctors should ensure that the patient has consented to the forensic examination, the provision of medical care and the disclosure of forensic evidence and any other information likely to affect the outcome of the case.
- While carrying out the examination, doctors should consciously attempt to separate out forensic evidence, other information obtained that is likely to affect the outcome of the case and information not germane to the case but provided solely in the therapeutic context.
- A statement should be provided for the police giving all forensic evidence and any other information obtained that is likely to affect the outcome of the case.
- If the police request further information about the medical examination that was not included in the report, the specific consent of the patient should be sought before the information is disclosed.
- If the patient refuses to consent, or consents to only partial disclosure, the doctor should abide by that decision unless, exceptionally, disclosure can be justified by the potential for serious harm to others or the order of a court.

## 5 Particular needs of people held in police stations

### 5.1 The mentally ill

Mentally disturbed people may come into contact with the criminal justice system for a variety of reasons. It is possible that some mentally disturbed offenders have committed nuisance offences with the intention of obtaining shelter, warmth and food by being detained in police custody or in prison. Guidance from the Home Office, for England and Wales, emphasises the desirability of using alternatives to prosecution, such as cautioning or admission to hospital, where detainees are suffering from mental disorder and it is not in the public interest to prosecute.<sup>28</sup>

There is a range of mechanisms through which mentally disordered offenders may be entered into the health system rather than the criminal justice system where this is considered appropriate. In deciding whether to prosecute, the needs of the defendant must be balanced against the needs of society and a decision whether to charge the individual should be guided by the public interest. If the offence is serious, prosecution will usually take place unless there are public interest arguments against prosecution that clearly outweigh those in favour. Similar points are made in guidance on services for mentally disordered offenders in Scotland<sup>29</sup> which focuses on the need for multi-agency planning, geared at meeting the needs of mentally disordered offenders and wherever possible diverting them away from the criminal justice system at the earliest opportunity. The importance of obtaining an appropriate balance between the needs of mentally disordered offenders and those of the public interest is also emphasised.

The decision of whether to prosecute falls to the police initially and subsequently to the Crown Prosecution Service, or Procurator Fiscal in Scotland, and the courts. Nevertheless, forensic physicians need to be aware of this policy of ensuring that the medical needs of mentally disordered offenders are met and that wherever possible, and consistent with the public interest, judicial proceedings should be avoided. Custody officers are required immediately to call a forensic physician or health care professional if a person brought to a police station or already detained there appears to be suffering from a mental disorder. Forensic physicians are also frequently required to assess fitness for interview, to advise on the need for an appropriate adult and to provide medical advice for the police on the individual's mental health. All of these assessments may contribute towards the decision of whether to prosecute.

Some offenders never enter the judicial system but are referred straight to hospital without being arrested or taken to the police station. Mental health legislation gives police the power to remove an individual from a place to which the public have access to a place of safety if he or she appears to be suffering from mental disorder and to be in immediate need of care and control (see sections 3.4 and 3.5). This provision is likely to be used for people who have not committed an offence, but are causing a nuisance in a public place, and people who have committed, or are suspected of committing, an offence but it is not in the public interest to arrest that person. Research in the mid-1990s showed, however, that the police were reluctant to use this procedure preferring to use standard police powers of arrest, with which they were more familiar, rather than applying mental health legislation on which they felt ill-equipped to make judgements.<sup>30</sup> The inevitable consequence of this is that more people with mental disorders, arrested for minor offences, attend police stations and need to be seen by forensic physicians. Where the forensic physician believes that alternatives to prosecution should be considered, this view should be made known to the custody officer.

## 5.2 Patients with alcohol-related problems

Alcohol related consultations with forensic physicians are common and include forensic and therapeutic examinations as well as assessments for fitness to be detained. Research undertaken in two metropolitan areas with late night entertainment areas found that 73 per cent of the 169 individuals brought into custody, between 10.30pm and 3.30am on the days being studied, were thought by the researcher to be intoxicated. Those who had been consuming alcohol were also more likely to need medical assistance; 30 per cent of those who were intoxicated were attended by a forensic physician, compared with 17 per cent of those who were not intoxicated.<sup>31</sup>

The police are generally cautious in dealing with vulnerable detainees and some custody officers have expressed concern about the possibility of such patients dying while in their care.<sup>32</sup> There are considerable risks associated with the management of a patient dependent on, or under the influence of, alcohol in police custody. A forensic physician is not in a position to constantly observe intoxicated patients who need regular review. Since alcohol withdrawal can be dangerous, it is often not appropriate or safe for a detainee to be kept in a police cell. However, referral to an accident and emergency department is also not appropriate. Referrals, if necessary, should be made to the emergency medical team of the local hospital. Where there is any suspicion that the patient may have received a significant head injury, the patient should immediately be referred to hospital irrespective of their alcohol consumption.

The problems associated with this group of patients are well recognised. Recommendations for improving the situation include: the installation of closed-circuit TV in certain cells to enable remote supervision of vulnerable detainees, having medically trained personnel in custody suites during peak periods and greater use of detoxification centres (see below).<sup>33</sup> It has also been suggested that, in an effort to reduce alcohol-related incidents among certain groups, forensic physicians could make greater use of 'brief interventions' in the custody setting.<sup>34</sup> Brief interventions usually consist of:

- an alcohol intake assessment
- information on hazardous/harmful drinking
- clear advice, with booklets and details of local services
- attempts to understand the triggers for drinking and then negotiate around setting realistic goals.<sup>35</sup>

At the time of writing the Home Office was assessing a number of pilot schemes for dealing with detainees who are drunk and incapable on arrest. The principle behind such schemes is to break the arrest-discharge-arrest cycle, which characterises the lifestyle of many persistent drinkers, by offering referral to a detoxification or treatment centre, as an alternative to being arrested. These are known as 'arrest referral and diversion schemes'. The intention is to extend these schemes to other police forces in England and Wales once their success has been properly evaluated. Similar schemes also operate in Scotland.

## 5.3 Patients suffering from drug misuse

The police have powers to drug test detainees for certain trigger offences under the Drugs Act 2005 and these tests are usually performed by designated detention officers. Detainees will be tested for heroin, crack and cocaine on arrest for acquisitive crime offences (eg, street robbery, burglary). Those who test positive will then be required to attend a compulsory drug assessment by specialist drugs workers to determine the extent of their drug problem and help them into treatment and other support, even if they are

not charged. Those who fail to provide a sample or comply with a required assessment face a fine of up to £2,500 and/or up to three months in prison.

Arrest referral schemes for drug-using offenders have been in place since 2000 and by the end of April 2002, all police forces in England and Wales were operating such schemes. Dedicated drugs workers, based in police stations, identify problem drug-using offenders in the criminal justice system and refer them for treatment. Participation in the scheme is voluntary and is not an alternative to prosecution. Formal evaluation of the programme has found that:<sup>36</sup>

- arrest referral schemes have been effective in targeting prolific problem drug-using offenders
- over half of those screened had never entered drug treatment services
- 48,810 individuals were screened between October 2000 and September 2001 in England and Wales of whom 58 per cent were referred to specialist drug treatment service. Of those referred 25 per cent entered structured drug treatment services
- the level of police re-arrest rates significantly declined six months after contact with an arrest referral worker, compared to the six months before contact
- there were reductions in self-reported drug use.

Arrest referral schemes for drug offenders are in operation in a small number of custody suites in Northern Ireland and there are plans for this to be expanded. Similar schemes are also established in Scotland.

Despite the progress made with arrest referral schemes, drug users are likely to continue to make up a large proportion of those detained in police stations and seen by forensic physicians. Specific guidance is provided for the management of substance withdrawal of detainees in police stations.<sup>37</sup> In addition to providing immediate medical care or attention, forensic physicians can also provide guidance and advice to drug users. This can include:

- encouraging them to participate in arrest referral schemes (see above)
- providing information about local agencies involved in counselling and treatment of substance abusers
- providing education on the hazards of injecting drugs, particularly needle-sharing
- providing education about the risks of overdose; and
- providing advice regarding the loss of tolerance and risk of fatality following reduction in regular use as may occur in prison or rehabilitation.<sup>38</sup>

Some detainees may be part of an existing substitution treatment programme at the time of their arrest and substitution treatment should be continued if, in the doctor's judgement, it is safe to do so.

## 5.4 Patients suffering pre-existing medical conditions<sup>39</sup>

The management of insulin dependent diabetics in police cells may be difficult and potentially dangerous. There is the potential for deliberate overdosing and a lack of facilities and trained staff to monitor blood glucose levels when required. Additionally, there are generally poor arrangements for specified diets. Doctors should be alert to these risks, and assess the potential difficulties of managing such cases against the need for continued detention.

Epilepsy is a surprisingly common complaint amongst prisoners, but is often associated with a history of alcohol, or other drug-related withdrawal. It is usually not difficult to

manage in police custody – unless the prisoner is an ‘unstable’ epileptic when hospital admission will be indicated. Police officers should be advised to put the patient in the recovery position, in the event of a fit, and contact the doctor. A patient having more than one fit or his or her first ever fit should be referred to hospital.<sup>40</sup>

## 5.5 Patients with head injuries

Head injuries particularly when associated with alcohol consumption are potentially dangerous cases to manage in police stations and such cases are a common cause of death in police custody. Although custody officers are advised to rouse and speak with the drunk detained person every 30 minutes, it is unreasonable to expect non-medically trained police officers to keep close clinical observation over detainees with a head injury. Custody officers must be given clear instructions about what to look out for and when to call a forensic physician. The FFLM<sup>41</sup> advises that a head injured patient should be referred to hospital if **any** of the following are present.

Impaired consciousness (Glasgow Coma Score <15/15) at any time since injury.

- Any focal neurological symptoms or signs, eg problems understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking.
- Any suspicion of a skull fracture or penetrating injury, eg cerebrospinal fluid leak; black eye with no associated damage around the eyes; bleeding from or new deafness in one or both ears; signs of penetrating injury; visible trauma to the scalp or skull.
- Pre- or post-traumatic amnesia.
- Persistent headache since the injury.
- Any vomiting since the injury.
- Any seizures since the injury.
- Medical co-morbidity, eg previous cranial surgery; anticoagulant therapy; bleeding or clotting disorder.
- A high-energy head injury, eg fall from a height of more than 1 metre or more than five stairs.
- Significant extra cranial injuries.
- Continuing uncertainty about the diagnosis after first assessment.
- Aged over 65 years old.

Untreated or part-treated injuries can generally be managed quite easily, but the lack of trained personnel to change dressings may present a problem.

## 5.6 Continuing health care and referrals

For the majority of prisoners in police cells, the provision of continuing care and referral for specialist treatment is not required.

Instances where some form of continuing care is necessary are as follows.

- Remand prisoners: where the prisoner has been remanded in custody by a court, commonly for periods of one or more weeks. Such prisoners would normally be held in prison, but owing to inadequate provision of prison accommodation, are often held in ordinary police cells.<sup>42</sup> (The FFLM has specific guidance on this issue.)<sup>43</sup>
- Short-term remand prisoners: two or three days, usually remanded in custody following a request by the police to enable further investigation to take place.
- Prisoners arrested towards the beginning of a weekend or bank holiday period, who are to be held until the ‘next available court’, eg offenders with no fixed address, or arrested as a result of a court warrant.

- Prisoners held under the prevention of terrorism legislation.<sup>44</sup>
- Those people whose immigration status has been challenged or are awaiting transfer to immigration detention centres who are being held by the police on behalf of the immigration service and for whom PACE does not apply.

There is often no reliable information available about the prisoner's past history and drug history (therapeutic and misuse). Detainees may conceal from forensic physicians their medical history and their prescribed or misused drugs. Many do not have a GP with whom checks can be made and frequently the need to know occurs at evenings or weekends when the GP is not available and the deputising service is not in possession of the medical record.

In the past prisoners transferred to the police, via court or from a prison, frequently arrived without information from the prison authorities about their current or past medical history. The introduction of the PER form (see section 4.7) was intended to ease this problem but it may still be the case that they are transferred without their regular medication.

For acute conditions, a forensic physician should have little difficulty in transferring the patient to a hospital. Bed availability may, however, present a problem. If hospital care for the detainee is essential, the need for secure detention remains. This should not be so intrusive that the practical arrangements interfere with the provision of health care or ethical considerations. The BMA has general guidance on the ethical responsibilities of those providing treatment to prisoners.<sup>45</sup>

## 6. The changing face of forensic medical services

In 1998 the Audit Commission published its review of the provision of forensic medical services to the police.<sup>46</sup> The report concluded that the service, which had developed in a piecemeal fashion over the last 150 years, needed to reform in order to meet the complex demands of modern-day policing. It highlighted a number of points that needed to be addressed:

- the difficulties in some areas of recruiting sufficient doctors to cope with the demands
- the variable standards provided by the service around the country
- the inadequate facilities for examination and monitoring in some custody suites
- poor communication and feedback
- the lack of formal contractual arrangements in some areas; and
- the lack of any clear management structure and scrutiny.

The report distinguished between forensic and non-forensic work of forensic physicians. It pointed out that although forensic work made up only about 15 per cent of total call-outs, this could at times be of crucial importance to the pursuit of criminal investigations. Of the non-therapeutic work, two-thirds of call-outs were for examinations relating to fitness for detention or interview.<sup>47</sup> This breakdown led the Audit Commission to question whether all of the work needed to be undertaken by an experienced doctor. Recognising that there is an element of risk involved in moving away from doctor-only examinations, the report nonetheless recommended that consideration should be given to some of the work being undertaken by other health professionals, such as paramedics or nurses. This would solve some of the problems of a shortage of doctors to undertake the role, reduce costs and leave forensic physicians to focus more on the forensic aspects of the work. The Government has taken up this suggestion and in England and Wales the necessary legislative changes have been made to facilitate this (see section 3.2).

The report also made a series of recommendations about contracts, recruitment, training, quality assurance and improving facilities. A number of changes have taken place in the provision of forensic medical services as a result of this report. In some areas the changes have been very successful, in others less so. The BMA and FFLM both support the need for modernisation and to tailor the service to meet the demands of the police. Such changes must however meet the general principles on which the service is based: that detainees receive a high quality of care, equivalent to that received in the NHS, and that ethical standards are maintained.

### 6.1 Extending the health care team

In 2003 amendments were made to the PACE Codes of Practice (see section 3.2) to allow appropriate health professionals – principally nurses and paramedics – to work alongside forensic physicians in the care and treatment of detainees in England and Wales. Local protocols are required to clarify the relative roles of different health professionals and the levels of responsibility of different members of the health care team. In addition, the Home Office has provided guidance on appropriate procedures/duties to be undertaken by health care professionals in the custody environment.<sup>48</sup> This guidance also emphasises the importance of health professionals receiving appropriate training before undertaking tasks that fall outside the usual sphere of practice for their profession. The BMA and FFLM support the need for adequate and appropriate training before other health professionals share the range of tasks previously undertaken by forensic physicians. There are also some tasks that should, appropriately, remain within the domain of a registered medical practitioner such as caring for detained prisoners with significant physical disease or undertaking a full assessment of mental health state. Issues such as safety and legal liability need to be fully explored.



### 6.1.1 Patient group directions

Patient group directions have been extended throughout the UK to police custody suites. Under these arrangements, patient group directions, drawn up by a multidisciplinary group and signed by a senior doctor and a pharmacist permit certain named health professionals to supply medicines to patients within strict protocols but without the need for an individual prescription. These are reserved for limited situations where this method offers an advantage for patient care without compromising patient safety. The BMA's general advice is that, as with individual prescriptions, doctors should not sign patient group directions if they have any doubts about the safety or efficacy of the medication or doubts about the ability of the named health professional adequately to assess the patient's suitability for the treatment or provide any necessary supervision. Doctors who have any concerns in this respect should discuss indemnity with their medical defence organisation.

Some specific concerns have been expressed about the use of patient group directions in custody suites. This is because of the added complication of the frequent difficulty of obtaining an accurate and full medical history for those detained and because the use of drugs and alcohol – common among detainees – may affect the safety of the medication prescribed. This is a particular problem given the requirement that the doctor who signs the patient group direction must not be employed by or providing services to any police force<sup>49</sup> and may not therefore be familiar with the specific difficulties associated with prescribing to detainees. For this reason the BMA and FFLM believe that a doctor with experience of treating this category of patients must be involved in discussions to draw up the protocols. The doctor who signs the protocol must be satisfied both about the safety and efficacy of the medication recommended for that patient population and that the named health professional had received adequate training to assess such risks.

### 6.1.2 Guiding principles

The Home Office has set out general principles that should guide the recruitment and management of all members of the health care team in the custody environment.<sup>50</sup>

*Professional independence:* irrespective of their contractual arrangements with the police, health professionals must retain their professional independence and will continue to be bound by the code of professional conduct of their regulatory body.

*Clinical supervision:* local protocols must define the clinical supervision arrangements for health professionals working within the custody environment.

*Clinical governance:* satisfactory audit trails must be maintained for clinical governance. Obligations of confidentiality imposed by professional bodies and by data protection legislation should be complied with by all health professionals.

*Confidentiality and disclosure of information:* local protocols should carefully define the extent to which information may be disclosed to third parties. This should be made clear to detainees. Detainees should be informed if information about their medical history or treatment needs to be disclosed and health professionals should ensure that informed consent has been obtained for such disclosure.

The BMA and FFLM support these principles but fear that in practice they may not be achieved. These concerns are reinforced by the findings of a review into one of the first forensic nurse schemes in the country.<sup>51</sup> Time, thought and training will be needed before the range of tasks undertaken by non-doctors can be extended.

## 7. Training and accreditation

### 7.1 Training of forensic physicians

In addition to their basic medical training, forensic physicians should also have specific training in the following core competencies:<sup>52</sup>

- knowledge of the legal framework governing police powers and procedures
- consent, confidentiality and ethics with particular reference to the custodial setting
- understand the particular requirements relating to the care and custody of individuals regarding fitness to be detained and fitness to be interviewed
- the importance of contemporaneous, comprehensive, clinical note taking, statement and report writing, giving evidence in a confident and precise manner, court procedures including the laws of evidence and the role of the professional and expert witness
- the requirements for obtaining, handling and packaging forensic samples
- a basic understanding of forensic science
- documentation and interpretation of injuries
- a knowledge of police organisation and structure
- the role of the doctor in suspicious and sudden deaths
- knowledge of the legal requirements of the doctor in driving offences
- the performance of intimate searches
- mental health assessments
- assessment of substance misuse detainees
- the law relating to sexual offences and the role of the doctor in the examination of complainants and suspects in assault cases
- the role of the doctor in child protection matters.

In addition, some forensic physicians opt to specialise in specific areas of work, requiring additional training. The four key areas of specialist training are:

- examining adult complainants of serious sexual assaults and the alleged perpetrators
- examining alleged child victims of neglect or of physical or sexual assault
- undertaking assessments under mental health legislation
- examining and advising in cases where substance abuse presents particularly difficult issues of diagnosis, treatment or interpretation.<sup>53</sup>

Initial training should include a combination of theory and practical work and should be undertaken under the close supervision of an experienced forensic physician. A number of specialised training and medico-legal courses are available around the UK. Many lead to higher qualifications such as Membership of the FFLM. The FFLM is a source of information on training courses and has guidance on practical induction training for forensic physicians.<sup>54</sup> As with other doctors, forensic physicians are subject to revalidation. The process by which this is undertaken will, in itself, help to improve standards by encouraging forensic physicians to assess and monitor their own practice and methods of working.

### 7.2 Oversight

The Report of the Home Office Working Group on Police Surgeons recommended the establishment of a national advisory body to oversee the delivery and quality of police surgeon services, to provide a central forum for the development and dissemination of good practice, standardise training requirements and help to ensure a consistently high quality of service throughout the UK.<sup>55</sup> The BMA and the FFLM consider these to be important aims and will continue working with the relevant authorities to achieve them.

## Further information

### **For further information about these guidelines BMA members may contact:**

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