A Day in the Life of a Forensic Physician

October 2003…

I currently work for the Metropolitan Police Service that is notoriously busy at all times but I have worked for many years in the provinces where, although activity is lower, there is broad similarity in the case mix.

Each Friday I work from 7am-7pm and the worst part is the early start from home to beat the rush hour traffic, as the calls tend to start early on in my shift. I enjoy the time in my car en route and between calls during the day to self-reflect and indulge in my choice of radio rather than the music my children select!

Last Friday my calls were:

- To reassess four detained persons (DPs) in custody who had been intoxicated when seen by the Forensic Physician (FP) on call at night. Liaison with the police on arrival is essential for information sharing and seldom is conducted without a cheery smile and joke that the police enjoy –and so do I! DPs may be intoxicated with, or withdrawing from, alcohol, drugs or both. I have to perform a comprehensive assessment concentrating on observable signs rather than subjective symptoms, bearing in mind that drug dependency often leads to confusion between good care and a ready supply of drugs. I need to ensure that DPs are safe to remain in custody, fit to attend court, prescribe if necessary and reflect on their vulnerabilities that may affect an interview if planned. Commonly, substance misuse shares co-morbidity with other medical and mental health problems and this lends great diversity and challenges. The joy is that I have longer for my consultation time than as a GP, good clinical guidelines to work within and the possibility to reassess later if I feel this is required. Often there can be an opportunity for intervention at this crisis point and we work closely with local drug and mental health teams as well as GPs. Feedback to the police is essential after my assessment within the bounds of confidentiality.
- I assessed injuries on two victims needing to reassure and advise as well as carefully map and record their injuries in medico-legal terms.
- I was then asked to see the alleged perpetrator and assess her injuries as she had made a counter allegation of assault. Can their injuries add any information to assist the police investigation?
- I attended a sudden death and needed to consider whether there were any suspicious circumstances - likely to be of increasing importance post Shipman.
- I was asked to assess three cases where there was believed to be a mental health problem all of whom also used a variety of illicit and licit substances. One had learning difficulties, one a personality disorder with attention seeking behaviour and the last a past history of paranoid schizophrenia and later that day I reassessed him with the local psychiatrist and we signed a recommendation for compulsory admission to hospital under Section 2 under the Mental Health Act 1983 (MHA). Mental health assessments are an important part of the work of a forensic physician and many of us use our expertise to

become approved under Section 12 of the MHA as practitioners with special experience in the diagnosis or treatment of mental disorder.

- I had just parked up to enjoy a sandwich and coffee when I received a call to a suspicious death in a remote lodge where a man had been found hanging. Accidental, suicidal or even homicidal? There were some interesting body injuries that had been sustained prior to the hanging that appeared to be suicidal and these details were related to police at the scene.
- Two DPs with asthma, one hypertensive, one diabetic and one "epileptic" who was actually dependent on alcohol and Rivotril® (clonazepam – a drug used in the treatment of epilepsy that has the potential to be misused) completed the caseload for the day.

As I drove home I noted I had seen eighteen varied cases, been thanked by police for each attendance and, what's more, had been adequately remunerated! I may need to write statements for court on several of the cases I had seen, earning further revenue. I had discussed problems with police, mental health teams, social workers, GPs, prison medical staff and our drug worker who visits the cells daily.

Night work presents a similar pattern of cases although the case mix has a tendency towards more alcohol intoxication and injuries. Because of the antisocial hours night work is paid at a higher rate, so hourly earnings are greater. Further specialisation also means that I am involved in examining victims of alleged sexual assault, both adults and children, as well as children suspected of being physically abused.

These examinations tend to be done in different rotas to the 'general' work of a forensic physician.

So different work, challenging and rewarding with a capital F for fun much of the time and relatively well rewarded for most FPs –who could ask for anything more? As a professional group we are supportive, friendly and fun loving –join the Association of Forensic Physicians to find out more.

March 2007…

Two years further on and I reflect on how life has changed as Forensic Physician for the Metropolitan Police Service.

The workload has increased so my average number of cases for a twelve-hour day shift is now 20-24 with evening and night sessions being even busier. The gratifying aspect is that as we are paid per case the remuneration has also increased so one feels justly rewarded.

DNA retrieval technology has advanced in leaps and bounds so we increasingly need to be aware of the possibility of contamination and our sample taking needs to be meticulous with surfaces kept clean and clear. I seem to take more samples these days for firearms residues to assist the police (the doctor is asked to take nasal blowing) and this sadly mirrors the increase in this type of crime. Crimes and drug misuse are ever developing so there is never time to stand still or become bored.

We have more team members to support our work and this week we have welcomed a Home Office funded nurse to assist in alcohol misuse with particular regard to cases of alleged Domestic Violence.

Next week the doctors in our team (11 in number) have training for the launch of computerised custody records and the white boards that hold all information in the suites will be relegated to the scrap heap. Hopefully this will assist in information

transfer and safety but there is bound to be a challenging time at first.

The most exciting advance however over the last two years has to be the formation of the Faculty of Forensic and Legal Medicine. This will enable us to be fully recognised as a specialty, develop a proper career structure for new recruits and embrace education and research for our craft –exciting times indeed.

Forensic Physicians seldom leave their jobs except at retirement and we have several feisty 70 year olds who still practice regularly! This contrasts starkly with GP work where many seem to want to leave early. The reasons are simple this is great work, fun to do, well-rewarded and continuing to develop as you read. Why not join in?

Present Day: August 2011

Four years later and my workload as a forensic physician has evolved yet again. Custody nurse practitioners (CNPs) now work 24/7 in one of the two custody stations for the majority of the time and screen all detained persons in whom vulnerability is identified following risk assessment on arrival.

They are able to triage, manage injuries and most common medical conditions as well as take DNA samples. For many 12 hour shifts I am rarely called to visit that suite when a nurse is present. They are able to prescribe under a patient group directive for the majority of detained persons.

On my last duty I was called there to supervise a detained person taking prescribed Methadone, to assess a case where the TASER had been used and also to conduct an impairment examination on a driver. The CNP may liaise and discuss cases with the doctor, e.g. complex mental health or medical conditions. The new system works extremely well with doctor skills now being used in a more appropriate manner at this station. When the CNP is moved or absent the workload is extremely busy as understandably a CNP presence has increased requests for clinical assessments and this is sustained when they are absent although this is infrequent.

At the other station life has continued in a similar was to 2007 when I last reported but there are plans over the next few years to deploy CNPs throughout the Metropolitan Police Service custody suites.

We are called to fewer death scenes now as an agreement has been reached with Coroners that London Ambulance Service (LAS) paramedics may in many situations pronounce life extinct. Forensic physicians are therefore normally only called to suspicious death scenes or when LAS are not available.

The payment structure has moved to hourly payment that is increased for nights, weekends and bank holidays to reflect the unsocial hours. I now see approximately 12 cases over 12 hours with this number rising to 20-30 when a CNP is not available.

The Faculty of Forensic and Legal Medicine has now fully established the membership examination and several candidates have passed Part 1 and Part 2 in the disciplines of general forensic medicine (GFM), sexual offences medicine (SOM) and medico-legal advisors (MLA) with some candidates qualifying in both GFM and SOM.

Recognition of forensic medicine as a specialty has at long last arrived.

Life as a forensic physician is still varied, challenging and fun but with the arrival of CNPs thankfully less frantic than in years gone by.

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