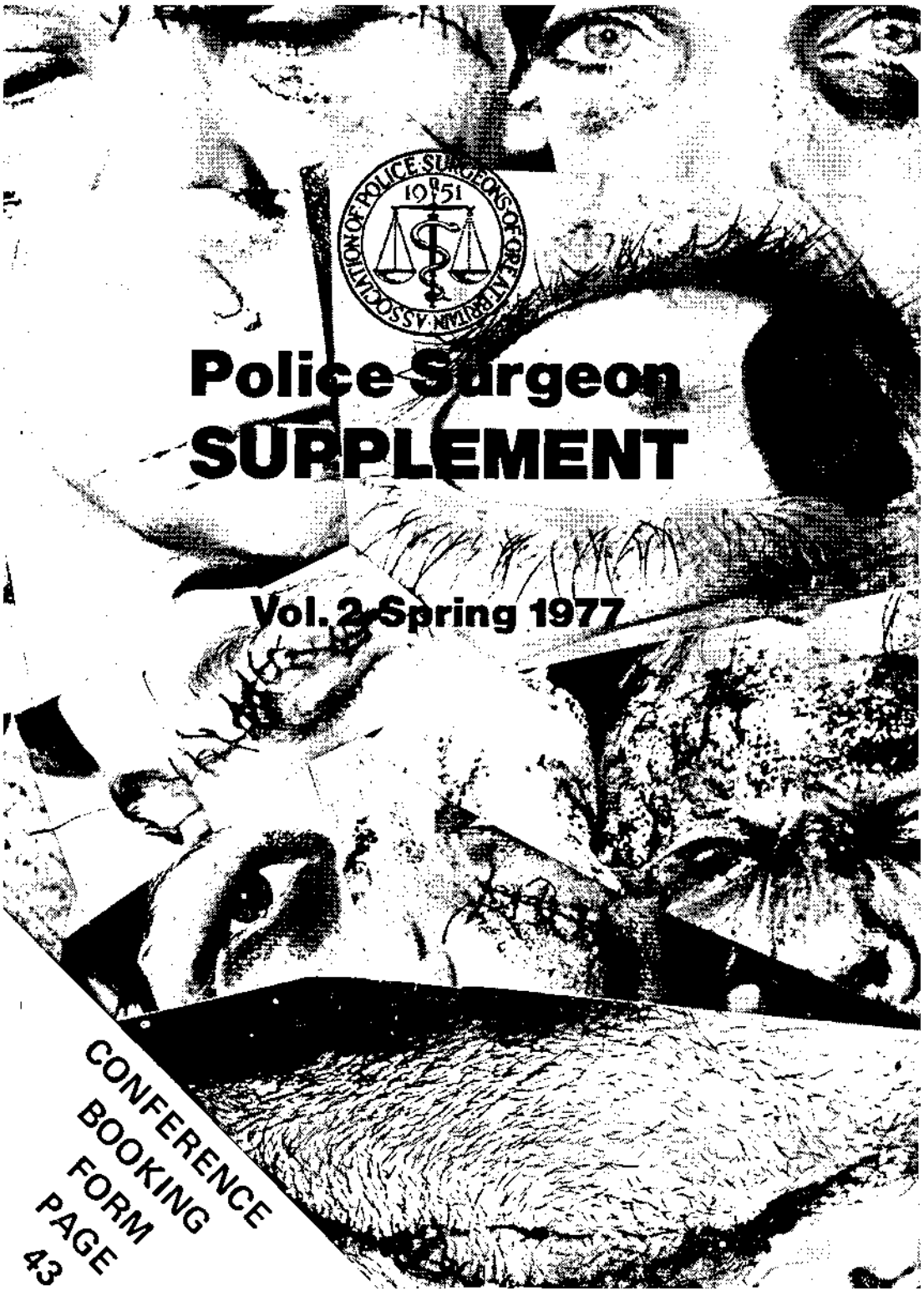

Police Surgeon SUPPLEMENT

Vol. 2 Spring 1977

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The Police Surgeon SUPPLEMENT

Vol. 2 Spring 1977

CONTENTS

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5 Editorial
9 President's Letter
10 Minutes of 25th AGM
12 Evidence to House of Commons Committee on Violence
16 The Problem of Rape
20 Hepatitis 'B'
21 Merseyside Medico-Legal Society
Northern Ireland Medico-Legal Society
22 Association Office
24 More Light Reading
26 Notify that Addict
29 The Association in Northern Ireland
33 Ulster Cup
34 The Diploma in Medical Jurisprudence
36 Cambridge Institute of Criminology
Huntingdon Research Centre
37 26th Annual Conference
43 Conference Booking Form
45 The Police Surgeon
52 Anglesey Abbey
57 My Bookshelf
59 Midland Institute of Forensic Medicine
60 Photography
Kodak Simplicity
63 Polaroid Camera – Instant
Notebook
65 The New Police Surgeon
Meetings for 1977 and 1978
67 Correspondence
72 Herbert's Hobby Horse
74 Glossary of Slang

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EDITORIAL

In 1971 a Police Surgeon wrote graphically of the conditions prevailing at his Police Station to his Chief Constable.

"The conditions for medical examination at the Police Station are primitive in the extreme. There is no room with adequate lighting and privacy for a medical interview. Limited examination of males is possible where privacy is not required. All examinations of sexual offenders and the subjects of sexual assault have been made at the local hospital. This is undesirable in that it causes unnecessary journeys where loss of trace evidence may be significant, and utilises hospital staff for work for which they are neither trained nor paid and uses hospital equipment for an improper purpose. Most examinations take place at night. It is undesirable for these to be done in my own surgery; again unnecessary journeys will be made, the surgery is unheated at night and the disturbance to private persons would be unwarranted. The taking of specimens for the Road Safety Act is undertaken perforce in the Police Station, but any subject or his defending lawyer would have grounds for complaint about the circumstances. There is not even adequate provision for the operator to wash his hands.

"For the use of all male personnel, policemen, civilian staff, court staff and witnesses, with the exception of magistrates, there is only one block of uncovered, unheated, inadequately lighted urinals. The entrance to these is in full view of the public. For the female staff, there are seven W.C.'s, one of which contains inadequate heating, the remainder none at all. Some have wash-hand basins, none with continuous hot water and none at the time of a random check contained a clean towel. There is not one W.C. in the whole of the Police Station which is immediately accessible without first obtaining the key from the Station Sergeant.

"The Station Sergeant's office is located over the boiler of the central heating system. The ventilation of the boiler room is inadequate. At all times when the boiler is drawing, fumes are noticeable in the Station Sergeant's office. When the boiler is being recharged that office becomes untenable and the Station Sergeants have volunteered to me the information that the room has to be vacated when the boiler is recharged – particularly during cold windless weather.

"Excluding complainants, witnesses, etc., there are at any time during the day up to 13 women helping on the premises. Apart from toilets the only room set aside for female use is the policewomen's room, which is used for a variety of purposes including interview and office. There is no accommodation for a retiring room for women employees".

It is not surprising that the British Academy of Forensic Science said in 1976 –

> "The Academy is of the view that the average Interview Room in a Police Station lacks all the comforts and amenities that would help to reduce the anxiety of the victim and that the Surgeon's Room in almost all the Police Stations in the country would compare adversely with the Dispensary in a Victorian Workhouse".

Strong words indeed but few would argue with them. The accommodation

provided for Police Surgeons has been looked at critically by many organisations — not least of all the Police Surgeons Association. Current writings and programmes on the media and recent legislation have all drawn the attention of the informed observer to the disquietening conditions which exist in many parts of the country. The costs of providing adequate facilities for the Police Surgeon and his patient are not excessive, using standardised equipment. Help and advice regrading that equipment can be obtained, without difficulty, from the Association.

Why then can the British Academy of Forensic Sciences still compare the majority of Police Surgeons Rooms with Victorian Workhouse Dispensaries? It is easy to blame Administration. As in the Health Service, the man who actually makes the decision, or indeed the Committee which helps make his mind up for him, would appear to be so removed from the problem that the problem itself seems remote and insignificant.

However, it is very likely that the Police Surgeon himself is partly to blame. He may well have protested verbally about the inadequacies of his Room in the local Police Station. He may well have argued with the Station Sergeant about the multiple uses to which the Medical Room is put. He might even have had a word or two with the Chief Constable at some social gathering. Unfortunately, words are soon said and soon forgotten.

To obtain improvements a campaign has to be waged. The Administration's life-blood is paper and the battle has to be waged on paper. The defects of the existing premises have to be detailed out — the dirty walls, the lack of washing facilities, the inadequate lighting, heating, equipment. Whatever is wrong must be put down in black and white. The proposals — new paint, new lighting, site of lighting, adequate cupboard space, desks, chairs. All these must be listed so that Administration is in no doubt as to what you require for an efficient Surgery.

Some Medical Rooms may be adequate for certain procedures, e.g. the drinking driver, the minor injury, but inadequate for dealing with major cases such as sexual offences. This should be clearly pointed out to the Police.

It is quite possible to become adjusted to working in inadequate premises. Fami-

Reproduced from the "Police Surgeon"

liarity makes one blind to the defects of one's environment. It may be more convenient for the Surgeon to perform an examination in inadequate premises when a better equipped Medical Room is available a mile or two down the road. If the Police Surgeon appears to be satisfied with his working conditions, then the authorities will make little or no effort to improve them.

Fortunately, the effectiveness of an efficient and well equipped Police Surgeon is becoming increasingly recognised by most Forces. In some areas Police Surgeons are asked at an early stage in the design of new premises as to the layout they would favour and the subsequent equipment of new Medical Rooms. However, there are still Forces which, whilst appreciating that a Police Surgeon's Room is required, do no more than put the appropriate label on a convenient door and do little or nothing towards equipping the Room adequately.

Any Police Force or any Police Surgeon requiring advice regarding the equipment and lay out of Medical Rooms can obtain advice from the Association by writing to the Hon. Secretary.

"Police Surgeon required – no previous experience or qualifications needed". A willingness to get up in the middle of the night and to arrive at a Police Station in a reasonable time and in a sober condition have been until now the prime requirements for being employed as a Police Surgeon. Most doctors, when appointed as Police Surgeons, recognise at once that the inadequate University Courses in Forensic Medicine (if any were held) were far from sufficient to equip them as Clinical Forensic Medicine Investigators. The tyro Police Surgeon endeavours to remedy this defect by study, by attending postgraduate courses in Forensic Medicine, such as are held at the Midland Institute of Forensic Medicine and the London Hospital, and of course by joining the Association of Police Surgeons of Great Britain. A number, still a minority, study for the Diploma in Medical Jurisprudence and persevere at that exam until they pass it.

On the other hand a handful of doctors appear to imagine that their appointment as Police Surgeons brings upon them instant knowledge and authority in clinical forensic problems. They make little or no effort to improve this matter by study or by attending courses and by their generally poor performance they bring the majority of Police Surgeons into disrepute.

Several Police Authorities in this country are sufficiently enlightened to realise that the tyro Police Surgeon is like the man just out of Medical School. He may have a rudimentary knowledge of forensic medicine but he certainly has no practical experience. These informed Police Authorities are now requiring that newly appointed Police Surgeons undertake and pass the Diploma in Medical Jurisprudence within a set number of years or their services will be dispensed with.

The Police Authority has an obligation to provide and equip Medical Rooms to an acceptable standard. The Police Surgeon has an obligation to equip himself adequately for his speciality.

IMPORTANT NOTICE
PAGE 22

PRESIDENT'S LETTER

PROGRESS, APATHY AND HOPE

PROGRESS

In the inaugural issue of the Supplement, I gave you a resume of the early days of the Association. I also paid tribute to all those who unceasingly gave their time, effort and loyalty to the cause of the Police Surgeon. I am happy to say that this spirit has been maintained throughout the past twenty five years and has resulted in an Association in which all can take pride, and which is the envy of many others in the medical profession.

It is a pleasure to know that our first Hon. Secretary, Dr. Ralph Summers, is writing an article on the development of the Police Surgeon Service from the earliest days in the last century. It will be interesting to know when we were first called Police Surgeons.

The progress made by the Association has been phenomenal. In the 25 years of its existence, the membership numbers have almost doubled. The numbers of those attending Conference has steadily increased.

Enormous strides have been made since the 1940's, when there were very few appointed Police Surgeons in the United Kingdom outside the Metropolitan area. Appointments then were honorary. Conditions of service were poor. Fees were miserably low and differed greatly from one county to another.

APATHY

Although we have achieved much, we are forced to admit that there is apathy among many of our members.

All members are fully informed about the Association, but the numbers who contact and make use of the Association are disappointingly small. If you have any problems, grievances or suggestions, please bring it to the attention of Council or any Council Member. Your Council will do all it can to assist whatever the problem and always values constructive advice and criticism. By pooling our knowledge and ideas together we will further the progress of the Association.

Our friends in Northern Ireland (Area 1a) and Metropolitan and City (Area 8) set an excellent example to members in other areas. They meet regularly and are active academically and socially. They have contributed much to the life of the Association. I know there are difficulties in other areas, but I appeal to Council representatives to wake their areas up and emulate our colleagues in Northern Ireland and London. I am quite sure that with extra effort it could be done.

I appeal to all members to join us at our Annual Conferences and Symposia. At these meetings we get to know each other better, learn more about our work and establish lasting friendships.

HOPE

I am a born optimist. My hopes for the brightest future of the Association cannot possibly be put in better words than those of the Police Surgeon's Editor, Dr. Bill Thomas, in the 10th edition. He writes: "The Police Surgeons of Great Britain warrant an active and healthy Association to advance their science and assist each other. Only the members can determine by their support and their willingness to explore new activities, how healthy and influential the Association will be in the next 25 years". Thank you Bill.

MEETINGS

We welcome the chance to meet again with our friends from the Forensic Science Society in Glasgow at the beginning of April. Meetings between the Association and the Society have proved most fruitful in the past. I personally recommend that all those who can take the opportunity attend this meeting.

The academic and social programme for Cambridge look most promising. My wife and I look forward to meeting you, your wives and friends during the Conference.

Fuad Gabbani

MINUTES of the 25th ANNUAL GENERAL MEETING of the ASSOCIATION OF POLICE SURGEONS of GREAT BRITAIN HELD AT PEEBLES HYDRO ON WEDNESDAY 19th MAY 1976 at 6.0 p.m.

The President Dr. W.M. Thomas took the Chair

1. Notice for convening the meeting was read by the Hon. Secretary.
2. Apologies of absence were accepted.
3. Minutes of 24th AGM were adopted.
4. Hon. Treasurer's report and the accounts were accepted after a proposal by Dr. M. Watson seconded by Dr. J.F. Newman.

   Hon. Treasurer reported a credit balance of nearly £3000 after a deficit of £619 the previous year. This had been achieved by the collection of the increased subscriptions and a reduction in expenditure. The services to the membership had been maintained throughout the year despite the economies that had taken place.
5. The report of the W.G. Johnstone fund was accepted after a proposal by Dr. Fuad Gabbani seconded by Dr. M. Cosgrave. Dr. Ralph Summers in his report mentioned the progress made in the preparation of "The New Police Surgeon — A Practical Guide". He thanked especially Dr. J. Hilton and Dr. S.H. Burges the joint editors for their efforts (applause) and also the contributors who had between them produced a book which will be accepted as an original work of authority, the like of which cannot be found anywhere else. A publisher had been found and production would be completed by the end of the year.
6. Dr. Ralph Lawrence proposed and Dr. M.A. Knight seconded the acceptance of the Secretary's report. Motion passed.

6a. Dr. H. Rosenberg proposed, seconded by Dr. D. Filer, "that Minute No. 8 of the Annual General Meeting of 9th May, 1973 be rescinded".

This was passed nem con.

Minute No. 8 of 1973:— "Dr. W.M. Thomas read the amendment to rules 6, 7 and 8 of the Constitution to delete 'Hon. Sec.' and insert 'Sec', and called upon the Hon. Treasurer to pay an honorarium" (to the Secretary).

7. Members stood in silence in respect of the death of Dr. C.H. Woodward, the first Clerk to the Association, and four other members who had died during the year.

   Hon. Secretary reported 53 resignations during the year but there was 31 new full members and 13 Associate members approved by Council. The total Association membership stood at 535 Full
   51 Associate
   29 Life Associate
   11 Honorary
   10 Corresponding

Total 636

A motion was put by Dr. David Jackson, seconded by Dr. Filer, in respect of Honorary membership, but an amendment proposed by Dr. Ralph Lawrence seconded by Dr. Myles Clarke "that all the Honorary members be re-elected" was passed.

Hon. Secretary explained that according to the Constitution Honorary members should be re-elected every year, some members considered that once elected an Honorary member should be a member for life unless he or she resigned and asked that Council consider changing the constitution to allow for this.

8. **Election of Officers**
   After being duly proposed and seconded with no other candidates being proposed from the floor the following Officers were elected:

President: Dr. Fuad Gabbani
President Elect: Dr. S.H. Burges
Hon. Secretary: Dr. H. de la Haye Davies
Hon. Treasurer: Dr. Arnold Mendoza
Hon. Ass. Secretary: Dr. Myles Clarke
Hon. Ass. Secretary (Scotland): Dr. Peter Jago.
Hon. Ass. Secretary (N. Ireland): Dr. R.B. Irwin.

The President after being installed by the retiring President presented a Past Presidents badge to Dr. W.M. Thomas. Dr. John Clarke presented the Honorary Secretary with his badge. Both presentations were warmly applauded and members spoke in appreciation of the services rendered to the Association by both Dr. Thomas and Dr. John Clarke.

9. **Urgent business arising since preparation of Agenda.**

a) It was requested Council considered changing the name of the Association to read "The Association of Police Surgeons" the main reason being that Ulster is not part of Great Britain and that members from Eire and the Common Market countries may be eligible for membership under the new title.

b) Dr. John Havard from the BMA joined the meeting at this point and a discussion on implications of the Blennerhassett Committee's report followed. A full discussion took place with notable contributions especially from Dr. John Clarke and Dr. Robert Irwin. Hon. Secretary reported the special sub-committee of Council would be sitting on Friday the 21st May at which the points discussed would be considered and he would also welcome written or verbal opinions from any members. He received a paper from Dr. W.A. Eakins (Belfast) which would be of help to the sub-committee.

c) Dr. John Stewart in proposing the motion from Ulster "That the present financial situation of the Association of the Association give cause for concern" explained that at the time the motion was drafted in January, his members had no knowledge of the Treasurer's report and the recovery of the Association's finances but were dismayed that two hundred members had still not paid their subscriptions. They also felt that direct representation by the Association to the Ministry of Environment should take place in respect of the Blennerhassett report. Because of the heavy workload in Ulster some of our members were receiving comparatively high fees which they felt might induce the Government to reduce "item of service" payments and he pointed out the danger of a salaried service being introduced some time in the future.

On being reassured by the Hon. Secretary that the outstanding subscriptions had nearly all been collected thanks to the diligence and efforts of the Clerk, and after discussion on the other points he raised, Dr. Stewart agreed to withdraw the motion having been asked by the President to convey our thanks to his members in Ulster for their interest in the Association and the enthusiasm they showed in all activities of the Association.

d) Dr. David Filer's motion that the Annual General Meeting for 1978 took place at the University of Wichita (May 22 to 26th) during the Eighth International meeting of Forensic Sciences was defeated but Hon. Secretary reassured members that the Association would almost certainly not hold its 1978 Conference during that week in order that members may attend and perhaps make a contribution*.

10. The time and date of the next AGM would probably be on the Wednesday morning during the week of the 1977 Annual Conference at Cambridge subject to final Conference arrangements being completed.

*Annual Conference 1978 Torquay 8-13th May.

EVIDENCE PRESENTED TO THE HOUSE OF COMMONS SELECT COMMITTEE ON VIOLENCE BY THE ASSOCIATION OF POLICE SURGEONS OF GREAT BRITAIN.

Introduction

1. The Association membership comprises doctors nearly all in practice as family doctors who have a special interest in clinical forensic medicine and many have after post graduate study obtained the Diploma in Medical Jurisprudence.

2. Our membership is unique among members of the medical profession in having first hand experience in dealing, not only with the victims of violence, but also on many occasions with the perpetrators of violence, especially in the family situation.

3. This evidence is directed to the problem of Non Accidental Injury to Children (otherwise known as the Battered Baby syndrome) but comments in the Draft could be applicable to other types of violence which occurs in the family situation.

4. The Police Surgeon has a role involving three main aspects:—
   (a) As a medical investigator with specialised knowledge of the interpretation of wounds and injuries.
   (b) As a liaison officer between the disciplines of Medicine, Law, Social and other agencies.
   (c) As a competent witness to present proper relevant evidence to Courts of Law, and also if necessary withstand cross examination on his evidence and opinions.

5. The full potential of Police Surgeons is in some areas exploited fully by some of their hospital colleagues who regularly call them in for consultation or advice when "suspect cases" arrive in Casualty Departments or in their wards, but this is the exception rather than the rule. This Association submits that every hospital Casualty Department should have access to a Police Surgeon of the right personality and experience who can be called on especially by junior staff to assist in medico legal problems. While it is realised that some of our members by virtue of other medical commitments or for other various reasons would be unable to carry out such work, the majority of our members are keen to assist and would make necessary arrangements to be available (especially, as in the case of most of our members, they have made arrangements to provide 24 hour cover for police stations, often in close proximity to the hospital.)
   As Honorary Secretary of this Association I can advise and introduce medical colleagues in the hospital service or in general practice to police surgeons in their area who are willing to assist in this manner.

6. The Association is pleased to note that many of its members serve on Area (or District) Review Committees in their capacity as Police Surgeons (rather than as family doctors), but we feel that this again is the exception rather than the rule. We note in some areas these committees function efficiently in the true spirit in which the D.H.S.S. suggested they were organised, but that in many areas of the country only lip service is being paid to the ideas suggested by the D.H.S.S. (memorandum on Non Accidental Injury to Children D.H.S.S. April 1974 Circular LASSL (74) 13 – CMO (74) 8).

7. Individual members of our Association have made contributions to the literature on the subject and I recommend

that members of your committee may find helpful background reading in Police Surgeon journal No. 6 of October 1974 and also the chapter dealing with Non Accidental Injury in the Associations latest text book "The New Police Surgeon – A Practical Guide" which is shortly to be published.

The Police Surgeon as a Medical Investigator

1. Police Surgeons by their training and experience have specialised expertise in the interpretation of injuries. They are suspicious by nature as in their professional work a great deal of time is spent in dealing with members of the community who do not tell the truth and who often are deliberately attempting to deceive those who are investigating the cause of the injuries.
2. A Police Surgeon on examining an injury should ask himself "Is this injury consistent with having been caused in the manner alleged?" – this is especially important in young children who cannot speak for themselves. Also in children who can speak for themselves, it is common for them to be inaccurate in their descriptions of causation of injuries to themselves for many reasons e.g. mental block as a result of the trauma suffered, fear of further ill treatment, confusion by questions, or quite often a desire to be helpful to the investigator giving rise to fantasy and exaggeration.
3. Police Surgeons being family doctors are aware of the wide range of normal variations in people, for example the dfferent susceptibilities of healthy children to bruising, the wide variation in heights and weights of children in the same age group – these factors are considered before a police surgeon gives an opinion and in many cases may remove suspicion from innocent persons. Especially in cases of alleged non accidental injury or cot deaths the police surgeon may be the publics only protection against a high coefficient of police suspicion – for example it is not uncommon for our members at the scene of a tragic cot death to have to explain to police officers the difference between bruising and post mortem lividity (a normal post mortem change) so that wrongful accusations are not made to the bereaved relatives.
4. Whereas the low level of suspicion among doctors and nurses often leads to many cases of the battered baby syndrome not being diagnosed until more than one assault has taken place on the child (or else when the child has died), the recent education of medical and nursing personnel has now led to a greater awareness of the problem but in some areas the pendulum has swung too far and wrongful accusations are being made. In view of the difficulty in reaching a proper diagnosis, often with emotional overtones prevailing, it is prudent for any doctor who is faced with a problem case to call on a second opinion. We submit the experienced Police Surgeon is the proper medical authority to approach, especially as he will not have to be responsible for future medical care of the family or the child as is likely for either the General Practitioner or hospital doctor.
5. We commend the action of those hospital paediatricians in several areas of the country who call in police surgeons for joint consultation on suspect cases within 24 hours of the childs admission. We stress the importance of calling this expert aid as soon as possible and hope that this practice will spread to other areas.

The Police Surgeon as a Liaison Officer

1. The Police Surgeon is unique in having "a foot in both camps" with respect to the professions of both Medicine and the Law. He is also in a position to liaise with other agencies such as the Social Services, the probation service, Housing Department, Samaritans, etc.
2. He is able to receive information of a confidential nature from medical

colleagues and using his knowledge of medical ethics able to communicate properly with other agencies. Although medical confidentiality is always considered in these cases, the doctor dealing with a case also has a professional duty of care to the child as well as considering the parents interests. With the help of a Police Surgeon colleague it is often easier for such information as is necessary to be passed not only to the police but also to other agencies (a) in the best interests of the child and (b) in a manner of keeping with the ethical standards of the profession. This liaision function has in the past in many areas been carried out by the Medical Officers of Health (now replaced by Community Physicians) but those areas which utilise Police Surgeons for this purpose find that the traditional barriers which prevent proper communications between the Police and the medical profession are very quickly broken down.

3. Our Association has informed police colleagues on a national basis that any Police Surgeon who carries out this function of liaison duties must have a high ranking police officer as his opposite number since it is essential that the other agencies as well as the medical profession see for themselves that "a person who walks in the corridors of power at County Police Headquarters" is the person involved in such delicate matters involving professional secrecy.
   Q.V. Police Journal July 1971 – Maltreated Children. A report of an early detection and follow up scheme, practised by the Northampton and County Constabulary.
4. A Police Surgeon is also in a position to explain to medical colleagues and other agencies that the police also have confidential information which should be restricted in communication (e.g. criminal records) and in the matters of domestic violence where Police Officers attend case conferences they often have a wealth of material to contribute which no other source is aware of.
5. In those areas where police surgeons are notified by the paediatrician in the *early* stages of a suspect case of Non Accidental Injury being admitted to hospital, the police are generally prepared to take no action other than holding a watching brief, allowing other agencies to carry out investigations, but they will always assist if called in an emergency (for example – parents trying to remove a child from a place of safety).
6. Our Association deplores the practice prevalent in some areas of only using the police when the hospital doctors or G.P. decide they should be called in – usually as a panic measure when the child is seriously injured or dead? Those of our members who carry out these liaison duties find the early discussion and early notification of all suspect cases, although probably giving rise to large numbers of "false alarms with good intent", has led to a very good working relationship between the medical profession and police in the area.
7. Medical and nursing personnel are often unable to cope with a crisis situation especially in the suspect case, with the result that a child is either left in the dangerous environment or removed from a place of safety by the parents to suffer further injury or even death. The Police Surgeon with a knowledge of the law and emergency procedures can by summoning the help of the local police quite often deal with the situation, especially when Social Services duty officers are not available. This is not a criticism of the latter but it is a fact that the police who work on a shift system are more readily available to attend these crisis situations as a Social Service duty officer may be (and often is in our experience) committed on other duties at the time of the emergency.
8. All agencies in our experience are unaware of the ability of the police to enter a house where a suspected

case of child abuse is residing by using the procedure of either a Place of Safety warrant (which requires the signature of a J.P.) or any constable taking an 8 day Place of Safety Order (which does not require a J.P.'s signature although a Police Officer usually of Inspector rank signs the order).

9. The Association is aware that the success of these liaison duties does depend not only on the personality and experience of the Police Surgeon but also on his acceptability to medical colleagues in the area. No legislation can cover this aspect, but we as an Association do attempt to impress this on our members and hope that medical colleagues, especially in general practice or paediatrics, will at least consider using the Police Surgeons service, especially in the early stages of *the management* of these cases.

The Police Surgeon's Role in Court

1. There is widespread agreement among our members that in many cases prosecutions are contraindicated in the best interests of the child, and we are pleased to note that this is also the view of most enlightened senior police officers. Our members working closely with the Police realise this, but unfortunately there is still considerable ignorance of this fact among other members of the medical profession.
2. Despite the foregoing there are certain cases where prosecution would normally be the duty of the police especially violence to a child committed by a non-related person (e.g. common law husband, step-father, baby sitter or foster parent), and in cases of repeated brutality or very serious injury where the child is in risk of dying or being left as a brain damaged cripple. The medical evidence in such cases may be required not only for Court proceedings but also for the Criminal Injuries board if the child has a claim.
3. When evidence has to be presented in care proceedings, if this is not done properly the child may be returned to the enviroment to suffer further injury. These cases are nearly always vigorously contested, and often the parents are represented by a barrister of considerable experience, whereas there is none to represent the child. In the experience of many of our members the case for the care order is often presented by a relatively inexperienced member of the local authority staff.
4. A Police Surgeon with experience of the Courts of Law (especially one who holds the Diploma in Medical Jurisprudence) is better equipped than other doctors to present the evidence properly and also withstand cross examination in respect of his evidence and opinions.
5. As previously mentioned the Police Surgeon has no duty of care to the child or the family, so many general practitioners and hospital doctors who may have to continue an ongoing relationship with the family after the court proceedings are relieved not to have to give evidence themselves if this can be given instead by a competent Police Surgeon.
6. Apart from Police Surgeons very few members of the medical profession are happy about giving evidence to Courts of Law for various reasons, foremost of which are disruption to practice organisation, time wasted waiting to give evidence and sometimes the discomfort suffered by being cross examined.

In conclusion my Council have instructed me to express their willingness for representatives of our Association with specialist expertise in this subject to attend for the purpose of giving oral evidence to your committee or to assist in any way we are able to.

H. de la HAYE DAVIES
M.A. (Oxon.), B.M., B.Ch., D.M.J.
HON. SECRETARY
ASSOCIATION OF POLICE SURGEONS OF GREAT BRITAIN

The Problem of Rape

M. LOIS BLAIR M.B.Ch.B. (Edin).

WOMAN MEDICAL OFFICER, GREATER MANCHESTER POLICE

Rape is an emotive word. To some it conjures up pictures of the Rape of the Sabine Women or of the ancient Viking landings and the consequent emotional distress of the victims going even as far as suicide. Some picture a woman or a child brutally battered and bruised left lying helpless in a shocked condition in a hedgerow. Others think of a woman of "notorious loose character" getting her just deserts. Others, again, visualise Soames Forstye raping his wife Irene.

What is Rape?

Although rape is a major offence under Section One of the Sexual Offences Act of 1956, until the Heilbron Report there had been no modern definition. Previously the Common Law definition existing since the 17th century was that rape consists in having unlawful sexual intercourse with a woman without her consent by force, fear or fraud. In the past this emphasis on the physical aspect of assault has been misleading.

The *Actus Reus* in rape which the prosecution must establish for a conviction consists of: 1. U.S.I.; 2. absence of the woman's consent. "The mental element which the prosecution must additionally establish is an intention by the defendant to have sexual intercourse with a woman either knowing that she does not consent or recklessly not caring whether she consents or not".

Rape is a serious criminal offence carrying on conviction a heavy sentence. This is one side of the situation. I am sure that everyone agrees that men and youths must be protected from wild accusations which can be made very easily by a woman seeking to get herself out of trouble with her husband, boy-friend or parents out of spite or, simply, fantasy. In a case in which I was involved a girl accused a young soldier of raping her. He had taken her out once, the following day she hung around the barracks gate waiting for him but he refused her offer; she retaliated by going to the police and complaining. Fortunately for the soldier there was no physical evidence and her demeanour was quite inconsistent with her story. At the time of the alleged offence there were, in

Dr. M. Lois Blair

fact, a number of people within earshot including police who heard nothing. She very quickly confessed and withdrew her complaint.

The situation is further complicated by the fact that women use the term "rape" very loosely. At my psychosexual clinics I am told wonderful stories about "their rape" at some time or other but eventually it transpires that all that really happened was that a man or youth at some time tried to take her knickers down: all the rest of her story is pure fantasy of wish-fulfilment.

A girl may permit through alcohol or otherwise an act of intercourse following which there is amenorrhea. She fears pregnancy, then she alleges rape. I recall examining a little boy of six who had been missing from home on a very wet, cold night. When found he said he had been buggered. He described his assailant to the police who started a full-scale search. However, there were no signs of buggery. The truth was he had been day-dreaming, forgot the time and was trying to explain his lateness. This illustrates that boys can and do fantasise as well as girls.

For many years I nave been concerned at the tendency of prosecuting and defence counsel and, even the Court, to accept a plea of guilty for a lesser charge — e.g. indecent assault — without due regard to the medical and other evidence that may be available. I have vivid recollections of an old woman, aged 82, with one leg amputated midthigh, who said she had been raped by a young man who had broken into her house. A good neighbour had seen him enter and had telephoned the police. The old lady was sexually excited. There was congestion of her private parts. On this occasion I was fortunate to be allowed to give evidence, following which the defendant changed his plea to guilty — in spite of the fact that the prosecuting counsel had earlier told me privately that it was the most ridiculous story he had ever heard.

Women, victims of genuine rape or attempted rape, have been faced with a series of indignities at various stages following the lodging of their complaint. First, she has to convince the police that her complaint is genuine. Though the police are concerned they inevitably from experience tend to be cynical. A medical examination is essential, which some women find embarrassing especially in the wake of a real assault. It must be remembered that signs of physical assault are not necessarily confined to the genitalia, the whole body has to be examined.

It is my opinion unfortunate that, because it is a crime, the CID have to be called in by the policewoman and take over. This is often traumatic for the victim. Every woman and child has the right to opt for a woman doctor if they so wish but, in their emotionally-disturbed state, they fail to realise this; regretfully their rights are not always explicitly stated to them. I am not a female chauvinist; there are many experienced, very sympathetic male police surgeons who deal positively with distraught women and children thus enabling them to carry out detailed examination accurately with minimal further distress.

Later, there is the Magistrates' Court and then the Crown Court should the accused be committed. Here the victim finds herself pilloried, exposed to verbal assault upon her virtue and past life — trial of the victim rather than the defendant. The resultant publicity in court and in the media proves very distasteful. The anonymity of the victim proposed in the Heilbron recommendations should go far to remedy this. No longer will the complainant's past sex life, in ordinary circumstances, be exposed for public titilation.

The crux of the matter is the lack of consent of the victim. I am concerned that the police and courts still regard rupture of the hymen, even partially, as constituting a serious sexual assault. Little girls' hymens are often spared, due to the shape of their anatomy. Despite the presence of bruises or finger-nail marks around the area, the charge is reduced usually to indecent assault although the damage done is as great as if the hymen had been penetrated. I consider that there should be an alteration in the Law in this respect. *The Police Surgeon* (N.8, October

1975), carried a picture of a girl 13 years old, her hymen intact – eight months' pregant! The risk of infection is ever present (with all the complications thereafter and the urgent need of early treatment) and should be looked for.

Psychological Aftermath

To some extent the psychological aftermath relates not so much to the incident itself but to the subsequent emotional reactions of parents and boy-friends or husband, the examining doctor and attitudes of policemen and policewomen. The delays and sometimes repeated cancellations of the case can have a very deleterious effect upon the victim, be she girl or woman, and this can influence the quality of the evidence which she may give to the court.

The damage to the victim is not much less if, at the end of day, she is informed that she will not be required to give evidence. The lesser charge to which, no doubt, the man pled guilty may alleviate his sentence but it does little for the victim. Certainly in girls and adolescents – and even married women – the latter effect can be an inability to maintain a normal maturation and married life: "It is emotional health that provides the basis for developing sexuality". These sometimes catastrophic effects can be graver if the aggressor belonged in the family or remote family unit.

It must now be obvious that the quality of the medical examination is both legally and medically critical. I do not consider it advisable to take these women or girls to a hospital casualty department where they will be examined by whoever is on duty and face a staff unused to this aspect of medical work. The examination must be in a suitable place with good light and privacy. The doctor must take time to build a relationship and obtain the co-operation of a distressed woman or girl. As full a history as possible taken. Any friend or relative present should also be interviewed separately. Full notes must be made at the time. The state of the clothing should be carefully noted as she undresses and, where appropriate, the clothing and debris thereon should be preserved for forensic examination. It is essential that her whole body be examined for bruises, excoriation, bite and suck marks. Particular attention must be paid to finger-nails and the physiological state of the genitalia. Are there signs of sexual arousal as well as signs of trauma? It is advisable to have police photographers available to record, preferably in colour the appearance of clothing, marks on the body, etc. Above all, her demeanour, state of shock, are of paramount importance.

Forensic Information

Forensic science today can provide an immense amount of invaluable information – for example, identification of blood, semen, saliva groups, identification of soils, plants picked up at the scene of the assault, hairs, nail parings both of the girl's, and the accused when found examined. I regret to say that in a number of cases there is an apparent lack of appreciation by the officers of the extent to which modern forensic technology can assist in this type of case.

Substantial evidence that could be obtained from such investigations is lost by failure to care for forensic specimens and delay in forwarding them to the laboratory. On one occasion the C.I.D. did not act for over 12 hours and, although they knew the identity of the man concerned, he used the time to cut his nails short. The evidence was lost. A girl missing from home – many years ago now – was found at 8 a.m. I was 'phoned at 5.30 p.m. and asked to see her. When she arrived she had been allowed home for a meal, had had a bath and changed her clothing which was now in the washing-machine. It is becoming progressively easier to identify scientifically the assailant and X-rays can now be used for finger-prints on textiles.

Another aspect which concerns me – not, I think, the fault of individual constables – is that an accused may informally intimate that he will plead guilty. Then there is a tendency not to send the specimens to the forensic laboratory without reference to the doctor. All he has to do

is plead not guilty and the valuable evidence has not simply been lost — it was never acquired.

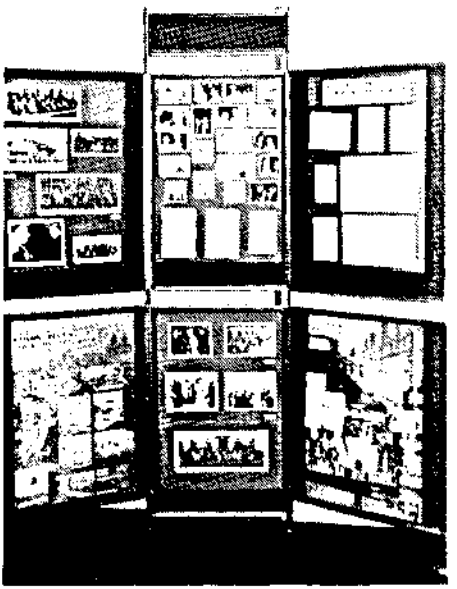
Police Surgeons know what specimens to take and how to take them and preserve them. The risk of infection is ever present and should be looked for, samples taken and, where appropriate, early treatment ordered. The same may apply to the accused. I appreciate, however, that women can fantasise and create a lot of needless work for very busy people.

A Magistrates' Court acquitted an accused. This woman had been attacked by a friend of the family, a rent collector; he pushed her against a piano. There were bruises on her back which confirmed this. She had, however, as told me by their friend, changed from a vivacious young woman to a withdrawn, timid personality who collapsed verbally in the witness-box.

Nurses in the community can play a very big part. They can encourage women and mothers to report alleged rape as soon as possible, tell them they will be seen by a sympathetic police surgeon and advise them of their right to opt for a woman medical officer. They can explain why a detailed history is required, why a full examination is necessary and the taking of samples essential. Subsequently community nurses are in a position to counsel victims.

The anonymity, the curtailment of the cross-examination as recommended in the Heilbron Report, and above all, the recommendation that the mental aspect is as important as actual physical signs, will make it much easier for women to complain successfully. It will be interesting to see, in the future, what effect a new attitude to rape will have on criminal statistics and whether perhaps they will reflect more truly the real situation.

Reprinted from the September 1976 issue of Midwife, Health Visitor & Community Nurse by kind permission of the publishers.



This notice board has been presented to the Association by NORGINE LIMITED. The company will be exhibiting during the Annual Conference.

HEPATITIS 'B'

An Occupational Hazard for Police Surgeons

Hepatitis "B" (serum hepatitis) has a long incubation period compared with infective hepatitis ("A").

It is now identified immunologically by the recognition in the patient's blood of a specific marker — the Australian antigen — or HG Ag. The antigen may disappear from the patient's blood before the jaundice appears, or may persist for years after the patient has recovered. It may be present in people who have not shown signs of infection. This may well be the case in the family group or in long-stay institutions such as mental hospitals or prisons, where the appearance of a case of jaundice may stimulate the search for antigen carriers. However, in many antigen patients, a previous contact with a case or a carrier may not be established. A negative result of testing for HB Ag does not rule out past or present infection.

The HB Ag positive patient is potentially infective to those in contact with him. The virus is not present only in the blood; it may be found in the saliva, faeces, semen or vaginal secretions. Transmission may be by direct introduction into the blood stream via transfusion or dialysis, through the skin barrier by pricking or accidental incision, or through broken skin by contact with any of the mentioned body fluids. As the antigen is present in saliva, droplet infection can occur.

In mental institutions, soiling with faeces and with semen following masturbation is common. Infected saliva may be injected by bites. Tattooing instruments are indicated as vectors as are, incidentally, blood sucking insects. Sexual contact as a mode of transmission has been verified.

Immunological methods are becoming more accurate. The Public Health Laboratory Services recorded 913 HB Ag positive hepatitis cases in the period April 1975 to June 1975. Of these 18% were drug abusers and 19% had been tattooed within the previous six months. Fifty-eight patients (6%) were thought to be infected in the course of their work and included doctors, nurses, laboratory technicians and dentists. There are, of course, an unknown number of unnotified cases. Although the fatality figure is probably less than 1% (one), morbidity and inconvenience are significant.

The Police Surgeon is dealing with a section of the public who may well be more likely to carry the BH Ag Antigen. The precautions taken should be reviewed and the following suggestions are made:

In dealing with drug abuses, homosexuals, long-stay inmates of mental institutions and prisons, or if a history of hepatitis in the subject or the family is established, or suspected, gloves should be worn for vene-puncture.

Care should be taken not to spill the blood. Police officers and others handling containers should wash the hands well afterwards.

Any blood stains on furniture or floor should be cleaned up there and then by the Police Surgeon and not left for the police station cleaner.

Syringes, needles, gloves and other articles should be disposed of carefully and hygienically. Before placing the syringe in the box provided the needle should be pushed into the barrel to impinge on the rubber or plastic piston seal. Otherwise the infected needle could pierce the cardboard and be a hazard. This procedure should apply in all cases where blood is taken, including RTA cases.

Obviously precautions are taken for hygienic, forensic and aesthetic reasons in the examination of sexual offence cases (including homosexual) and gloves are worn whenever possible. If the criteria mentioned above apply, extra care should be taken.

If blood and other samples are taken from a person known or suspected to be HB Ag positive the forensic laboratory should be warned. It would be grossly unfair to expose laboratory staff to unnecessary risk.

In hospital practice plastic bags marked with red "high risk" labels are available. Forensic samples can be packed as usual but also marked "high risk".

The surgeon exposed e.g. by pricking a finger with a needle used for taking blood from a confirmed or suspected carrier should arrange to be given a specific serum (immunoglobulin) containing HB antibody. (Transfusion Centres usually have a stock of this). After exposure it would be justifiable to use part of the suspect's existing blood sample or to take a further sample from him/her for testing for antigens. If antigen is found exposure is confirmed.

Hepatitis (A & B) is a notifiable disease in the United Kingdom. Hepatitis "B" has been classified as an industrial disease and the relevant conditions of the National Insurance Industrial Injuries Act of 1965 apply.

It is estimated that 110 million people in the world are infected with Hepatitis "B" virus. Although most cases occur in countries with warm climates new techniques for detecting HB Ag show an increased incidence in temperate zones. Although this incidence is low the Police Surgeon, because of the nature of his work, is at risk and he should take the necessary precautions to avoid infection. The provision of well equipped medical rooms reduces the risk for the Police Surgeon and police personnel.

H. B. KEAN, MERSEYSIDE

MERSEYSIDE MEDICO-LEGAL SOCIETY

23rd March, 1977
Symposium – "The Wallace Case"
Chairman: His Honour Judge Keith Lawton.
Prosecution: Mr. Robert Montgomery
President: MMLS
Pathological Evidence: Dr. Charles St. Hill, Home Office Pathologist
Defence: Mr. Richard Whittington-Egan, Author and Script Writer
Additional Research: Chief Constable, Merseyside Police: Magistrate Clerk's Office: Liverpool Echo

5th March, 1977
Annual Dinner
Principle Speaker: Dr. L.A. Liversedge, President, Manchester Medico-Legal Society.

Meetings of the Merseyside Medico-Legal Society are held in the Liverpool Medical Institution, 114 Mount Pleasant, Liverpool 3.

Further details from:–

Dr. M. Clarke,
Hon. Secretary, MMLS,
24 High Street,
Liverpool 15.

NORTHERN IRELAND MEDICO-LEGAL SOCIETY

March 8th, 1977
Dr. Alex Lyons MB, FRCPI, MRC, (PSYC), DPM.
Consultant Psychiatrist
"The Psychological Sequelae of the Civil Disturbances".

April 26th, 1977
ANNUAL MEETING, followed by "Forensic Science" – short talks by Dr. W.H.D. Morgan, Mr. R. McLean and Dr. J. Martin from the Northern Ireland Forensic Science Laboratory.

The meetings will be held in the Ulster Medical Rooms, Belfast, and will commence at 8.0 p.m.

For further information please write to:–

Dr. Elizabeth McClatchey
Hon. Secretary,
Northern Ireland Medico-Legal Society
40 Green Road
Belfast BT5 6JA

ASSOCIATION OFFICE

IMPORTANT NOTICE

With effect from 1st March 1977 the Office of the Association will be transferred to:

CREATON HOUSE,
CREATON,
NORTHAMPTON, NN6 8ND.

TELEPHONE NO. (CREATON) 060-124 722
Office Hours: 2-6 p.m. Monday-Friday

Note:

Creaton is situated 8 miles to the north of Northampton on the A50. From the north the best approach is down M6 or M1 and leave the M1 at Crick flyover (Junction 18). If coming down the M45 then leave M1 at Heyford flyover (Junction 16).

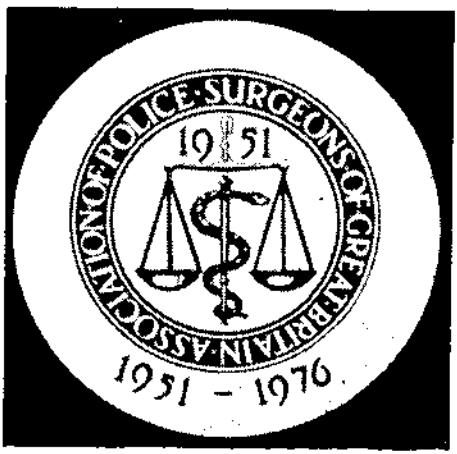
From the south leave the M.1 at Collingtree flyover (Junction 15) and proceed via Northampton to the A50.

Association Emblems:

The following articles bearing the Association Motif may be obtained from the Association Office.

1. Aide Memoirs, documents for recording notes made at the time of Forensic Medical incidents
   ..... packet of 60 .....£2.55
   packet of 100 .....£4.70
2. Key Fob with the crest in chrome and blue enamelled metal £1.00
3. Terylene Ties. Silver motif on blue £2.00
4. Car Badges, chrome and blue enamel. (for hire only) ..... £5.00 each
5. Car Stickers for the windscreen (plastic) ..... 50p each.

(cost includes postage and packing)



COMMEMORATIVE TILE

Some of the tiles are still available and may be obtained from Myles Clarke (for address see page 3).

Cost 70p each, £3.00 for six including postage and packing.

AMENDMENTS TO MEMBERSHIP LIST

We apologise for the following omission from Supplement No 1.

Life Association: Dr. C. Clark (F), Eltham SE9

NEW MEMBERS

Area 1	T.M. Doran	Wigan
	M.J. Hoey	Wallasey
Area 1a	J.D. Keatley	Magherafeit
	P.G. Murphy	Downpatrick
Area 3	J.P. Paw	Walsall
	K.S. Rajah	Birmingham 13
Area 4	P.J. Keavney	Nottingham
Area 5	Z. Ludwig	St. Leonards on Sea
	N.C. Modi	Wellingborough
	I.C. Micholson	Gosport
	T.G. Zutshi	Sevenoaks
Area 6	R.N. Hodges	Cheltenham
Area 7	E.W. James	Llandudno
Area 8	J.P. Kanodia	London N1
	Phillis Turvill	London NW3

ASSOCIATE

Area 3	B.T. Davis	Birmingham
Area 4	H.R. Dickman	Lincoln

We regret to report the death of Dr. I.W. Hughes, Llandudno

RESIGNATIONS

A. Berry	Brighton
G.P. Percival	Southampton
E. Bruce-Wilson	London N22
J.D. Busfield	Hull
P.D. Mackay	Carmoustie Angus
C.A. Kovachich	Liverpool
D.C. Jeffery	Bristol
C.B. Swan	Southport
M.J. Smith	London SE1
H. Mclean	Worthing
W. Richie	Downpatrick
B. Kapur	Rotherham
S.D. Spence	Lurgan
E.J.E. Parker	Lurgan
J. Dunlop	Belfast
M.M. McSwiney	Mansfield
D.G. Bonner	March
R. Cooper	Camberley
P.A. Gimson (Associate)	Aylesbury

MORE LIGHT READING

My last contribution, your editor told me, was well received* — so here I go again.

My magistrate wife and I (with my medico-legal training) have fun in bed! I play a provocative game and directly oppose my wife's views. Sometimes this play has results — as, for example, when I pointed out that a driver was fined for driving without due care and attention around a bend which did not carry the appropriate warning sign.

A sign was duly erected!

Legal and medical marriages (my wife is also the practice nurse) can produce complications. One doctor, reluctant to go out on a night call, prompted a long lecture from her barrister husband on the law of negligence.

I have a schizoid doctor/lawyer relationship with myself on lines of treatment for my patients. To forget my problems I took up hang gliding. It is amazing what you spot in the bracken as you soar overhead and the scramble for clothes your appearance provokes. Hang gliders were conscripted to hunt for a rapist in the Australian Bush. Will the future Police Surgeons and policemen fly overhead to get a bird's eye view of the scene of the crime?

The subject of flying reminds me of jumping out of windows. My partner in crime, Anthony Ferris, had an interesting experience. He reminds me that in his tale he felt the unfortunate patient was attempting to fly, run, swim and bury his head in the sand like an ostrich. What happened was this:

My partner, just as he was about to start morning surgery, received a 'phone call from a patient's spouse stating the patient had swallowed his eye drops. My partner told the good lady that he would 'phone her back a little later. Before he could do so the 'phone rang again. Tha patient had now jumped out of the bedroom window. The good doctor hastened to the scene and found the patient had sustained no injury from his fall. He had, however, subsequently dragged himself through a hedge and across a field to a bath (used as a horse trough) in which he tried to drown himself. Unable to succeed in this, his final attempt was to stuff himself into a wet plastic sack.

Some months later when the patient felt better he turned up at my surgery and asked me to sign the application form for him to obtain a shot gun licence!

Recently I received a call from a neighbour who told me one of my patients had approached him to say she had taken an overdose of tablets and that he must not tell the doctor. The neighbour had wisely told me. As I was going to the patient uninvited I rang the local police and arranged to meet a constable outside the house. I always get a bit mixed up with the architecture of some of these modern housing blocks; I think the constable does too. These consist of an upstairs and downstairs flat. Having rattled the letter box several times and having no reply, I was all for using a brick on a glass door but the constable restrained me. I said "something's got to be done" — a well used phrase with some of our patients. We compromised and went round the back of the building where we could see, through a closed window, a door leading from the kitchen. With the aid of a bit of stick, some grating and the constable's

Dr. and Mrs. Glanville

* "Order Out of Chaos", The Police Surgeon, April 1973, Ed.

hands we got the latch free. My backside was shouldered onto the sill and I dropped quietly into the kitchen and let my confederate in.

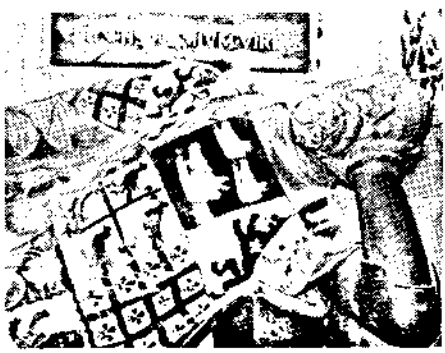
The awkward moment had arrived when I realised we were in the wrong house! What was more embarrassing was that the T.V. was fully on and there was one of my other patients with her back to me. I would not have minded particularly except that she was one of my cardiac cases. I decided it was too late for retreat as she might see us disappearing again. So I chanced it and tapped her on the shoulder quietly addressing her. She screamed blue murder and I envisaged treating two cases. We ended up by smashing the correct window, to be admonished later by the sergeant for not putting sticking plaster on the glass before breaking it because it made things less messy afterwards. I am glad to say that both the patients are well and happy to date.

I was running a peaceful untroubled surgery the other morning and something occurred for the first time in 28 years of general practice. A chap walked into my consulting room and said he had had a rough night and felt bilious. He flung his spectacle case on my desk and asked if he could have a form to have his eyes tested. Just as I was about to write an OSC1 form he dropped dead at my feet. Attempts at resucitation failed. I had never clapped eyes before on this newly registered patient so I picked up the 'phone to report to the coroner an unexpected and sudden death in my surgery, and to seek permission to remove the body. I was a bit put out when the clerk in the coroner's office helpfully suggested (as if this sort of incident was common-place), that I push the body into some convenient room until the police arrived. I had many more patients to attend to! My imagination ran riot. I could see myself explaining to each patient who followed — "please don't worry about the heap in the corner, it's the last patient, he died!" Then horror of horrors, the same clerk suggested I ask the local undertaker to bring his van up to my surgery and discreetly remove the body. Eventually the first class ambulance service we have in this area came to my rescue and the body was removed to the chapel of rest.

Mr. Editor, you asked for some more light reading — now you've got it!

Acknowledgements to Mrs. M.J. Glanville for kindly typing and reading the proof of this article.

MICHAEL GLANVILLE



What do you think of it so far?

Practical Photography

Makes a change from battering

NOTIFY THAT ADDICT

A regular feature of most Police Surgeons' forensic practice is attendance upon persons in custody taking drugs. Medically prescribed drugs may, by unexpected side effect, bring the patient to the notice of the Police, e.g. a driver suffering side effects of antihistamines.

Persons arrested in connection with offences unrelated to drugs, may require regular therapy whilst in custody, e.g. epileptics, and the Surgeon's advice is sought regarding the tablets in the prisoner's property and their continued supply. Most Surgeons are familiar with prisoners who take drugs, usually not prescribed, for the variety of sensations they produce rather than for any therapeutic purpose. A proportion of these patients become addicted to their drugs.

The Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973, require Doctors to notify annually addicts who are dependent on certain drugs. This enables the authorities to maintain an effective confidential register of drug addicts, a counter to those addicts who use aliases and changes of address as a means to getting drugs. The register also offers a means of epidemiological assessment.

The notifications for the register come chiefly from hospital doctors and doctors in general practice. However, if an addict is seen by a Police Surgeon, an obligation falls on the Surgeon to notify the Home Office, unless (1) he had notified that addict during the previous 12 months, (2) the Police Surgeon's partner or deputy in general practice had notified the addict during the previous 12 months, or (3) the Police Surgeon also works in a hospital, and a different doctor at that hospital has notified the addict during the last 12 months.

In practice this means that, unless the Police Surgeon works regularly with drug addicts outside of the Police environment, he will almost certainly be obliged to notify the Home Office concerning the addict.

An addict is defined as a person who, as a result of repeated administration of a drug, has become so dependent upon the drug that he has an overpowering desire for the administration of it to be continued.

The controlled drugs, to which the Regulations apply, are as follows:—

Approved Name		Trade Name
Cocaine		
Dextromoramide	—	Palfium
Diamorphine	—	Heroin
Dipipanone	—	Diconal
Hydrocodone	—	Dicodid
Hydromorphone	—	Dilaudid
Levorphanol	—	Dromoran
Methadone	—	Physeptone
Morphine	—	Cyclimorph, Duromorph, Mortha Omnopon, Papaveretum
Opium		
Oxycodone	—	Proladone
Pethidine	—	Pamergan, Pethilorfan
Phenazocine	—	Narphen
Piritramide	—	Dipidolor

All information notified by doctors is treated in the strictest confidence. Any

registered medical practitioner may obtain advice or information about an addict if he needs it by telephoning:—

General Enquiries 01-212 0335 or 01-212-6071.

Enquiries about individual addicts:
Surnames beginning with:

A—G	01-212-6337
H—P	01-212-0838
Q—Z	01-212-6564

The doctor will be asked to identify himself clearly and any information will normally be telephoned back to the doctor who made the enquiry.

It is not essential to use the notification form — a letter will suffice.

Letters or completed forms should be sent to:—

The Chief Medical Officer,
Home Office,
Drugs Branch,
~~Ramsay House~~, Queen Anne's Gate
~~Marsham Street~~,
London ~~SW1P 3BY~~. SW1H 9AT

Notification forms and franked envelopes may be obtained from this address.

Notification should be made within 7 days of seeing the patient.

Notification form

NOTIFICATION OF DRUG ADDICTION

Name:

Address:

Sex: Date of Birth:

Nationality:

N.H.S. No. (if known)

Drugs to which addicted:

Drugs prescribed:

Height:

Colour of hair:

Colour of eyes:

Distinguishing marks or other outstanding features:
(i.e., scars, tattoos, deformities, etc.)

Signed. . . . . .

Date . . . . . .

THE ASSOCIATION IN NORTHERN IRELAND

Until 1971, there was no Police Surgeon Service in Northern Ireland. Prior to that year, an unsatisfactory system existed whereby certain doctors in a district were available to assist the police, but were not obliged to do so, and could decline if they wished. In addition, it was not unusual for calls to be directed towards a particular doctor, to the exclusion of colleagues who might also be willing to assist.

However, because of poor fees, and because a doctor "assisting the police" was regarded as a form of police lackey, the police found that in many areas, it was impossible to obtain any form of medical assistance.

The first signs of progress towards a proper Service appeared in 1968 with the drafting of the new Road Traffic Act (NI) by the Minister of Home Affairs, the Right Hon. William Craig. A special committee was invited by the GMSC (NI) to meet at BMA House, Belfast on 16th July 1968, to consider the Road Traffic Bill and to advise the Minister thereon. The doctors who formed this committee had been doing police work for many years and were R.B. Irwin and J. Dunlop of Belfast, C. Dick of Ballymena, K. Henry of Dungannon, J. Mitchell of Londonderry, and the author. Following representations which we submitted to the Minister, certain modifications were made in the Bill before it was finally passed through Parliament.

In 1970, the Minister of Home Affairs informed the BMA in Northern Ireland of their intention to establish a Police Surgeon Service similar to that operating in Great Britain. The doctors who served on the RTA sub-committee were re-convened by the BMA, under the chairmanship of Dr. A.J.G. Dickens, at that time BMA Assistant Secretary (Northern Ireland). At a considerable number of meetings, both on our own and with Ministry representatives, we were able to express many of our opinions. I must pay tribute to Tony Dickens who has been a good friend to the Association over a number of years, and whose wise guidance and counsel did much to ensure a sound basic framework for the Service.

The Service Introduced

In 1970, the Police Authority was formed and took over responsibility for the provision of a Police Service (the Royal Ulster Constabulary) in Northern Ireland. It was unfortunate that the Police Surgeon Service was introduced on 1st April 1971, as the Police Authority staff had only recently been appointed and were still finding their feet. The concept of a Police Surgeon Service was something entirely new to them and regrettably some of our advice in those early days was not heeded. A prime example of this was when we advocated the absolute necessity of the medical examination, before and after interrogation, of persons detained under anti-terrorism legislation, both in the interests of the individual detained and of the security forces. This plea fell on deaf ears for many months, and the British taxpayer is now only too well aware of the disastrous consequences in the shape of very substantial Court awards.

We were not consulted on the form which the press advertisements should take when the first appointments were made, nor on the area for which each

appointed Surgeon would be responsible. These administrative errors caused difficulties which need never have arisen. Happily staff changes within the Authority during subsequent years have resulted in a totally different situation, and it is pleasant to be able to report that decisions affecting Police Surgeons are now rarely, if ever, taken by the Authority without prior consultation with representatives of the Association.

The first 23 appointed Surgeons signed their contracts, took up duty on 1st April 1971, and nominated their Deputies who were duly ratified by the Authority.

There were many problems, mainly of standardisation of procedure, because while all the Surgeons appointed had previous experience in police work, each had been "doing his own thing" over the years.

Branch Meetings

A meeting of all Surgeons and Deputies in the Province was held at Ballymena in June 1972. A Northern Ireland Branch of the Association was formed that evening, Bertie Irwin being appointed Hon. Secretary, and myself Chairman. These positions we still hold, having been democratically re-elected from time to time by our colleagues! Subsequent annual meetings have been held at Dungannon, Antrim, Armagh, Bangor and Coleraine, the intention being that by taking the meetings around the Province as much as possible, the same members do not always have to undertake the longest journeys. It is proposed to hold the 1977 business meeting in Newry, where Paddy Ward is our surgeon. Attendance at the meetings has averaged 22 Surgeons and Deputies, which we feel is creditable in the circumstances. One of the outstanding features on each occasion has been the hospitality shown by our hosts, the local Surgeon and Deputy and their wives. Members have found the discussion of the many aspects of the service at the meetings very useful.

Professor T.K. Marshall, State Pathologist and an honorary member of the Association, has given us immense support from the beginning. He has arranged a number of very successful day courses for Surgeons at the Royal Victoria Hospital, Belfast.

Initially, the Police Authority refused to agree to a Police Surgeon sitting on appointment boards. However, the situation has now been reversed, and not only does Tom Marshall act on all such boards, but either Bertie Irwin or myself also take part.

In March 1976, we held our first weekend clinical meeting at Enniskillen. The attendance of members was excellent and this encouraged us to arrange a similar symposium for March 1977 at the same venue. We are delighted that Dr. Stan Burges, President-Elect of the Association, has accepted an invitation to visit us on this occasion and to act as our main speaker. Dr. T.C. Kennedy of Larne has been appointed Secretary for the symposium.

Throughout the Province, all Surgeons except one, and all but four Deputies, are fully paid-up members of the Association. We continue to urge non-members the advantages to be gained from membership (and indeed perhaps the immorality of accepting the benefits obtained by the Association for *all* Surgeons regardless of whether or not they are members). The Authority make it clear that while they do not wish to operate a "closed-shop" policy, they much prefer to negotiate with the representatives of the Association rather than with individual Surgeons.

Co-operation

We appreciate the co-operation and help which we have received from the Authority staff, particularly from those with responsibility for the Police Surgeon Service. Bill Meharg, Assistant Chief Constable with responsibility for crime has rendered exceptional assistance. He fully understands our difficulties, and is an example to some of his colleagues who do not appear to appreciate the concept and value of a Police Surgeon Service. Bill is a regular visitor to Conference.

For six years we have provided a medical service to the RUC and to the community in Northern Ireland. The work has often been arduous, occasionally

dangerous, not infrequently frustrating, rarely lacking in variety and interest. There is a Surgeon and Deputy in every area of the Province, with the exception of Omagh and Limavady, where so far there has been no response to advertisements.

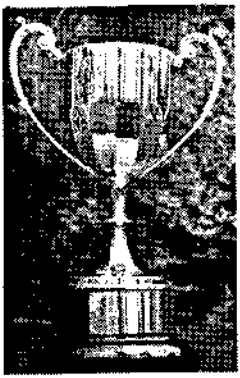
The pattern of work is changing. The drinking driver continues to provide our bread and butter, but assaults on both males and females are increasing in number, and examinations under the anti-terrorism laws are commonplace.

A totally inexplicable change in procedure in drinking driver cases introduced by RUC Headquarters earlier this year following a Court judgment has led to a marked drop in the number of such cases, increasing the dangers to other road users from these irresponsible drivers (and to the detriment of the Police Surgeon's income). I fail to see the need for change from the previous satisfactory procedure. If the Blennerhassett Report is fully implemented in Great Britain, our colleagues on the mainland will find their workload diminishing.

We will always be grateful to the Officers of the Association for their constant guidance and encouragement over the past six years. We greatly appreciate the warmth of the reception we receive at Conferences and Symposia. We are well aware that the unhappy state existing in the Province could so easily involve the mainland in the next few years.

My personal thanks to Bertie Irwin, Branch Hon. Secretary and Council Representative, and to our Northern Ireland members for their loyalty and enthusiasm. Without them, this branch would not exist.

JOHN H.H. STEWART
Chairman
Northern Ireland Branch

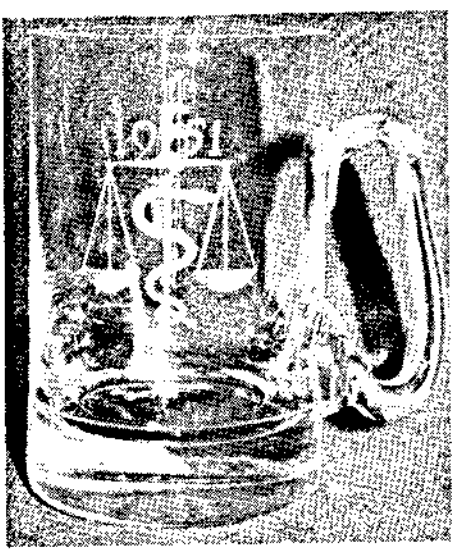


ULSTER CUP

The ULSTER CUP will be played for on Friday 20th May, 1977, during the afternoon, on the Cambridgeshire Hotel Golf Course. The competition will be Stapleford over 18 holes.

The winner will hold the Cup for one year, and will receive a handsome glass tankard engraved with the Association Crest as a momento. There will also be prizes for the Runner-Up, and for the Best Ladies Card.

Dr. Robert Hunt-Cooke has been appointed non-playing Captain. Combined entrance fee and sweep £1.50, payable to the Captain during the Conference. Competitors will be required to pay green fees, unless advantage is taken of the concessional green fee for the conference.



THE DIPLOMA IN
MEDICAL JURISPRUDENCE

"THAT BLOODY DIPLOMA"

"Why should I bother to take the D.M.J., I've been a Divisional Surgeon for over 25 years. I do not need a Diploma to tell me that I know what I am doing".

How often have we heard such a conversation over the past 12 years or so, and how often have we also heard the disgruntled remark, after a very sticky time in the witness box of a Crown Court:—

"What are Locard's bloody principles anyway?"

Crimes involving medical matters have not changed greatly over the past 25 years — but the standard of scientific proof has changed enormously. Blood and body fluid grouping, analysis of body fluids for drugs, the effects of medication upon behaviour, non-accidental injury to children, intoxication by drugs of abuse, the management of the drug addict in custody, industrial hazards, psychiatry and the Mental Health Acts in Police Surgeons practice, procedure at sudden deaths — these are the matters that concern a Police Surgeon in 1977, and will concern him more with each passing year.

The object of The Diploma in Medical Jurisprudence (Clinical Division) is now and always has been, to demonstrate to the courts that certain doctors have taken the trouble to undertake a certain amount of postgraduate study in a field of medicine that has undergone great changes in the recent past.

The syllabus for the Diploma covers every aspect of Clinical Forensic Medicine, and encompasses every situation that a practitioner in the field is likely to meet in the course of his work. It follows that every candidate who presents himself for the examination has read and studied all aspects of the subject. If he has not done so he will not satisfy the examiners.

The examination has undergone some radical changes in the past two years or so. As one of the examiners who has taken part in this change I am very proud of the broad base and practical approach that is now part of the examination.

The original PART 1 consisted of a three hour paper in which only FIVE questions had to be answered, and a Viva. As every candidate knows, examiners always set the only FIVE questions that he did not cover in his studies.

PART 1 now consists of a large number of multiple choice questions, which explore the breadth of the candidates knowledge of the subject. It is said that a chimpanzee has a fifty percent chance of passing a multiple choice paper — there must be many candidates who are less well qualified than a chimpanzee in that case for the multiple choice paper has shown up a very narrow knowledge of the subject in a great many instances.

PART II used to consist of a three hour paper in which only FOUR questions had to be attempted, an Essay paper of 3 hours, and a Viva. It now consists of a TWO hour paper with FOUR questions to be attempted, a one and a half hour essay paper, a CLINICAL examination of 20 minutes followed by a clinical discussion of the case examined for a further 10 minutes, and a Viva.

In addition to the change in the format of the examination, the actual questions are slanted more to the practising clinician. May I illustrate this by demonstrating

two papers, one from 1972, and one from this year, 1977.

1972

1. What medico-legal considerations apply to the giving of consent to surgical procedures.
2. Comment upon the working in practice of the Abortion Act, 1967.
3. How would you investigate a suspected battered baby in clinical practice?
4. Write short notes on:
   (a) Paraquat.
   (b) Blood dyscrasias from drug therapy.
   (c) Methadone use in addicts.
   (d) The age of criminal responsibility.
5. Describe the clinical, biochemical and pathological features of hypothermia in the elderly.

1977

1. Discuss the importance of bite marks in:
   (a) Non-accidental injury to children.
   (b) Sexual offences.

What information can be obtained by a careful examination of such marks and what specimens should the examining doctor take for the laboratory?

2. Write short notes on the following:
   (a) Abrasions.
   (b) Osteogenesis Imperfecta.
   (c) Section 60 of the Mental Health Act, 1959.
   (d) Paraquat poisoning.
3. Compare and contrast the physical signs of intoxication by:
   (a) Alcohol.
   (b) Amphetamines.
   (c) Cannabis.

Indicate what samples you would send to the laboratory to confirm your clinical diagnosis in each case.

4. Discuss the effects of compression of the neck in the living. What clinical signs may there be to confirm such an allegation?
5. You are called upon to examine a woman who it is alleged has been delivered of a child within the preceding six days. Describe your examination indicating the physical signs that would support the allegation.

The emphasis in 1977 is on How you would examine; What are the physical signs; What specimens you would take in very common situations; The differential diagnosis between intoxications by common substances of abuse.

A successful candidate in the D.M.J. (Clin.) has the qualification to establish as an expert in the field of Clinical Forensic Medicine when he gives evidence in court — he may be wrong at times, but the mere possession of the Diploma is proof that at some time he has undertaken comprehensive postgraduate study in the field. The Police Surgeon without the Diploma must be suspect as an expert — he has no proof at all that he has made the slightest effort to study his subject and he must establish himself as an expert in the eyes of the court.

The examination for the Diploma is not easy. The pass rate is about 50% of the candidates who present themselves for the examination. The maintenance of a high standard is essential if the Diploma is to mean anything.

It is to the advantage of the police, the courts, and to the good name of the Association of Police Surgeons of Great Britain, that all doctors who are called upon to examine the live victims of crime, and the perpetrators of such crimes, are as well qualified as is possible.

Failure to carry out a proper medical examination, or to take proper and relevant specimens, or to interpret correctly the findings of an examination have very far reaching results. In this modern age where assaults often carry heavier penalties than homicides, it is only right that society should expect the same expertise from the doctors who examine the living as they expect from those who examine the dead in medico-legal situations. Maybe, if the possession of the D.M.J. was a requisite for re-appointment as a Divisional Surgeon we would not hear Counsel say "Of course doctor, you are just an ordinary police doctor".

Having said that the examination is not easy, I must also say it is easily within

the reach of any practising clinician who has read the current text books, reads such journals as Medicine, Science, and the Law (the journal of the British Academy of Forensic Sciences) and who attends the postgraduate course in Forensic Medicine at The London Hospital, or at the Midlands Forensic Institute at Birmingham, or who bothers to attend the teaching seminars run by the Association of Police Surgeons.

It is no use whining after a mauling in court because Counsel knew more of your own subject than you did. The answer is to improve your own knowledge and expertise. This can only be done by postgraduate study, and the depth of your knowledge can only be measured by others if you have a qualification to show them.

Let me end by quoting a sentence from a paper that was given at the International Meeting of the Forensic Sciences in Toronto in 1969 entitled "THE PLACE OF THE CLINICIAN IN LEGAL MEDICINE".

Surely in the field of legal medicine, the living are as entitled to highly qualified and expert opinion as are the dead.

DR. DAVID M. PAUL, M.R.C.S., L.R.C.P., D.R.C.O.G., D.A., D.M.J. (Clin.)

Cambridge Institute of Criminology

The Institute was established in January 1960 (together with the Wolfson Professorship of Criminology) with the help of a generous grant from the Wolfson Foundation. A University Department, for administrative purposes, it is part of the Faculty of Law. It also has links with other disciplines, such as Medicine, and the staff includes the Reader in Clinical Criminology.

The Institute was created with two main aims: the teaching of Criminology – especially at the post-graduate level – and research of a penological, psychological and sociological kind. In addition, it provides Senior Courses for selected personnel in the penal system, and holds periodic Conferences for the discussion of recent developments or topics of special interest. Its extensive library is open to accredited visitors from other Universities and research institutes.

Graduates studying for the Diploma in Criminology must take five compulsory subjects: criminological theory and the sociology of crime; its psychiatric and psychological aspects; methods of criminological research; prevention of crime and treatment of offenders; and developments in criminal law and the administration of criminal justice.

The Director of the Institute is Dr. Nigel D. Walker, Ph.D., Litt.D., Wolfson Professor of Criminology. The Reader in Clinical Criminology is Dr. Donald J. West, M.D., Ph.D. Dr. West's published work includes: "The Habitual Prisoner" (1963), "Murder followed by Suicide" (1965), "The Young Offender" (1967), "Homosexuality" (1968), "Present Conduct and Future Delinquency" (1969), "The Future of Parole" (1972), and (with D.P. Farrington) "The Delinquent Way of Life (1977).

Dr. West will be addressing Conference on "Sexual Offenders and their Treatment".

Huntingdon Research Centre

Huntingdon Research Centre is a private concern which was formed in 1952. Contracts for research and routine testing are undertaken, and have included specific pesticide and pharmaceutical analyses, irritancy tests, full-scale investigations of drug safety which may require a number of animal species to be maintained and examined over a period of years, together with associated studies in metabolism and human pharmacology, and in clinical medicine.

A visit to the Centre will be made during Conference.

ASSOCIATION OF POLICE SURGEONS OF GREAT BRITAIN

26th ANNUAL CONFERENCE 16th - 21st MAY 1976

PRESIDENT : DR. FUAD A. GABBANI

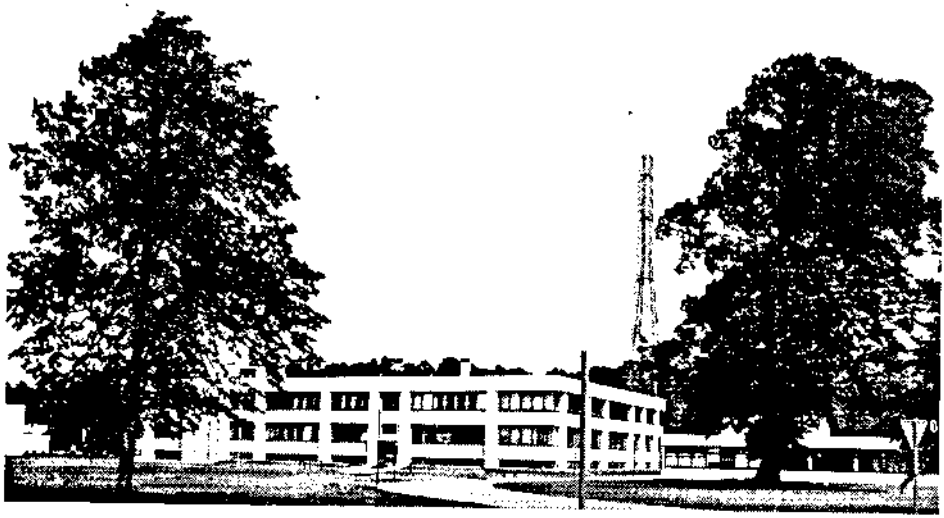
Cambridgeshire Hotel, Bar Hill, near Cambridge

CONFERENCE PROGRAMME

SPEAKERS

Dr. S.H. Burges, MB, BS, MRCGP, DMJ, President-Elect, Association of Police Surgeons of Great Britain.
Dr. Nicholas G.I. Cawdry, MB, BChir, Police Surgeon, Cambridge
Mr. Drayton Porter, QPM, OBE, Chief Constable, Cambridgeshire Constabulary.
Dr. P. Drummond, MB, BS, DIH, Divisional Medical Officer, Agrochemical Division, Fisons Ltd., Hawseton, Cambridge.
Mr. Fulton Gillespie, Crime Reporter, Cambridge Evening News.
Mr. Bruce W. Given, Fellow, Armed Forces Institute of Pathology, Washington D.C., Special Agent, Naval Investigative Service Headquarters, Alexandria, Virginia, U.S.A.
Professor G.A. Gresham, TD, MD, ScD, MA, FRCPath., Professor of Morbid Anatomy, University of Cambridge, Home Office Pathologist.
Dr. Peter Holland, MB, BS, MRCS, LRCP, MSc, BPharm, Chemical Defence Establishment, Porton Down, Salisbury.
Chief Superintendent B.E. Hotson, Cambridge Division, Cambridgeshire Constabulary.
Dr. I.H. Johnston, MB, BCh, BAO, Police Surgeon, Dungannon, Northern Ireland.
Mr. Norman Lee, BSc, FLS, East Midlands Forensic Science Laboratory, Nottingham.
Dr. Arnold Mendoza, MB, BS, MRCS, LRCP, DObst, RCOG, DMJ, MRGCP, HM Coroner for St. Albans and Watford, Hertfordshire, Deputy Coroner for Northern District, Greater London. Hon. Treasurer, Association of Police Surgeons of Great Britain.
Det. Chief Superintendent Naan, Criminal Investigation Department, Cambridgeshire Constabulary.
Dr. B.A.M. Smith, MBChB, MRCP, DCH, Consultant Paediatrician to the Sheffield Hospitals, Honorary Clinical Lecturer, Department of Paediatrics, University of Sheffield.
Dr. D.J. West, Reader in Clinical Criminology, Institute of Criminology, University of Cambridge.

Cambridgeshire Police Headquarters, Huntingdon



MONDAY, 16th MAY, 1977

Arrival

TUESDAY, 17th MAY, 1977

9.00 a.m. Leave Hotel.

Optional full day tour.

a.m. Guided tour of Cambridge Colleges with interval for coffee at the Blue Boar Hotel. Luncheon at Gonville Hotel, Cambridge.

p.m. Visit to Anglesey Abbey, 8 miles N.E. of Cambridge. Extensive grounds. Tour of House. (See page 52 for further details). Entrance to the Abbey is *free* to members of the National Trust on production of membership cards; nonmembers pay on admission.

7.00-8.30 p.m. Dinner.

8.30 p.m. Council Meeting.

WEDNESDAY, 18th MAY, 1977

a.m. Visits for limited numbers to:—

1. Cambridgeshire Police Headquarters, Huntingdon (Courtesy of Chief Constable).
2. Huntingdon Research Centre, Huntingdon.

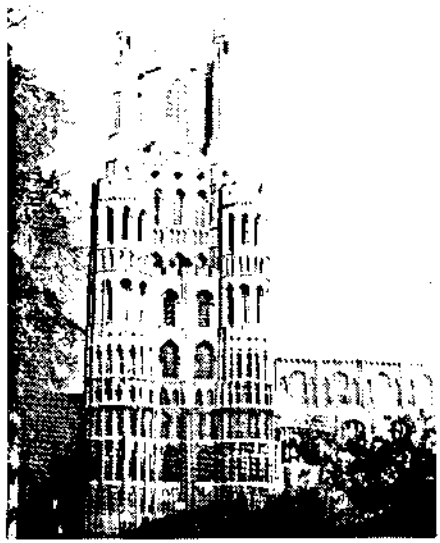
Optional visit to Ely Cathedral during the morning for other members and the ladies, coffee will be provided at the home of Dr. and Mrs. J. Hine of Ely.

12.15 p.m. The President entertains members of Council, first-attenders and their wives.

Lunch

Registration

Ely Cathedral



The following pharmaceutical firms will be exhibiting during Conference:—

Allen & Hanburys Limited
Geigy Pharmaceuticals
Hoechst Pharmaceuticals
Norgine Limited
Smith Kline & French Laboratories Ltd.
E.R. Squibb & Sons Limited
Syntex Pharmaceuticals Limited
Tillomed Laboratories

Other firms also exhibiting will include:

Air Call Limited (radiotelephones)
J.C.G. Hammond (antiquarian and out-of-print books on crime).

2.00 p.m.	**COMMENCEMENT OF LECTURES** Opening address by the Chief Constable of Cambridgeshire, Mr. Drayton Porter.
2.15 p.m.	Dr. P. Drummond – "PESTICIDES"
3.00 p.m.	Dr. Peter Holland – "ORGANO-PHOSPHOROUS POISONS"
3.30 p.m.	Tea
4.00 p.m.	Professor Gresham – "FORENSIC PATHOLOGY IN EAST ANGLIA"
5.00 p.m.	ANNUAL GENERAL MEETING
7.00 p.m.	Sherry Party given by Mrs. Gabbani for the ladies.
8.00 p.m.	Dinner
9.30 p.m.	Dancing. Display of Morris Dancing by Staploe Hundred Morris Men

THURSDAY, 19th MAY, 1977

SYMPOSIUM: THE CAMBRIDGE RAPES

9.15-12.00	Det. Chief Supt. Naan and Chief Supt. Hotson – "THE POLICE INVESTIGATION" (Interval for coffee)
12.00	Dr. N. Cawdry – "OBSERVATIONS OF THE POLICE SURGEON"
12.30 p.m.	Buffet Lunch
2.00 p.m.	Mr. Norman Lee – "FORENSIC SCIENCE ASPECTS OF THE CAMBRIDGE RAPES"
2.30 p.m.	Dr. D.J. West – "SEXUAL OFFENDERS AND THEIR TREATMENT"
3.30 p.m.	Tea
3.50 p.m.	Mr. Fulton Gillespie – "THE LAY OBSERVER"
4.20 p.m.	Discussion led by Dr. S.H. Burges

For the Ladies:–

2.30 p.m.	Cosmetic Demonstration by Vanda Cosmetics

6.00 p.m.	Dinner
7.30 p.m.	Buses leave for Theatre
8.00 p.m.	Arts Theatre, Cambridge "Double Edge" – a thriller by Leslie Deerbon starring Kate O'Mara On return from Theatre – Sandwiches and Soup. Dancing until 1.00 a.m.

FRIDAY, 20th MAY, 1977

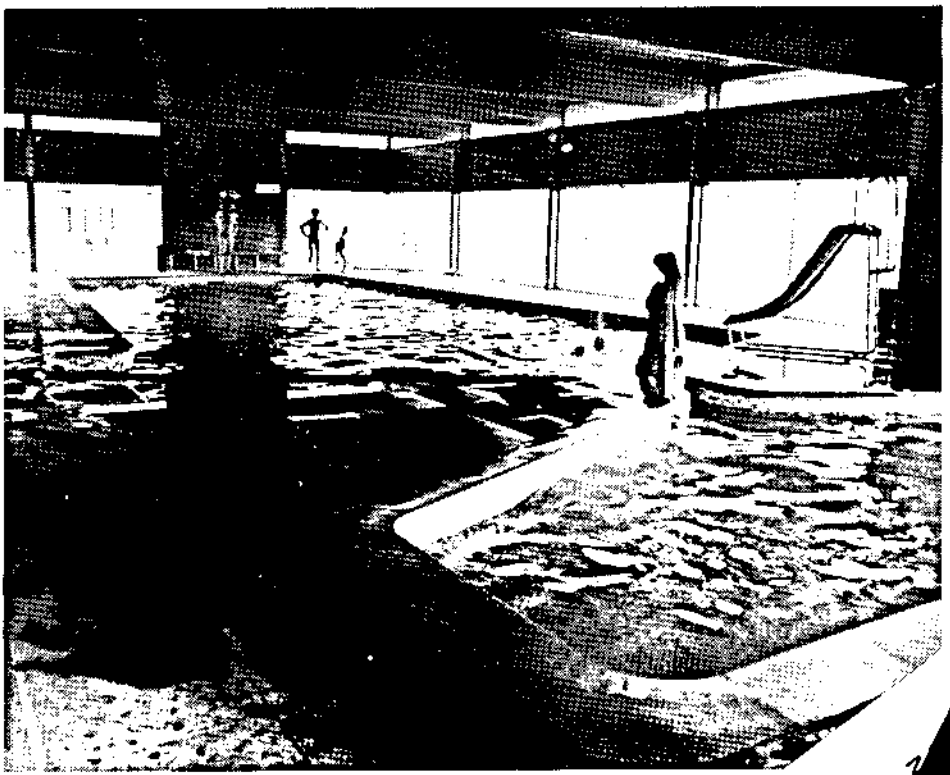
9.15 a.m.	Dr. I.H. Johnston – "RURAL CASEBOOK"

10.00 a.m.	Dr. B.A.M. Smith – "RECENT PROGRESS IN UNDERSTANDING COT DEATHS"
10.45 a.m.	Coffee
11.15 a.m.	Mr. Bruce W. Given – "THE COLLECTION, PRESERVATION AND ANALYSIS OF MEDICO-LEGAL EVIDENCE"
12.00 noon	Dr. Arnold Mendoza – "THE CORONER AND THE POLICE SURGEON"
12.45 p.m.	Group Photograph
P.M.	ULSTER CUP
7.30 p.m.	Reception by the President and his lady, Dr. and Mrs. Faud A. Gabbani
8.00 p.m.	Banquet
10p.m.-2.00a.m.	Dancing

SATURDAY, 21st MAY, 1977

Dispersal

Cambridgeshire Hotel Swimming Pool



VENUE:

Cambridgeshire Hotel, Bar Hill, Cambridge. A modern hotel with a purpose built conference suite. The hotel is five miles north-west of Cambridge on the Huntingdon road (A604). There are good car parking facilities at the hotel.

Leisure facilities at the hotel:

Tennis	—	free — bring your own equipment
Squash	—	light supplied by meter — bring own plimsols (not black soled).
Swimming Sauna	—	indoor heated pool — free
Golf	—	concessional rate £6.00 a day covers any golf played between 16th and 20th inclusive, payable in advance. Daily green fee is otherwise £2.00 per day.
Riding	—	1 mile from hotel.
Fishing	—	Grafton Water — 10 miles from hotel.
Hairdressing	—	For Ladies on Fridays — Advance bookings will be made if required (see booking form).

SECTION 63: The Conference has been recognised by the Post-Graduate Dean of Medicine, University of Cambridge as 4 full sessions towards the educational requirement for postgraduate training allowance and seniority payment. Claims for subsistence allowances and travelling expenses should be made on the appropriate forms and sent to your Family Practitioner Committee.

THE 'ULSTER CUP'

The "ULSTER CUP" will be played for on Friday, 20th May, 1977 on the Cambridgeshire Hotel Golf Course — 18 holes — Stapleford system of scoring.

The Winner will hold the cup for one year, and will receive a handsome glass tankard engraved with the Association Crest as a momento.

Combined entrance fee and sweep £1.50, payable to the Golf Captain during the Conference. Golf Captain: Dr. Robert Hunt Cooke.

GENERAL INFORMATION

Cambridgeshire Hotel, Bar Hill, Nr. Cambridge, Cambridgeshire. Tel: 0954 80555.

Manager: Mr. Umberto Marconi. Senior Assistant Manager with responsibility for conference arrangements: Mr. M.L. Harrison, MHCIMA.

Cost: 24 hour rate per person *exclusive of VAT:*

Twin occupancy	£19.50
Single occupancy	£23.00

The rates include English breakfast, morning coffee, lunch, afternoon tea, dinner, accommodation and service charge. All rooms have bathrooms attached.

Supplement for Banquet: Residents ..... £1.75 per person
Guests for the evening ..... £5.75 per person

All charges for accommodation, meals etc. to be paid direct to Hotel at the end of the stay.

Conference Fee (£15.00), Concessional Golf Fee (if required) and Excursion charges to be paid to H.G. TYSON & COMPANY, with application form.

ALL hotel bookings to be made through Association Travel Agent:
H.G. TYSON & CO., 53 Long Lane, London EC1A 9PA. Tel: 01-600 8677.

Conference Secretary: Dr. M.D.B. CLARKE, Vine House, Huyton Church Road, Huyton, Nr. Liverpool L36 5SJ. Tel: 051-489 5256.

BOOKING FORM FOR 26th ANNUAL CONFERENCE
16th to 21st MAY, 1977

Complete and return with cheque to H.G. TYSON & CO. LTD, 53 Long Lane, London EC1A 9PA.

1. TRAVEL TICKETS
   Please indicate 1st or 2nd Rail Tickets if required.
   From . . . . . to Cambridge

2. ACCOMMODATION (All rooms with bath).

   PLEASE RESERVE. . . . . Twin Bedded/Double Bedded rooms

   PLEASE RESERVE. . . . . Single Rooms

   FROM: ARRIVAL . . . . . TO: DEPARTURE . . . . . .

(Please note that the number of rooms with double beds is limited, and will be allocated in order of application).

3. GOLF
   I/we do/do not intend to play in the "ULSTER CUP" competition
   (please delete) on Friday 20th May, 1977.

4. HAIRDRESSING (Ladies)
   Please make a hairdressing appointment for:

   Mrs./Miss . . . . . .

   for a.m./p.m. Friday, 20th May, 1977.

5. NATIONAL TRUST
   I am a member and will be bringing my membership card
   I am not a member but will probably join
   I am not a member (Please delete)

6. BANQUET: Friday 20th May, 1977
   I will be / may be / will not be bringing . . . . . guest(s) to the annual banquet.

(Supplement charges for the banquet for resident guests will be charged on their accounts, unless specific arrangements have been made beforehand with the Conference Secretary. The charge for non-resident Guests for the evening will be £5.75 per head, payable to Conference Secretary *before* the banquet.

7. FIRST-ATTENDERS AT CONFERENCE
   Is this your first Association Conference Yes/No (please delete)

8. EXCURSIONS:
The following are required:
a) Tuesday 17th MAY, FULL DAY
..... SEATS @ £6.40 £ .....
b) Wednesday, 18th MAY,
Cambridgeshire Police HQ
..... SEATS @ £1.50 £ .....
Huntingdon Research Centre
..... SEATS @ £1.50 £ .....
Ely Cathedral (including coffee)
..... SEATS @ £3.15 £ .....

Seats for Police HQ and Research Centre are limited. Do you wish to go to Cathedral as alternative? Yes/No

c) Thursday, 19th MAY.
Visits to Arts Theatre, Cambridge
..... SEATS @ £3.15 £ .....
(including coach to and from Theatre and cost of Theatre Seat).

TOTAL £ .....

9. GOLF: Concessional rate for Conference, payable in advance (£6.00 per person) £ .....

10. CONFERENCE FEE: £15.00 per delegate £15.00

TOTAL PAYABLE TO H.G. TYSON & Co. £ .....

11. SPECIAL REQUESTS

12. IMPORTANT: COMPLETE IN BLOCK CAPITALS

SURGERY ADDRESS
(if different)

YOUR NAME. .....
ADDRESS: .....
.....
.....
.....
Tel. No:. .....Tel. No:. .....
Responsible Family Practitioner Committee/Health Board Cipher. .....
Prescription Pad Number .....
DATE RECD:. .....NO. .....
CONF. SENT:

THE POLICE SURGEON

Stanley H. Burges, MB, BS, MRCGP, DMJ

The Police Surgeon's job must be one of the few specialities in the medical profession about which the public, and, indeed, members of the profession itself are so ill informed.

This is not entirely their fault since 'who dunnits', the television, and alcoholic acquaintances recounting brushes with the law cannot be relied upon as sources of authoritative information. In fact, the title 'police surgeon' is misleading for no police surgeon is a policeman and rarely does he practise surgery.

The confusion is further compounded by the widely differing abilities, expertise, experience and workload of all those having a contractual arrangement with a police authority as a police surgeon. In many cases, the arrangement is that the police surgeon will confine himself to determining the forensic implications of alcoholic intoxication and driving. In others the practitioner is expected to be an expert with specialist knowledge of all aspects of clinical forensic medicine.

Members of the former group continue in the traditions of the public image of the police surgeon and still form the majority. Those in the latter group, though fewer in number, are represented in most conurbations of 150 000 persons or over. That such a cadre exists owes much to the Association of Police Surgeons of Great Britain who, over the past 20 years, have initiated and encouraged the dissemination of knowledge and formulated an acceptable code of practice.

To answer the question 'what is a police surgeon?' is as easy, or as difficult, as trying to define a nurse. He (or she) is a registered medical practitioner who, while exercising his professional obligations to the community in general and to his patients in particular, has contracted to provide medical assistance to agents of a police authority in the execution of the statutory duties of those agents. These duties are usually combined with those of a general medical practice.

The type and frequency of medical assistance provided is dependent upon the qualification and experience of the practitioner concerned, the incidence of clinical medico-legal cases in the area served and the degree of importance placed upon clinical forensic medicine by the police authority. It is usual for a police surgeon to make himself available to the police 24 hours a day. Appointed deputies share the workload to a greater or lesser degree.

Although working in close liaison with the police, a police surgeon should never become a constabulary puppet. A partial police surgeon quickly loses the respect of those he examines, his colleagues, the police and the courts.

This article first appeared in NURSING TIMES and was published on November 5th, 1976. It is reproduced by kind permission of the editor.

Forensic pathology

With few exceptions, those choosing to practise clinical forensic medicine are police surgeons. Forensic pathology is a closely associated discipline but forensic pathologists concern themselves, in the main, with the dead. Inevitably our paths cross, sometimes literally at a 'scene'. Here the fact of death has been established by the police surgeon and the circumstances are such that they warrant the attention of an available forensic pathologist who elects to start his examination before removal of the victim to the post-mortem room.

Forensic pathologists may be full-time specialists, as are those in university departments of forensic medicine, or they may be general pathologists with an interest in the forensic aspect of pathology. This interest may attract Home Office recognition – hence the so-called Home Office Pathologist.

Forensic pathologists have no contractual arrangement with a police authority but usually a working relationship develops between a particular pathologist and the police in any one area.

Clinical forensic medicine

To assume that police surgeons have a monopoly of clinical forensic medicine is presumptuous, arrogant and unrealistic. All medical practitioners – and indeed nurses – are aware of the ramifications of both criminal and civil law into the realms of medicine. Consent, negligence, wounding, diminished responsibility, place of safety orders, professional secrecy, are but a few examples of how the law can complicate our daily lives.

In the main most medical practitioners avoid becoming party to a criminal investigation. However, the police surgeon finds the work satisfying, and at the same time, provides a prerequisite for the adminis-

Fig. 1. The police surgeon's examination room at the Ipswich Divisional Police Headquarters

tration of certain aspects of justice.

The inexperienced soon become painfully aware that there are many differences between ordinary medicine and clinical forensic medicine. In clinical medicine, co-operation and honesty between patient and doctor are assumed; in forensic medicine, one assumes that the patient will not be co-operative nor honest. In clinical medicine, a diagnosis is usually a distillate of the probable; in forensic medicine, the remotely possible has to be given disproportionate consideration. In clinical medicine, there is time for thought, further examinations, and perhaps a second opinion; in forensic medicine, it is rare for the examiner to indulge in such luxuries; indeed in most cases a second examination is not only impossible but positively misleading. In clinical medicine, critical scrutiny of an examination, the method of that examination, and the conclusions of that examination by professional lay advocates would be intolerable; in forensic medicine it is the rule.

Figure 1 shows the police surgeon's room at Ipswich, the Divisional Police Headquarters, but, sadly, it is not typical of the facilities available to the majority in the UK. The general principles of good hygiene, adequate lighting and heating, functional medical and office furniture, accessible washing facilities, all pertain, but there are different emphases. It is absolutely vital that the room is sacrosanct and kept scrupulously clean, thus avoiding any possible risk of contaminating an examinee with false evidence.

Every effort should be made to overcome the almost insoluble problem of providing an atmosphere suitable for the examination of, on the one hand, a violent psychopath and, on the other, a recently assaulted child. The illustration demonstrates an attempt at such a compromise — impressionist prints on the walls and steel bars on the windows!

Types of case

The following types of case illustrate a representative workload of a forensic clinician serving a population of say, 100,000 people.

Drinking and driving

All police surgeons, however well qualified, find themselves involved with large numbers of drivers charged under Section 6 of the Road Traffic Act of 1972. The ill-informed assume that taking a blood specimen is the sum total of the exercise. Nothing could be further from the truth. The police surgeon, as well as following precisely the legal requirements necessary for a successful prosecution, has responsibilities for ensuring that disease, injury or drug intoxication are not factors in causing what is assumed by a policeman to be simple drunkenness (Fig. 2).

Fig. 2 Road Traffic Act 1972. Taking a blood sample

Fit for detention

Persons in custody do not have the rights of a normal citizen to provisions of the National Health Service. Medical attention when requested by the prisoner (or thought prudent by the station sergeant), is almost always sought from the police surgeon.

This duty has assumed particular importance in Northern Ireland where tireless police surgeons examine all prisoners, before and after questioning or detention, in the pursuance of the exposure of injustice or false allegations of brutality (Fig 3).

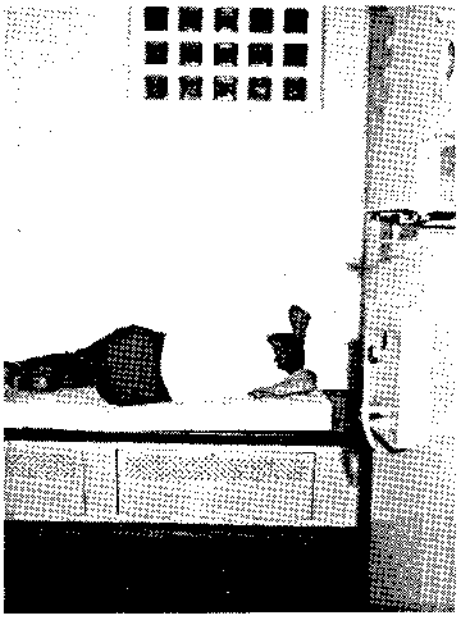


Fig. 3 Fit for detention?

Sexual offences

A competent examination in a case of alleged sexual assault requires much expertise if definitive and reliable evidence is to be obtained from the person examined, whether victim or accused. The police surgeon has a unique and important role in these instances. His failure to recognise or correctly interpret injuries or contact traces may have serious consequences.

The manner of the examination is important. No police surgeon should subject a victim to further unnecessary stress. Nor should he fail to make proper arrangements for the diagnosis of an unwanted pregnancy or venereal disease (Fig. 4).

The most common sexual offence for which a person is required to be examined is often referred to, albeit incorrectly, as 'USI' or unlawful sexual intercourse. In these cases, it is hoped that the police surgeon will provide evidence confirming or otherwise that a girl under 16 years of age has experienced sexual intercourse.

Fig. 4 Victim of rape?

Injured persons

Injuries sustained by a person may result in another person or persons being charged with a variety of offences; actual bodily harm, aggravated injury, maiming, grievous bodily harm, attempted murder (Fig 5). It is essential that these and other acts can be substantiated by accurate and responsible medical evidence if the courts are to be properly served and justice done.

Fig. 5 Assault occasioning actual bodily harm

Surprisingly, the police surgeon, perhaps the best equipped to examine these cases, sees only the minority. Most are dealt with by casualty officers or house surgeons. Surprisingly also, since not only are the hospital officers concerned often the most inexperienced, but they are the most reluctant to involve themselves in criminal proceedings.

While it is acknowledged that immediate and proper medical attention should be afforded to the injured, valuable and sometimes vital medical evidence might be the better obtained by a police surgeon acting in concert with the hospital doctors. How often is irreplaceable 'trace evidence' (that is, minute amounts of solids or liquids derived from another person or place), lost for ever by the enthusiastic efforts of the casualty nurse determined to clean a wound but unaware of the medico-legal implications? How often is a wound sutured before an expert opinion is sought to relate the original appearance to a possible causative instrument? How often is the victim's clothing destroyed, laundered or lost before blood stains or other identifiable evidence from an accused can be obtained from that same clothing?

Battered babies

The clinical features of the battered baby syndrome are now well chronicled. (Incidentally, a very significant part of this chronicling has been contributed by police surgeons).

The principles of examination are those practised in any other case of actual or grievous bodily harm. The forensic medicine clinician has become particularly involved for several reasons. First, he is often the first medical practitioner to examine the case, usually at the request of the police or the NSPCC. Second, when the victim is admitted to hospital, the consultant paediatrician is only too pleased to avail himself of the expertise of an experienced police surgeon. Third, the police surgeon can obtain his evidence without destruction of the patient-doctor relationship so often especially necessary between the paediatrician or general practitioner and the parent. Fourth, the police surgeon is able to assume the responsibility for presenting evidence at any subsequent court proceeding. Fifth, he can act as a line of communication between the medical staff and the police.

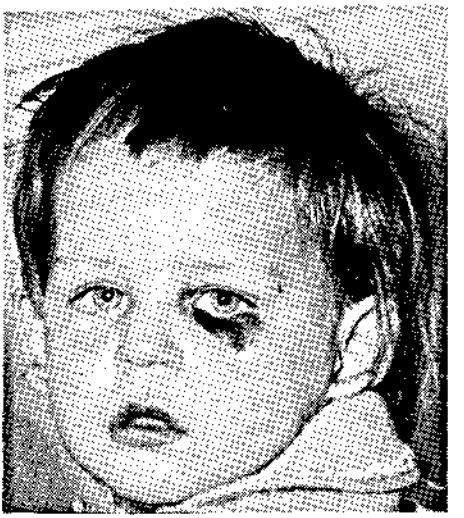


Fig. 6 Non-accidental injury?

It is interesting to note that, as a general rule, a police surgeon is tolerated in hospital in only two types of cases: in drinking and driving offences, where he has the backing of a Statute, and in suspected non-accidental injury when he readily accepts the more unpleasant aspects of the management of those cases (Fig 6).

Confirmation of death

A high suspicion index, humility and awareness of one's limitations, and a respect for associated disciplines are essential qualities in a police surgeon. These must be backed up by a good knowledge of police procedure and on awareness of forensic science laboratory requirements which will only be obtained through postgraduate study and, of course, by experience.

In cases of sudden death, particularly if there are suggestions of homicide, the skills of the police surgeon are particularly called to the fore. At a 'scene', a police

Fig. 7 Natural causes? Accident? Suicide? Homicide?

surgeon can, by his actions and opinions, destroy, preserve or reveal vital evidence, alert and deploy at vast expense significant resources of a police force either to good cause or wastefully, prejudice the apprehension of a homicidal maniac, contribute significantly to the prevention of further infirmity or death by submitting opinions to a coroner. He may also play a vital part in any subsequent investigation, especially in the examination of any person thought to be associated with a case of homicide.

Cot deaths, sexual asphyxia, carbon monoxide poisoning, suicidal death, and hypothermia are common examples of when a forensic medicine clinician may offer significant contributions (Fig 7).

Examination of police personnel

The physical examination of police recruits is within the terms of contract of many police surgeons. He is particularly well placed to conduct those examinations if only by virtue of his intimate knowledge of the working conditions of a policeman.

Furthermore, policemen have 'industrial' injuries, accidents and diseases akin to members of any other work force and again the police surgeon is particularly suited to assist in the proper functioning of the constabulary either by performing a medical examination or by giving professional advice (Fig 8).

The police surgeon in court

Since 1967 the police surgeon has been obliged to appear much less frequently in court to give evidence of fact or his expert opinion. The changes were effected by the conditions of the Criminal Justice Act of that year which provided that, in certain circumstances, evidence of fact may be presented to the court in the form of the written rather than the spoken word.

By and large the change has been enthusiastically received by police sur-

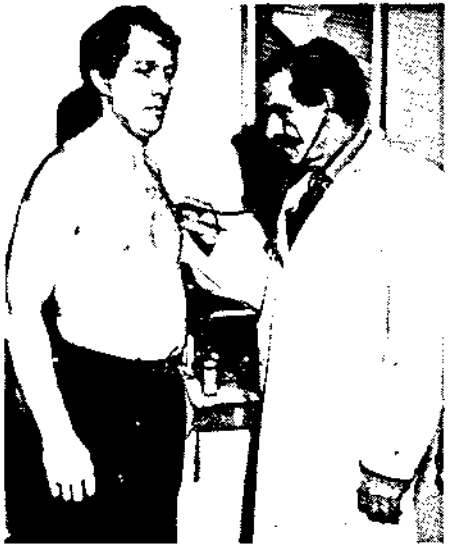


Fig. 8 Examination of police personnel

geons for many hours of time that was wasted pacing the corridors outside waiting to be called can now be put to more useful purposes. It has also obviated the experience, sometimes very traumatic, of cross-examination.

On the other hand, it is only by such scrutiny that the police surgeon remains aware of the absolute need for impartiality and fairness in offering evidence. A court appearance and a searching cross-examination can be of inestimable value in teaching the inexperienced vital lessons in humility, human fallibility and the importance of complete indifference by the professional witness to the verdicts of the court.

The future

Finally, what of the future for police surgeons? We look forward to an ever increasing number of interested persons becoming competent forensic medicine clinicians. We regard with fear and apprehension the continuing policy of politicians and university establishments in starving all aspects of forensic medicine, clinical and pathological, of the facilities at best to sustain the present establishment. Greater co-operation and liaison with associated disciplines is desired and we acclaim all efforts being made to encourage this. Last, but not least, we would welcome the consideration of a national body of forensic medicine clinicians who would devise a realistic career structure for those engaged in this type of work.

I acknowledge the help and encouragement of Mr. S.L. Whiteley, QPM, Mr. W.J. Ross, QPM, and other police officers of the Suffolk Constabulary for their assistance in the preparation of this article. I am also grateful to Mrs. Gwen Watt for typing the manuscript.

ANGLESEY ABBEY

Situated in remote fen country Anglesey Abbey was founded in 1135. It was a religious house for almost four centuries, its inmates professing the rule of St. Augustine.

In the four centuries of secular ownership that followed the dissolution of the monasteries in 1535, two men are worthy of note. The first is Thomas Hobson, who acquired what was left of the Abbey in the early seventeenth century. A Cambridge carrier who consistently refused to let out any horse except in its proper turn, he was the origin of the phrase "Hobson's choice" meaning "the choice Hobson offers you, or none!" The property went to his son-in-law, Thomas Parker, in 1627 and descended for a century in the Parker family. It was then sold to the second owner of note, Sir George Downing, whose estate went in 1800 to the foundation of Downing College, Cambridge.

In 1926 Anglesey was bought and transformed by Huttleston Broughton. The house and garden as they exist today, and the large collection of works of art, were his remarkable creation and achievement over the next forty years.

Huttleston Broughton was born in 1896. His father made a fortune in the United States in mining and railways between 1887 and 1912, and then returned to England and sat as M.P. for Preston from 1915-18. In 1929 Huttleston Broughton became Lord Fairhaven, being granted the barony that had been destined for his father.

Lord Fairhaven and his brother bought Anglesey because it lay conveniently near Newmarket and Bury St. Edmunds, where they owned the Barton Stud. The new owner was a dedicated and immensely

The South Front *photo: John Bettall*

wealthy patron of the arts. Methodically he set about the collection of the topographical paintings, the illustrated books, the eighteenth century snuff boxes, the Italian mosaics, the bronzes, the statuary, the tapestries and the furniture, which make Anglesey so fascinating and so unusual a house.

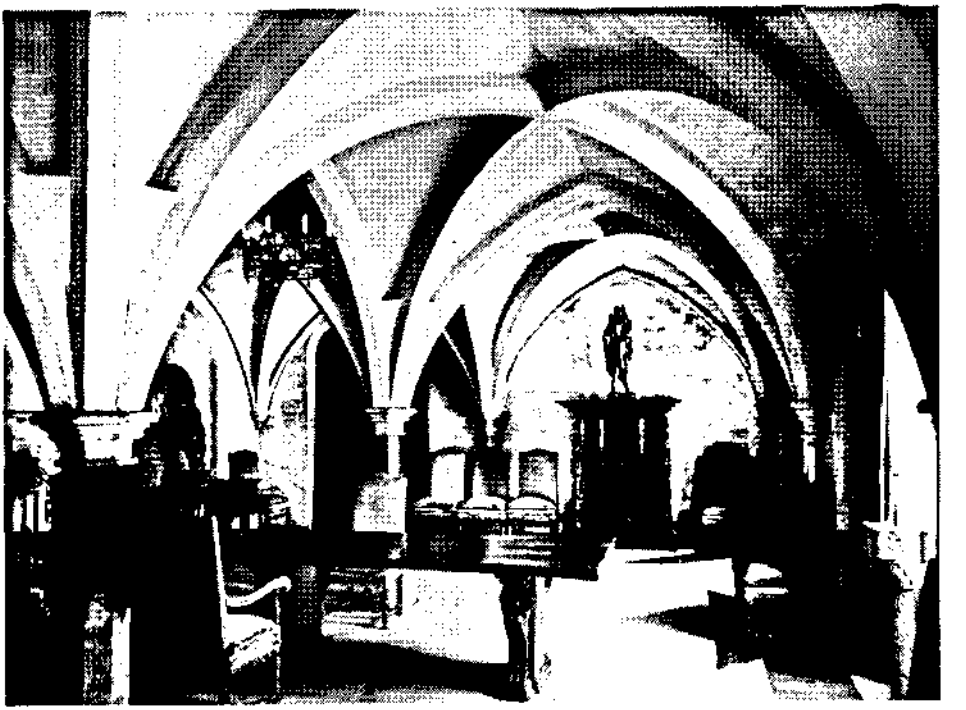
The House

Parts of the priory of Anglesey were substantially rebuilt in 1236 and the east end of the Chapter House still retains two thirteenth century buttresses. Somewhere about 1600 the Chapter House was converted into the main domestic dwelling. On the south or garden front it still retains the character of a manor house of the period. From 1926 onward Lord Fairhaven largely remodelled the interior of Anglesey, and made a number of additions.

The interior comes as a surprise. Its sumptuous furnishings and rare assemblage of Continental works of art perhaps evoke something of a great Long Island interior, recalling that Lord Fairhaven's mother came from New York. The muted lighting and the silver-gilt, the jewelled crucifixes, the Oriental hardstones, the Italian mosaics, the bronzes, the carved figure sculpture, and the tapestries, contribute to a richly exotic atmosphere that it would be difficult to parallel in this country.

The Dining Room, dating from the mid-thirteenth century, was once the Monk's Parlour, a common room used for meeting and recreation. The Long Gallery containing armour, mainly of seventeenth and eighteenth century manufacture, leads to the Living Room, originally the monastic Chapter House. One of many objects here with personal connections is the earliest known Garter, that bestowed by Henry VII on Maximilian I in 1489, four years before he became Holy Roman Emperor. The living room houses perhaps the most exotic of the numerous clocks for which this house is famous. It is an unusual Regency clock associated with

The Dining Room, once the Monk's Parlour *photo: A.F. Kersting*



the Brighton Pavilion, fashioned as a four-tier pagoda.

In the Oak Room the Jacobean plaster ceiling was copied in the late twenties from that of the Reindeer Inn at Banbury. This room is also noteworthy for its splendid display of continental silver.

Upstairs there are bedrooms, all furnished in the same sumptuous manner. There are several relics of the Napoleonic era including a circular tripod table used by Napoleon during his captivity on St. Helena.

The Anglesey library runs to some nine thousand volumes. Though there is an Aldine Catullus of 1502, and a number of other sixteenth century works, early printed books are not a notable feature of the collection. Its outstanding importance derives from the large number of colour-plate books, mostly published between 1770 and 1820, in which Lord Fairhaven specialised.

The library was added in 1938. The walls are lined from floor to cornice with bookshelves. The elmwood for these shelves was cut from the piles of John Rennie's Waterloo Bridge built in 1817.

Over half a lifetime Lord Fairhaven acquired a unique collection of views of Windsor. Comprising over 100 paintings, 150 water-colours and drawings, and 500 prints, the collection faithfully charts the changes in the landscape and architecture of Windsor Castle over a period of three hundred and fifty years and must be one of the most complete topographical records of any site. The Upper Gallery was built essentially to house this collection, but it contains other interesting works of art and furniture.

The Garden

The garden is among the most imaginative and successful combinations of formal and landscape gardening that this century has produced. With less than half a century behind them, the Anglesey gardens already have an authority far beyond their years.

A path from almost opposite the front-door porch in the East Wing, flanked by trees, winds through a belt of woodland known as the Winter Dell. In spring and early summer there are glimpses through the trees of grass bright with bulbs, speedwell, comfrey and cow parsley. The Dahlia Garden is entered between a pair of eighteenth century stone griffins. The garden is, quite simply, a curved enclosure between trimmed beech hedges. A single wide border within its outer curve is planted in spring with forget-me-nots and in autumn with mixed dahlias.

The Herbaceous Garden, a majestic semi-circle framed by beech hedges, illustrates the spacious proportions of Anglesey planning. A statue of Father Time presides over the generous green lawn, and the herbaceous borders are planted for early summer display, being at their best in June and July.

Beyond the herbaceous garden the path leads through a shelter belt to the river, which forms the natural boundary of the Anglesey layout along its north side.

Flanked on one side by poplars, a grass walk returns southward to the Emperors' Walk. This broad green walk, flanked by twelve busts of Roman Emperors and over a quarter of a mile long, is one of the best features of the Anglesey layout.

At right angles to the Emperors' Walk, a further grass walk stretching westward reveals the Temple, with Doric columns and copper roof in the Chinese taste. It shelters a unique porphyry urn, probably the largest piece of ornamental prophyry in England. Beyond the Temple, the grass walk crosses the Warriors' Walk — secret and umbrageous — to emerge on the informal expanse of the Arboretum.

Beyond the entrance drive, south of the Arboretum, the generous South Glade curves away to the west. The grassy hummocks flanking the opposing side of the glade mark the site of outbuildings and fishponds associated with the old priory.

Over half a mile long and planted in 1937 to commemorate the coronation of King George VI and Queen Elizabeth, the chestnut avenue is generous in scale and conception. A third of the way down its length there is a cross axis with vistas

north to the Circular Temple. This was set up in 1953 to commemorate the coronation of Queen Elizabeth II. It comprises ten Corinthian columns of Portland stone in an open circle, their bases are screened by a clipped yew hedge, and the entrance guarded by recumbent lions cast in lead. The central feature of the composition is a replica of Bernini's David.

At its far end the shelter belts close the Temple Lawn and only a narrow gap leads to the back drive. Thence a path winds through a wood past Narcissus, contemplating his image in a tranquil pool, to the Hyacinth Garden. This is one of the spring features of Anglesey, where four thousand hyacinths are planted every year to create a display of white and blue. They are followed in summer by dwarf dahlias.

Anglesey Abbey and its garden are the memorial to a man who was little known. Though he conscientiously fulfilled his duties in the country and regarded his wealth as in the nature of a public trust, Lord Fairhaven was outwardly reserved and austere. The ordered pattern of his life provided the framework for an elegance, a catholicity of taste, and a concern for works of art, that recall the eighteenth century rather than his own troubled times. This garden, his house and its contents, he endowed and left to The National Trust on his death in 1966.

The National Trust

Founded in 1895, the Trust is today the greatest conservation society in Britain and the country's largest private landowner. But it is not a government department: The Trust is a charity with membership open to everyone. It relies on the voluntary support of the public and the subscriptions and gifts of its members to maintain beautiful country and buildings of architectural or historic importance for the enjoyment of the present and future generations.

Conference Visit

Members will visit Anglesey House on Tuesday, 17th May. Entrance is free to members of the National Trust on production of Trust Membership Cards.

Members of the Association unable to visit the Abbey during the Conference may like to know that the House and Gardens are open from 2 to 6 p.m. on Tuesdays, Wednesdays, Thursdays, Saturdays, Sundays and Bank Holiday Mondays, from April to the Second Sunday in October. The Gardens are also open on Mondays and Fridays (except Good Friday) 2-6 p.m.

Cambridge

MY BOOKSHELF S.H. BURGES

The editor flatteringly requested of me "a list of current recommended reading material". There are two possible approaches to the problem, both unsatisfactory! One approach, of use only to booksellers and the British Museum, is to compile an exhaustive catalogue of all published works on the subject. The other, is to record what suits me. For this reason I have chosen the title "My Bookshelf" but readily accept that the choice reflects a personal viewpoint.

Forensic Medicine:

There is no textbook known to me which is entirely satisfactory for the needs of the Police Surgeon — Yet! There are many alleged textbooks of forensic medicine but most, in fact, are concerned with forensic pathology. Of those available, I refer most often to —

PRACTICAL FORENSIC MEDICINE
Camps and Cameron
Hutchinson

There is a no nonsense, reasonably priced, well presented volume by authors experienced in both the practice and teaching of forensic pathology.

My next choice is —

THE ESSENTIALS OF FORENSIC MEDICINE
Polson and Gee
Pergarmon

Though the emphasis in this book is even more on forensic pathology, it complements Camps and Cameron's manual by its contrasting presentation and style. Gee has written another book which, though lacking the elegance and sophistication of Polson and Gee, has usefulness as a handbook available in the glove compartment of the car —

LECTURE NOTES ON FORENSIC MEDICINE
Gee
Black Scientific Publications

Keith Simpson is well recognised as a prolific and reliable author on all aspects of forensic medicine but the seventh edition of —

FORENSIC MEDICINE.
Simpson
Arnold

is again more correctly a textbook of forensic pathology and the mould of the first edition of 1946 is still very obviously present in the text and style.

There are paperbacks on the subject and one worth reading is —

THE SCIENTIFIC ASPECTS OF FORENSIC MEDICINE
Polson
Oliver and Boyd

The justifiably well publicised —

GRADWOHL'S LEGAL MEDICINE
Camps
Wright

is on my shelf but in the form of the second edition. At £30 a copy, there can be few who can afford the third edition.

For most Police Surgeons, frequent visits to the Post Mortem Room is unrealistic and resort has to be made to an atlas for a visual impression of post mortem appearances. Production costs are high and ownership cannot be considered a top priority for Police Surgeons. I possess two and both have more relevance to forensic pathology than clinical forensic medicine —

A COLOUR ATLAS OF FORENSIC PATHOLOGY.
Gresham
Wolfe

ATLAS OF LEGAL MEDICINE
Watanabe
Pitman Lippincott

The Law:

I have no difficulties on this topic —

MORIARTY'S POLICE LAW
Butterworth

This book is authentic, definitive, relevant and the paper back version is cheap enough to replace with every new edition.

A very useful companion volume but, unfortunately, sadly in need of revision is.

GARSIA'S CRIMINAL LAW AND PROCEDURE
Sweet and Maxwell

Specialised Subjects:

The choice must depend upon the personal inclinations of the practitioner and I would not presume to impose my interests on others. In many cases, a trustworthy paperback is available on most subjects and I find my shelf has useful cheap editions on Drugs, Forensic Psychiatry, Violence, Alcoholism, Solicitors, The Police, as well as biographies of such persons as Marshall Hall, Bernard Spilsbury and Albert Pierpoint.

All textbooks have one big disadvantage — built in obsolescence. Scientific advances, changes in the Law and contemporary thought, are almost daily occurrences and no textbook can possibly be completely up-to-date. The practitioner of clinical forensic medicine should, however, be aware of these changes as and when they occur.

Changes in the Law:

Criminal Law Reform, either proposed or effected, may be gleaned from various sources. My own choice is —

THE CRIMINAL LAW REVIEW.
Sweet and Maxwell

This publication is authoritative and has contributors eminent in the fields of criminology and the law. It may be obtained by private subscription but few Police Stations are without a copy.

When an Act, Bill or Report has especial interest to a Police Surgeon, he may elect to purchase the authority itself. Amongst my own collection are included:

The Mental Health Act
The Abortion Act
Road Safety Act
Brodrick Report
Blennerhassett Report
Heilbron Report

Scientific Advances, Contemporary Thought and Review Articles:

There are many publications which provide the Police Surgeon with news of recent advances and trends as well as review articles on forensic subjects in general or of a specific nature. Most are the journals of professional organisations and are justification enough for the annual membership subscription;

The Police Surgeon is, of course, our own journal. The quality of production and content needs no comment.

Medicine, Science and the Law is the journal of the British Academy of Forensic Sciences and should at least be seen if not owned by every Police Surgeon.

The Forensic Science Journal is the journal of the Forensic Science Society and enjoys an international reputation as a means of communicating advances in Forensic Science. It is very academic and the emphasis is non-clinical.

The Medico-Legal Journal is the journal of the Medico-Legal Society. By no means obligatory reading for the Police Surgeon but highly desirable for a more complete appreciation of the whole spectrum of clinical forensic medicine.

graphed into the booth and place it at the correct height and distance, the booth would take a satisfactory picture on the insertion of the correct coin.

The method suggested below attempts to produce the same standardisation to the occasional photograph required by a busy non-photographer Police Surgeon.

For cheapness and simplicity, I chose a Kodak Instamatic 25 for my trials, but many other similar cameras will be equally satisfactory. The Instamatic 25 is a fixed focus camera, set at 15 feet, and will show in focus anything from 3 feet to infinity. Its F number is about 16. The Instamatic takes a film cassette, which is very easy to load, and almost impossible to insert incorrectly.

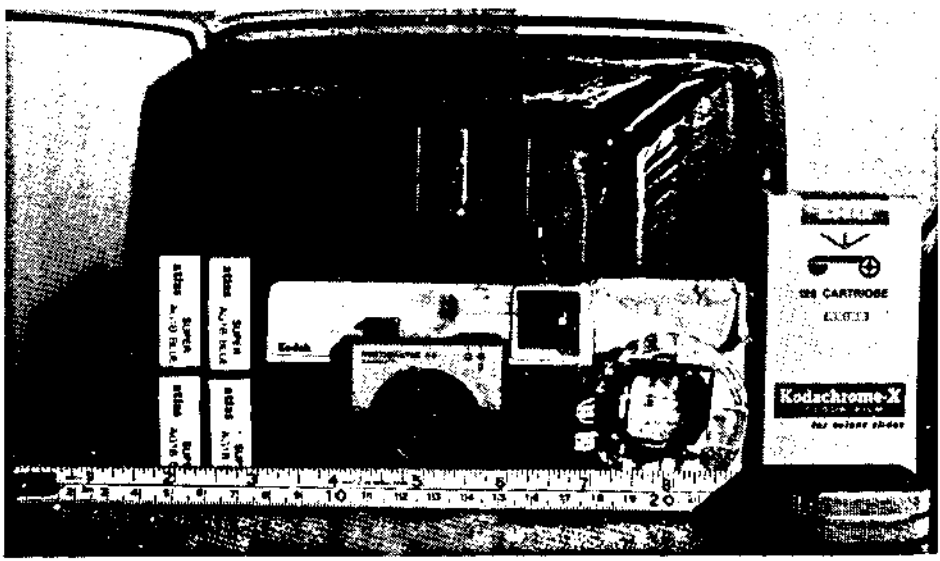
For close-ups between 2 and 3 feet, a close-up or portrait lens is required (1 dioptre) and this is easy to fit to the Instamatic. A flash attachment was used, taking AG1B flash bulbs. (Later models of the Instamatic use flash cubes). Electronic flash guns are not suitable for use with this type of camera.

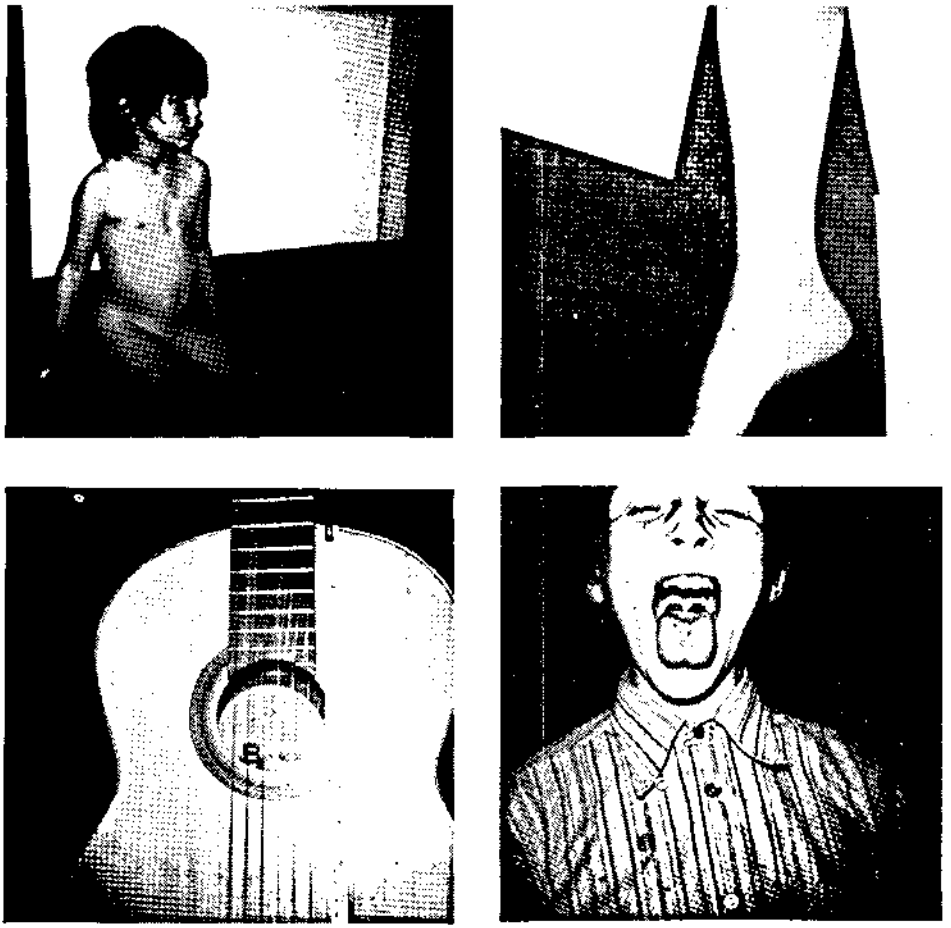
In my trials I used Kodachrome X film, which produces transparencies. Other films available are colour-negative film, from which colour prints are made, and black-and-white negative film, from which black and white prints are obtained. Whilst it is still cheaper to work in black and white, the price differential between black-and-white and colour is lessening constantly.

The flash bulbs or cubes are designed to be used with the object 4-9 feet from the camera, assuming average light reflection in an average room. At a distance of 2-3 feet, the flash would be too strong and would result in over-exposure. This can be avoided by making a diffuser from a small box, and replacing the front of the box with greaseproof paper. Alternatively, the flash bulb and its holder can be covered with a clean white handkerchief.

A measuring tape, preferably white, and marked in centimetres and inches, should be used to check the distance from camera to subject. It can also be used to lay alongside the lesion to be photographed to show its dimension. Lay the tape at right angles to the camera to avoid distortion. An alternative idea for measuring distances is to fix a piece of cord knotted at 2 and 3 feet to the camera. This gives an extremely easy and accurate method of checking distances for close-ups.

When taking close-ups, the view finder





Test photographs taken with the equipment described

on the camera will not be accurate because of parallax. By masking the upper third and outer fourth of the view finder with sellotape, a more accurate idea of the field of view of the camera lens may be obtained.

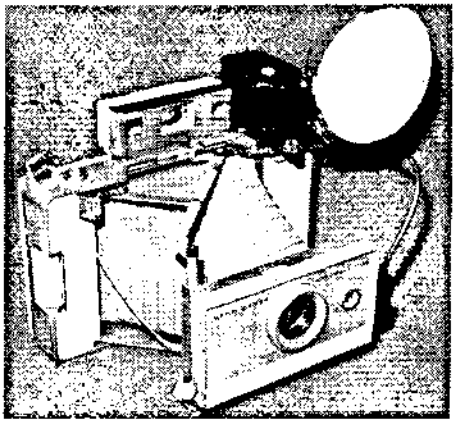
Taking close-ups may result in very dark shadows on the picture. These can be reduced by using a sheet of white paper or cardboard to act as a reflector, throwing the light into the shadow areas. White reflectors may "wash-out" skin features. Light green drapes, e.g. old operating towels, may be used as reflectors — the colour enhances the appearances of bruises, wounds and blood. Support the camera whilst taking the picture, if possible. This will reduce camera shake and subsequent blurring of the picture.

Practice is essential before adequate results are obtained. Use a notebook to record details of each photograph (distance, flash used with/without cover, time, date, etc.). Remember to get consent for the photograph when appropriate.

JOHN WHITE
CARDIFF

POLAROID CAMERA

INSTANT NOTEBOOK



The camera used to take the photographs illustrating this article.

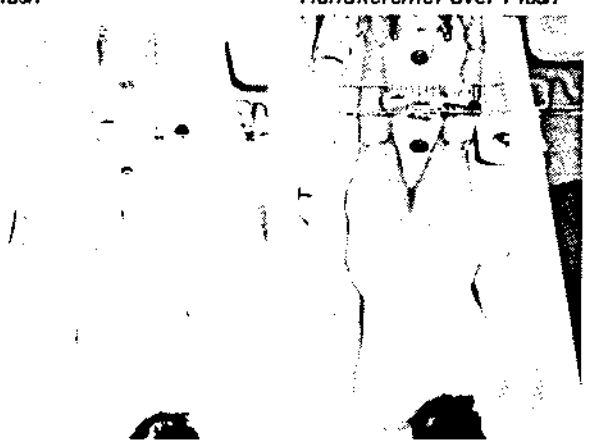
Recording the scene

For the inexperienced photographer, a Polaroid camera is of great benefit. If he doesn't get it right the first time — he can see the results in a minute or so — and take another shot. The 300 series of Polaroid camera is probably the most useful for the Police Surgeon, particularly the 355 model. The use of colour film with this camera does not justify the extra expense. The new but expensive 70SX Polaroid camera and colour film produce excellent results, but are probably too sophisticated and expensive to have significant advantage over the 300 series of camera for the Police Surgeon's work.

Mistakes can be corrected —

Available light

Flash



Handkerchief over Flash

Accidental death

Murder

As the Surgeon takes, develops and prints the Polaroid film himself, no problems arise with evidence.

Black and white prints can easily be duplicated or enlarged in the Police Photographic Laboratory.

The Polaroid camera can be used for:–

Recording the scene before disturbing it. If there are suspicious circumstances apparent from the onset, then police photographers must attend to record the scene. If there are no suspicious circumstances, it may not be possible to fully exclude a crime until a body is moved, and a record of the body and adjacent surroundings before movement can prove invaluable.

Recording general appearances and the state of clothing of a witness, prior to examination, particularly for one's own notes.

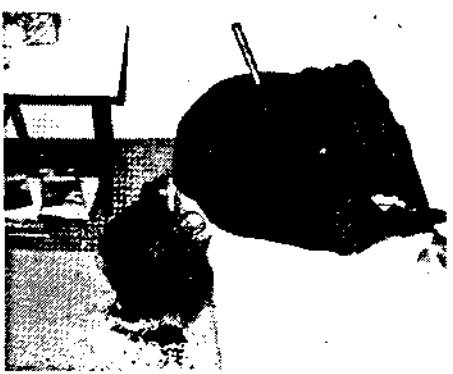
Recording the identity of a person examined. Impersonation at medical forensic examinations is not unknown.

Recording physical state of detainees before interrogation by the police, where allegations of assault by the police may later be made, e.g. terrorists. A photographic record can be made before and after questioning. As the photographs are taken and developed by the Police Surgeon, the police photographic department cannot be accused of "touching-up" the photographs.

The more sophisticated Polaroid cameras have close-up capability which produce quite satisfactory results.

Photographs should not be used for other than evidence or record purposes whilst legal proceedings are still being taken.

Murder



THE NEW POLICE SURGEON

PROGRESS REPORT

S.H. BURGES

I feel like the celebrated pianist who faced death at the end of a Colt 45 but was judged by an unprejudiced onlooker as a musician giving of his best.

Perhaps the next conference may include a lecture on "The absolute need for patience when embarking upon writing and publishing a textbook of Clinical Forensic Medicine".

May is still the target date for publication and I am still full of optimism.

How tempting to stimulate the publishers into a more enthusiastic approach by including, at this late stage, a chapter on "A ballistic appraisal of the guns of Navarone" by Alastair McClean, or, "Non-Accidental Injury at No. 10" by Joe Haines, or even, "Toxicology, a Leporine Viewpoint" by Richard Adams.

Not the least of my worries now is the task of grafting on to 18-month old stock the buds of Statutes, Bills and ideas introduced since late 1975.

Ralph Summers knew a thing or two when he nominated another editor!

CONTENTS

The Police Surgeon — Police Organisation — Examination of Police Personnel — Examination Room and Equipment — Examination of the Living, General Principles — Scene of Incident — Examination of Injured Persons — Injuries due to Gunshot Wounds, Explosive, and Fire — Sexual Offences and Allied Subjects — Non-Accidental Injury in Children — Sudden Death — The Management of Drug Problems — Alcohol Intoxication — The Examination of Mental Abnormalities — Poisoning — Forensic Pathology in the United Kingdom — Judiciary System in the United Kingdom — Legal Responsibility — The Police Surgeon as a Legal Witness.

MEETINGS FOR 1977 and 1978

Spring Symposium 1977 of the FORENSIC SCIENCE SOCIETY, in association with the Association of Police Surgeons of Great Britain.

1st and 2nd April
Strathclyde University

Annual Conference 1977 of Association of Police Surgeons of Great Britain.

16th-21st May 1977
Cambridgeshire Hotel, Bar Hill, Cambridge
(see page 37)

Autumn Symposium 1977 of Association of Police Surgeons of Great Britain.

16th and 17th September 1977
University Halls of Residence, Liverpool.

Speakers who have provisionally agreed to take part in the Liverpool Symposium include:

Dr. Godfrey, Divisional Police Surgeon — "Tattoos"
Dr. N.J. de Ville Mather, Consultant Psychiatrist — "Arson"
Mr. R.H. Nicholson, County Prosecuting Solicitor — "The County Prosecuting Service and the Police Surgeon"
Chief Inspector Owen, Drugs Squad Merseyside Police — "Current Trends in Drug Abuse"
Mr. Kenneth Oxford, QPM, Chief Constable, Merseyside Police
Dr. Elizabeth Rees — "Sexually Transmitted Disease and the Police Surgeon"

Annual Conference 1978 of Association of Police Surgeons of Great Britain.

8th-13th May 1978
The Palace Hotel, Torquay

Autumn Symposium 1978 of Association of Police Surgeons of Great Britain.

September 1978
Northampton

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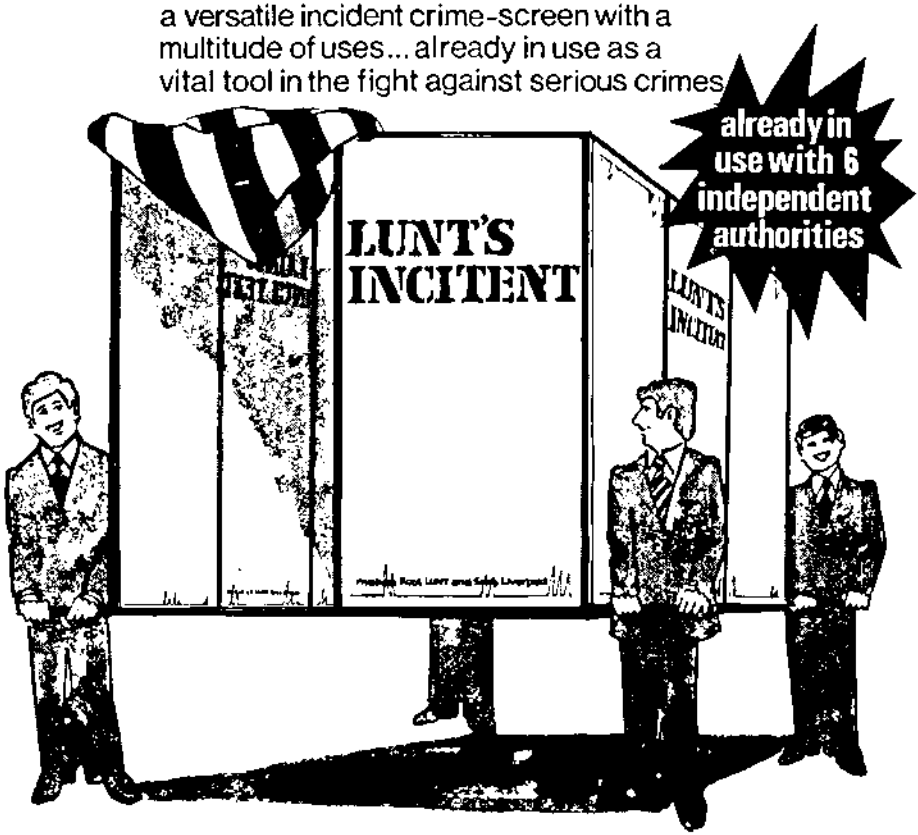

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CORRESPONDENCE

CHANGE OF NAME OF THE ASSOCIATION

To: Dr. Hugh de la Haye Davies, Hon. Secretary, A.P.S.G.B.

From: Dr. John H.H. Stewart, Chairman, Northern Ireland Branch.

Downings, 18, Portglenone Road, Randalstown, Antrim.

4th January, 1977.

Dear Hugh,

I recall that a suggestion was made at the last Conference regarding consideration of a change of name for the Association. With this in mind, we are intending to place a Resolution before Council — and if they accept it, before the AGM — to the effect that we should henceforth become —

THE ASSOCIATION OF FORENSIC MEDICAL OFFICERS

Our prime reason for this lies in the fact that there is now a tendency quite apparent here among miscreants and their legal advisers to equate the Police Surgeon with the Police establishment and to attempt to show thereby that the Surgeon is not in fact an independent Doctor. At the same time, I must hasten to add that so far no individual accusation has ever been successfully levelled at any of our Members to the effect that they have shown any bias whatsoever.

Nonetheless, we feel that it would be advisable to get away from the suggestion of close association with the Police which the present name implies, and indeed with the likelihood of the Blennerhassett Report helping to bring about a new Road Traffic Act in Great Britain which may well alter the whole scope of the work of our Members, the implication in the new title would be of particular concern in Forensic Medicine.

Our view has been very strongly reinforced by a Judge of the High Court here, who has taken many of the Diplock Trials (that is a Judge sitting alone without a jury) in cases of terrorism over the last few years, who told me personally only a few weeks ago that he considered it essential that we should change our name from that of Police Surgeon in view of the implied association. He went further and actually suggested a title along the lines of State Forensic Medical Officer.

A further pointer has been noted by one of our Deputy Surgeons in Belfast, Dr. John McClure, who found an advertisement in I think the Lancet for a "State Forensic Medical Officer" in the Federated Territories of Australia.

He kindly sent me a copy of this advertisement, and the job description was entirely similar to that of the Police Surgeon.

My earlier remarks in this letter, while initially applying to Northern Ireland, may well soon become equally apposite in Great Britain in view of the obvious attempts by so many groups to run down the Police at every opportunity. In so many cases, both on the Mainland and here, the only protection which the Police have is the fair and unbiased opinion of a Police Surgeon, and therefore I am sure that they themselves would be anxious to see any move made which would safeguard their position in this respect.

I thought that before this proposed Resolution was placed in front of Council, I should let you know the thinking behind what we are suggesting.

I should add that I personally would be very sad to see the old and respected title of Police Surgeon being dispensed with, and am mindful of the honour brought to that name and of the respect in which it has been held over so many years by reason of the dedication of

many of our Members, particularly those who led the Association throughout its early years. In those days however, law and order prevailed throughout our land and was upheld by all but the wretched few. Since we have now reached a stage where even allegedly responsible people and those in high places never miss an opportunity to discredit the Police, then we must accept that circumstances have sadly altered and be prepared ourselves to meet a new situation.

Yours sincerely,

JOHN

To: Dr. John H.H. Stewart.

From: Dr. Hugh de la Haye Davies.

Association Office,
Northampton.

21st January, 1977.

Dear John,

Thank you for the receipt of the Northern Ireland motion you wish to put forward at the AGM. I will circulate this to the membership in due course. Council did discuss the motion and everyone appreciated the reasons behind your suggestion, especially in the situation you and your colleagues find yourselves. We are agreed it must be seen that you are independent medical referees and that the title "Police Surgeons" can have grave consequences as a result of misinterpretation. May I suggest that those of you who wish to adopt the title of "Forensic Medical Officer" should do so immediately and notify the Judiciary and the Chief Constable of the R.U.C. that some or all of your members may adopt this title. We do have a precedent over here where I know of two Police Surgeons who have taken the title Forensic Physician in order to have an entrée into Hospitals dealing with battered baby cases where originally there was some resistance to police involvement.

The fact that your own members adopt such a title will not preclude them from membership of this Association as the Constitution quite clearly lays down that membership is open to all registered medical practitioners actively engaged in police work which of course your members are, whatever title they choose to adopt.

Regarding the change of name of the Association, as the matter will be debated at the AGM, it is not for me to comment here except to mention that in the Council discussion last Saturday some strong opposing views were put forward which will no doubt be re-iterated at the AGM.

Yours sincerely,

HUGH

Hon. Secretary

The relevant part of the advertisement referred to in Dr. Stewart's letter is as follows:—

Applications are invited from both men and women who are qualified medical practitioners for the position of **FORENSIC MEDICAL OFFICER** working in association with the A.C.T. Police Force. Salary, to be negotiated depending on qualifications, will be within the range $A20,000-23,000; at present exchange rate £1 = $A1.44.

The successful applicant will be required to carry out a number of diverse duties dealing with all forms of Forensic Medicine, including :—

a. Examination of people suspected of alcoholic impairment. Such examination should take into consideration the role of alcohol, diabetes, drugs, carbon monoxide, cardiovascular disease, mental disorder, epilepsy, or trauma. Provision of expert advice in Court may result from these examinations.
b. Examination of cases of common assault, rape, carnal knowledge and battery and provisions of expert advice in court.
c. Examinations related to alleged murder, alleged suicide, cot deaths, accidental deaths and sudden deaths of any nature.
d. Examination of cases of drug abuse.
e. Examination of police on sick leave or injured on duty.
f. Provision of medical support to police in dealing with dangerous persons at large, search and rescue operations and motor vehicle accidents.
g. Treatment of persons taken ill while in custody.
h. Lectures to police and recruits on the operation of the breathalyser, forensic medicine, alcoholism, drugs and first-aid.

27th January, 1977.

Feelings of discontent seem to be current concerning the title of our Association. Firstly, because of the inclusion of the word "police" implying that we may be partisan, and secondly, because the title does not technically include those members who work and practice in far flung parts such as the Channel Islands, the Isle of Man and Northern Ireland.

Speaking personally, after a long association with police and having professional and social links over many years, I am proud to be called a "Police Surgeon". I am pro-police and for the ethos that they represent. My professional integrity, however, allows me to stand apart and I equally value my independence as a medical opinion to the Courts.

Our Association has been in existence for 25 years and under its present name has international reputation. We welcome members from other countries, indeed we have a Dutch member, but I have yet to hear it mooted that the name of the Association should be changed to accommodate him. I would not expect, were I and a number of colleagues to join a medico-legal society in another country, that the name of that society be altered and for the reasons I have outlined in my letter I am strongly opposed to any suggestion that the name of our Association should be altered.

PROLEX

ACT OF RAPE

Letter sent to the British Medical Journal, Radio Times, Police Review, Pulse, G.P., and World Medicine.

10th February, 1977

Dear Sir,

re: "ACT OF RAPE", BBC 2, SATURDAY, 22nd JANUARY, 1977.

Further to the review by Professor Laurie Taylor published in the Radio Times 5th February and subsequent correspondence in the Radio Times of 12th February, we write on behalf of the Association of Police Surgeons of Great Britain. Many of our members have complained about the impression the play set out apparently quite deliberately and certainly successfully to give of the Police and to a lesser extent the Police Surgeon — the plaintive cries and later screams of the victim while in the Surgeons room together with the fact that the Police Officers outside could hear everything that was going on therein gave an impression of a complete disregard by the Police Surgeon of normal medical ethics and courtesy to one's patient. The Doctor and the Senior Police Officer on the panel were repeatedly interrupted by the interviewer who allowed uncomplimentary remarks by other members of the panel to go unanswered.

I would stress that this Association and indeed our Police colleagues would not tolerate such behaviour by a doctor who would be very quickly removed from the Police Surgeon's rota. We concede as Barbara Toner, author of the recently published report "The Facts of Rape" has implied in her chapter on the medical and forensic examination that all is not well in some areas and there is room for improvement in these areas but she has written a fair and well balanced chapter which gives a much more truthful picture of the subject than the BBC programme*.

Since 1967 this Association has been pressing for proper medical facilities at Police Stations and indeed in 1968 sent recommendations to the Home Office for the design and equipment of medical rooms. Following our evidence to the Heilbron Committee, Home Office Inspectors of Constabulary have notified Chief Constables that these facilities will

be specially inspected this year. We hope economic reasons will not be the excuse for failing to bring medical facilities up to the proper standard as the cost of providing these at one Police Station is less than the cost incurred in the investigation and subsequent trial of a rape case. Furthermore while deploring the type of behaviour shown on the programme this Association by education and example continues to improve the conduct of these examinations. Most Police Authorities now actively encourage their appointed Police Surgeons to become members of the Association from our personal knowledge of our members, we are sure that they do strive to carry out a difficult and sensitive task with the dignity and professionalism they would expect to be shown to one of their own family in such circumstances.

On a more general note let this programme serve as a warning to any expert of any discipline who chooses to appear in these "panel shows", whereby being allowed to only part answer a question, false impressions are created which may or may not be the intention of the producer who wishes to use experts unfamiliar with TV techniques to support his or her line of argument.

We remain,

Yours truly,

President: **Dr. Fuad A. Gabbani**

Hon. Secretary: **Dr. H. de la Haye Davies.**

***The Facts of Rape, by Barbara Toner Hutchinson & Co. (Publishers) Ltd. — hardback. Arrow Books Ltd. — paperback.**

NORTHERN IRELAND MEDICO-LEGAL SOCIETY

40 Green Road,
Belfast

February, 1977

Dear Myles,

I have to report the successful birth of the Northern Ireland Medico — Legal Society, in September 1976.

This brain-child is a product of genetic engineering rather than spontaneous combustion. It was conceived many times and in many places (superfecundation?) beginning in Belfast, on the over-crowded stony hard benches outside the Grand Jury Room (before the latter's unmourned demise) and subsequently in Edinburgh, London and Zurich.

The gestation period was unduly prolonged as the time never seemed to be right and always out of joint. Eventually we decided that the time was now or never, and that we should immediately undertake its ante-natal care and the induction of labour. There were six of us — and as someone remarked, Hitler started with less! Five Police Surgeons — Arthur Eakins, Bertie Irwin, Ronnie Ormande, John Stewart and myself plus our colleague Derek Carson, an eminent forensic pathologist, known throughout Ulster as the only pathologist who carries a stethoscope (since one of his bodies moved in the mortuary).

These enthusiastic accoucheurs decided to make the birth legal and so a meeting was arranged with and at the Bar. Bacchus being willing the enthusiastic co-operation of a trio of non-medically qualified midwives, i.e. our legal colleagues, John Creaney, Michael Lavery (both Q.C.'s) and the inimitable Fergus McCartan (Area Director of Public Prosecutions for South Antrim) resulted in a relatively painless birth with no complications but a lot of hard labour.

The date of induction was September 28th, and the place B.M.A. House, where those of our colleagues who attended the Joint Police Surgeon Association and Forensic Science Society meeting in September 1974, may remember having

lunch.

In line with current psychological thought, father was present at the delivery. But who is father?

The ultimate onus of paternity was laid on our first President, Sir John Biggart, by reason of his having given (? impregnated! ...) an abiding interest in forensic medicine during his lectures – the best attended and most popular in the medical student's curriculum.

The Society's first few months have certainly not been dull or uneventful. We now have a lusty thriving infant.

We hope our infant will grow up to be a force for good law and justice in the community and that relations and communications will grow between the two disciplines. We have ideas for pre- and post-graduate interdisciplinary education.

Our Vice-Presidents are The Right Hon. Sir Robert Lowry, Lord Chief Justice, and Prof. T.K. Marshall, State Pathologist.

The meetings have been held in The Ulster Medical Rooms in the Medical Biology Centre, by the kind permission of the Ulster Medical Society.

At our first meeting on November 30th, 1976, The Hon. Mr. Justice MacDermott gave a stimulating and thought provoking address on "The Expert Witness", which was received with attention and enthusiasm. A free discussion followed, which regrettably (if advisedly) was not taped.

Our second meeting was addressed by The Right Hon. Edward Jones, Lord Justice of Appeal, the subject being "Expert Evidence on the Criminal Side". Once again, we were very fortunate in our speaker, who leavened the law with anecdotes from his vast experience.

If any of our Police Surgeon colleagues would like to attend our meetings, we would be delighted to see them, and can promise them an entertaining meeting. Anyone interested please contact me.

With regards,

ELIZABETH McCLATCHEY
Hon. Secretary, N.I.M.L.S.

POLICE SURGEON SUPPLEMENT

Gillingham
Kent

November 1976

Congratulations on the Supplement which, I feel, is an excellent idea, well carried out. What sort of contributions do you expect from the members for it?

K.F.M. Pole

A number of letters approving of the first issue of the Supplement were received Two letters arrived noting that honours or qualifications had been omitted from the List of Members. The next List will be published Spring 1978, and any further corrections will be gratefully received.

Study of the first two issues of the Supplement will reveal that almost any type of contribution will be considered for publication. Reports of meetings, humorous occurrences, cartoons, letters, reports from abroad on medico-legal work, photographs and curious items from the press, particularly local papers, will all be welcome. Items more suitable for publication in "The Police Surgeon" will be forwarded to the Editor of the Journal.

Ed.

Hawkhurst Court
Wisborough Green
West Sussex

November 1976

Dear Daddy,

I received your magazine last night and enjoyed looking through it. My friends at school award you a 'B+' but I award you an 'A+'.

Nicholas

Thank you Nicholas. Meaningful talks concerning your pocket money will now be entered into. Ed.

HERBERT'S HOBBY HORSE

A PERSONAL VIEW

THE ROAD TRAFFIC ACT – A FUND FOR LAWYERS

CASE 1

Prosecuting Solicitor: "Do you think Doctor that Mr. M's refusal to provide a blood sample because he has a gastric ulcer was a justifiable reason?" Police Surgeon: "No Sir, the taking from Mr. M of 5 ml of blood would not effect his condition, and I told him so".

Police Surgeon in reply to Magistrate's question: "The taking of this amount of blood from a very ill patient in an Intensive Care Unit would not materially affect the patient's condition".

This was Mr. M's 3rd appearance in Court following his refusal to provide a blood sample.

First appearance – The usual adjournment for Legal Aid Application.
Second appearance – Adjournment to instruct Defence Council.

Then numerous postponements to ensure Police Surgeon and own G.P. could attend (the latter to say his patient did have a gastric ulcer and – a slip up – that he was advised not to drink).

During an adjournment the Police Surgeon had a quick cup of tea with defending Barrister.

"You have not got a case" he says, "I know", he says, "but I cannot tell my client that".

CASE 2

Refusal to provide sample of blood or urine.

Court scene after four adjournments –

1. For legal aid application.
2. To instruct Council.
3. For Prosecuting Solicitor to peruse case papers.
4. "My client has lost his driving licence" says Council.

Two months later, after duplicate licence is obtained from Swansea, Case goes on.

Time interval since offence – 8 months.

Defending Council spends all day trying to confuse witnesses.

He keeps telling Police Surgeon he spoke to his client in the corridor.

Police Surgeon keeps telling Council and Magistrate that he saw accused in Police Surgeon's room.

When Police Surgeon asks Magistrate, after 10 corrections of Council, if it could be accepted that accused was seen in Police Surgeon's room, Council demanded a new trial on grounds that if Police Surgeon's statement accepted, Bench implies his client is lying.

During lunch adjournment, Council tells a witness with whom he is lunching "my client has no case at all, all I can do is to try and tie up some prosecuting witnesses".

The above case did not go to Crown Court where so often a not guilty plea is precipitously changed to a guilty one.

CASE 3

Police Surgeon called later as defence witness, is sent for in the middle of the night by friend's hysterical wife to bring friend home from the police station. Friend reasonably co-operative and comprehends procedure. Colleague takes blood sample.

Crown Court Scene — Conference before Trial.

Expensive Council from London.

"Now doctor you told Mr. A (the accused's solicitor) that my client was reasonable and co-operative when you saw him in the police station. The police say that when they apprehended him one hour before, he was aggressive, abusive and obstructive. You will be able to say he was not".

Police Surgeon says that he cannot say, he was not there. Barrister (chides) "Come, come, Doctor, you will be able to say in your case that as he was co-operative when you saw him, he would in all probability have been the same one hour before".

Police Surgeon demures.

Council and Solicitor dismiss him contemptuously. He is not called as witness. His friend, the accused, when eventually acquitted does not speak to him for a year.

(By the way, it is not important and perhaps it should not be mentioned, but friend's blood alcohol was 248 mgm/100 ml).

The Blennerhasset Report, whilst certainly not acceptable in its entirety, does make the proposal that (1.24-4 Page 6) "the proof of an offence should not be unreasonably dependent on compliance with procedural requirements" and further (8-2 page 32) that, "the link between specified procedure and proof of offence ought to be broken" and ... "the Court should be empowered to disregard a departure from specified procedures or instructions, where no injustice would result".

One can envisage the arguments that would be put forward about what or was not specified procedure and the interpretation of the phrase "should not be unreasonably dependent" would provide even more loopholes for the driver who had a blood alcohol in excess of the prescribed limit.

The ability of defence Solicitors and Barristers to persuade the Court to ignore the blood alcohol level must be more strongly curtailed. There should be a fixed fee paid to finance the defence of drivers who have excess alcohol in their blood and who enter a "Not Guilty" plea. The fee could be negotiated between the Government and the Law Society.

If legal aid is granted to the defendant the amount granted should not cover more than half of this fixed fee — the balance to be paid by the defendant in advance of Court proceedings.

Fewer ridiculous defences would then be offered; the Police would be encouraged to apprehend drunken drivers and the roads would be safer for us all, including our legal friends.

N.B.: In order to stimulate the flagging interest of Solicitors and Barristers which would result, an incentive scheme could be devised e.g. Council and Barristers could receive bonus for getting the acquittal of an accused whose blood alcohol was above 200 mgm/100ml.

H.B. KEAN
MERSEYSIDE

A man appeared at Great Marlborough Street Court, charged with indecent exposure. He gave his occupation as "tool sharpener". The arrest was made by an Inspector Flashman.

Reported in The Sunday Times, 14.11.76

GLOSSARY OF SLANG

It will not take the tyro Police Surgeon long to discover that a working knowledge of slang and colloquialisms will be of considerable assistance in the police station. Both the police and their clients have their idioms. With increased contact, slang which originates within or without the law spreads to the other side, and before long, policeman and suspect are able to converse in a manner unintelligible to the uninformed outsider.

This glossary has been drawn up to assist the young Police Surgeon, and to refresh the memory of the expert. Its principle contributors are active members of Merseyside Police, specialists in their own fields. It is recognised that the brief glossary is far from exhaustive, and it is hoped that readers will be stimulated into sending in further contributions, particularly of slang with regional significance.

Principle contributors

Detective Superintendent Kenneth Anderson, Merseyside Police
Inspector F.B. Edgar, Plain Clothes Office, E. Division, Merseyside Police
Chief Inspector W.R. Owen, Drugs Squad, Merseyside Police

acid L.S.D.
acidhead An abuser of L.S.D.
A.H.I.R. At home if required
alphonse Ponce
amp Ampoule
amphetamine Bennies, black and white, black bomber, blue brown bomber, dex, dixies, dominoe, double blue, German blue, jolly beans, minstrel, nigger minstrel, pep pills, pills, purple heart, sweets
anytime Annie Prostitute
artillery Addicts' equipment — syringe etc.
ashpan lids Kids
at the bash Engaged in prostitution
at the bottle Stealing from the hip pocket
at the creep Entering room to steal from client of prostitute

Babylons The police
backtrack To withdraw the plunger of a syringe whilst injecting — if blood comes the needle is in the correct position
bag Container for drugs; prostitute
ball and bat Hat
ball of chalk Walk
bang Inject drugs; to have intercourse
barbiturates Goofballs, sleepers
bayonet practice Sexual intercourse
bennies Benzedrine
bent drag Stolen car
bent gear Stolen property
bernice Cocaine
bhang Cannabis
bindle A small quantity of drugs
bird Prison, imprisonment; a female
biz Equipment for injecting drugs
black and tan Ampehtamine (Durophet)
blackandwhite Amphetamine (Durophet)
black bomber Amphetamine (Durophet)
blanks Poor quality drugs
blasted Under the influence of drugs
blew the gaff Informed
blister Summons
blocked Under the influence of drugs
blocked up Under the influence of drugs
blow a stick To smoke a cannabis cigarette.
blower Telephone
blow out To spoil an injection
blue Amphetamine (Drinamyl); police officer
bluebottle Policeman
blue brick Police station; jail
blue cheer L.S.D.
bluey Lead; Drinamyl
bobby Policeman
bogey Policeman
bogey bell Burglar alarm
bomb or bombers Durophet capsules

bombed out Under the influence of drugs
bombido Injectable amphetamine
boo Cannabis
box Safe
boxed In jail
boy Heroin
bracelets Handcuffs
Brahms and Lizst Drunk
brain surgeon Unintelligent person
brass Prostitute
bread Money
brick Cannabis in compressed form, kilo weight
brief Warrant
Bristols Breasts
brought down A depressed state following drug abuse
brown and green Durophet M capsules
brown and red Durophet M capsules
brownie Male prostitute
brown hatter homosexual
Brussel sprout Informant
bucket shop Fraudulent company
bull Male using services of a prostitute
bullet Capsule
burned To receive false drugs
busie Detective
bust To arrest
busted Arrested
busy Policeman
busybody Prostitute
buzz Effect drug gives

C Cocaine
cabbage One pound note
California sunshine L.S.D.
canapa Cannabis
candy Barbiturates
cane Jemmy
cannabis Bhang, boo, canapa, charas, charash, charge, Congo-mataby, dagga, gage, ganga, gear, grass, griefo, hash, hashish, hay, hemp, herb, Indian hemp, jive, kief, locoweed, maconha, manicure, marijuana, Mary-Jane, mezz, moragrifa, mutah, plant, pot, Rangoon, resin, rope, shirash, shit, stuff, tampi, tea, Texas tea, ton, weed
cap Capsule
carpet Three months imprisonment
carrier Person who supplies drugs
carve up Share out of illicit proceeds
case Brothel
case keeper Brothel keeper
Castle, the Holloway prison
cat Man
charas Cannabis
charge Cannabis
charged up Under the influence of drugs
Charlie Cocaine
chief L.S.D.
chipping Using small amounts of drugs irregularly
chippy User taking small amounts irregularly
chiv Razor
clean Clear from drug injection marks
clear up To withdraw from drugs
coasting Under the influence of drugs
coating Police evidence as to character
cocaine Bernice, C, Charlie, coke, Corine, dust, flake, girl, gold dust, happy dust, snow, star dust
coke Cocaine
cokie A cocaine addict
cold turkey Sudden unaided drug withdrawal
come copper Inform
come down Withdrawal effects
Congo mataby Cannabis
connect To purchase drugs
connection A drug supplier
cook up To prepare an injection
cook up a pill Prepare opium for smoking
coon A coloured man
cop To purchase drugs; a policeman
copper Policeman
Corine Cocaine
cottage Urinal
cow Prostitute
crank up To inject a drug
crashed Raided
crutch Device to hold reefer together to stop burning fingers
crystals Methedrine
cut To adulterate drugs

D Detective
dabble Using small amounts of drugs irregularly
dabs Fingerprints
dagga Cannabis
dannymaher Car
deal Dose of drugs
dealer Drug peddlar
deck Small packet of morphine, cocaine or heroin

detached Under influence of drugs
dex, dexy or dexies Amphetamine (Dexedrine)
Dick Detective
dip Pickpocket
dipper Pickpocket
dixies Amphetamine (Dexedrine)
doctor Indian hemp
doing an Offman Absconding; making oneself scarce
doing bird Serving imprisonment
dominoes Amphetamine (Durophet)
double blue Amphetamine (Drinamyl)
dope Any drug
dragging Stealing from motor-cars
drain spuds Urinate
drag Something unpleasant
drappered Arrested
dropped Arrested
drum House, flat or building
drumming Knocking at houses to see if occupants are out
drying out Staying off drugs so that tolerance subsides and smaller doses can be taken
duck Warrant or search warrant
dust Cocaine

egg and spoon Coloured man
experience Effect of L.S.D.

factory Equipment for injecting drugs; police station
feel his collar To arrest some person
fence Receiver
five to two Jew
fix An injection of a drug
fixing kit Hypodermic syringe etc
flake Cocaine
flash Effect of stimulating drug
flasher One who indecently exposes his person
flattie Policeman
flea powder Poor quality drugs
flipped Under the influence of drugs
floating Under the influence of drugs
flowery (dell) Cell in prison or police station
flushing Withdrawing blood into syringe
four by two Jew
freak out Psychedelic experience
French blue Amphetamine (Drinamyl)
fresh and sweet Out of prison
frog and toad Road
full Under the influence of drugs
fuzz Police

gaff House, flat or building
gage Cannabis
ganga Cannabis
gas Something good
gat Gun
gear Addict's equipment
geezer A drug injection
German blue Amphetamine (imported)
gimmicks Addict's equipment
girl Cocaine
glim Torch
gobbler Prostitute specialising in oral sex
gold dust Cocaine
gone Under the influence of drugs
goods Drugs
goofballs Barbiturates
goofed up Under the influence of drugs
graft Work
grass Cannabis: informer
griefo Cannabis
green and white Drinamyl capsules
green and clear Drinamyl capsules
gun Hypodermic needle

H Heroin
habit Drug addiction
had it off Had intercourse
half a stretch Six months imprisonment
hamshank Bank
happening Psychedelic experience
happy dust Cocaine
hard stuff Addictive drugs
Harry Heroin
hash Cannabis resin
hashish Cannabis resin
hawk L.S.D.
hay Cannabis
heat Police
heavies Policemen
heavy mob Flying squad
heister Shop lifter
hemp Cannabis
herb Cannabis
heroin H, boy, Harry, Jack, joy, horse, powder, scat, schmeck, shmee, shit
hickory dickory dock Clock
high Under the influence of drugs
hog Addict who will use anything
hooked Addicted
hophead Drug addict
hopped up Under the influence of drugs

horse Heroin
hot lot Flying squad
hot shot Fatal dose of drugs
hung up Personal problem – unable to get drugs
hurry up wagon Police van
hustler Prostitute
hype Drug addict

ice cream habit A small irregular drug habit
Indian hemp Cannabis
instant zen L.S.D.
instant come down Appearance of known drug squad officer
iron hoof Homosexual
Island, the Parkhurst prison

Jack A heroin tablet; a detective
Jack dash Urinate
Jack up To inject heroin
jag A bout of drug taking
jam jar Car
jive Cannabis
job To inject drugs
joint Cannabis cigarette
jolly beans Benzedrine
joy-boy Male prostitute
joy-pop To inject small amounts of drugs irregularly
joy-powder Heroin
jug Police station or prison
junk Drugs
junkie Addict

karzi Lavatory
keeping it in the family Incest
Ken House
kick (n) Effect of stimulant drug
kick (v) To abandon a drug habit
kief Cannabis
kilo Brick of compressed cannabis 2.2 lb
kip Brothel
kite Cheque
knocked off Arrested
knocking shop Brothel

lakes of Killarney Insane
laugh and titter Glass of bitter
law The police
lay down Remand in custody
layout Equipment for injecting drugs
let ones hair down Talk freely
lit up Under the influence of drugs
loaded Under the influence of drugs
locoweed Cannabis
lord cough Meal
L.S.D. Acid, blue cheer, California sunshine, purple haze, strawberry fields, sugar, white lightening, Zen
lumbered Arrested

M Morphine
machine Syringe
maconha Cannabis
madam Handkerchief
mainline To inject drugs intravenously
make To obtain drugs
man The police
Manchesters Breasts
manicure Cannabis
manor District
marijuana Cannabis in plant form
Mary Jane Cannabis
mastermind Unintelligent person
mellow yellow Banana skins dried for smoking
meth Methedrine
methhead Methedrine user
metrognome London Metropolitan policeman
mezz Cannabis
minstrel Amphetamine (Durophet)
Miss Emma Morphine
mojo Drugs
monkey A physically addictive drug habit
moon 1 months' imprisonment
mora grifa Cannabis
morph Morphine
mouthpiece Solicitor
mud Opium
mush Male using services of prostitute
mutah Cannabis
mutton dagger Penis

N.A.H.I.R. Not at home if required
nark Informer
needle Hypodermic syringe
nick Police station or prison
nicked Arrested
nod Drowsy state following heroin injection
nose Informer

O Opium
off Withdrawal from drugs
on a trip Under the influence of L.S.D.

on the bash Engaged in prostitution
on the batter Engaged in prostitution
on the game Engaged in prostitution
on the job Engaged in sexual intercourse
on the nod Under the influence of heroin
outfit Injection fixing kit
over the hill Dartmoor Prison
over the wall Prison

pad Room, apartment
paper Prescription
Pat and Mick Sick
patsy Victim of robbery or swindle
peanuts Barbiturates
peeler Policeman
pellets Tablets
peter Safe
peterman Safebreaker
phial Ampoule – usually methedrine
pig Policeman
pill Amphetamine
pillhead Amphetamine abuser
pimper Peeping Tom
pinkie twistle, pinkie-twister Homosexual man who importunes for immoral purposes with other males
piss-artist Drunkard
pissed Drunk
pitch and toes The boss
plates of meat Feet
point Hypodermic needle
pole-squatter Prostitute
ponce Person who lives on immoral earnings
pop To inject drugs
porridge Imprisonment
pot Cannabis
pothead Cannabis abuser
pot of glue Jew
pouf Homosexual
prellies Preludin Tablets
psychedelic experience Effect of L.S.D.
pudding eater Man living on immoral earnings of prostitute
purpees Drinamyl
purple haze L.S.D.
purple heat Amphetamines (Drinamyl)
push To sell drugs
pusher A seller of drugs
put in the squeak Inform

queer fellow Homosexual
quill A folded piece of paper from which to sniff drugs

rabbit Informer: talk
railway carriage Miscarriage
rangy or Rangoon Bush cannabis
rave Condition induced by drugs or a drug party
reader A prescription
red biddy Cheap red wine, methylated spirits or the two mixed
red devil or red bird Seconal
reefer Cannabis cigarette
rainbow Tuinal
resin Cannabis resin
roach The but of a cannabis cigarette
rod Gun
Roger Charlie Roman Catholic
rolling up Preparing a cannabis cigarette
rope Cannabis
rozzer Policeman
rub-a-dub-dub Club
rubber Club
rubbish Indian hemp

sausage Cannabis cigarette
scat Heroin
scene The drug environment
score To buy drugs
scored Marks on a piece of cannabis resin to show the small pieces to be cut off for a set price
scratching Searching for drugs
screw *v.* Commit a burglary; have sexual intercourse; *n.* wages; prison officer
screwdriver Prison governor
screwing job Burglary
screwsman Burglar
scoff Meal
script Presciption
scuffer Policeman
semi-detached To have a small quantity of drugs but not enough
shebeen Unlicensed premises where alcoholic liquor is sold
sheet One pound note
ships hatch Football match
shirash Cannabis
shit Heroin or cannabis
shmee Heroin
shook the law Informed
shoot up To inject drugs
shooting gallery A place where addicts inject drugs
shopped Betrayed
shot Dose of hard drugs
sick Withdrawal symptom

skin popping Subcutaneous injection
skippering Sleeping rough or sharing with other addicts
slammed Imprisoned
slash Urinate
sleepers Barbiturates
slung Discharged, dismissed
smoke Amount of cannabis; to use cannabis cigarettes
smother Overcoat
smudge Photograph
sniffing Sniffing up the nose usually heroin or cocaine in dry form
snort To sniff drugs
snout Tobacco or cigarettes; informer
snow Cocaine
spade Negro
speed Amphetamine
speedball An injection combining a depressant (heroin) and a stimulant (cocaine, methedrine etc.)
spent Under the influence of drugs
spike A hypodermic needle
spliff A cannabis cigarette
split Detective
spout Informant
spring link Chinaman
square One who does not know what is happening
squirter Gun
star dust Cocaine
stash To hide drugs
stick A cannabis cigarette; a jemmy
stick carrier Person who lives on immoral earnings
stick-man Man employed to protect a prostitute from any form of attack
stoned Under the influence of drugs
strawberry fields L.S.D.
stretch One years imprisonment
strung out Withdrawal symptoms
stuff Drugs, heroin
sugar L.S.D.
Sweeney (Tod) Flying squad
sweeping the snow Stealing washing from clotheslines
sweets Amphetamines

T Marijuana
tail Follow
take a trip Experiencing the effects of L.S.D.
taking the cure Submitting to treatment
tampi Cannabis
taste A small quantity of drugs — sample
tea Cannabis
teahead Cannabis user
tea leaf Thief
tell the Royal Turn Queen's evidence
Texas tea Cannabis
the Law Policeman
the Man Policeman
tiddley wink Chinaman
tifta Hat
tit for tat Hat
tom Jewellery
ton Cannabis
torch A marijuana cigarette — they burn more brightly than ordinary cigarettes
torp or torpedo Capsule or spansule of drugs, usually Durophet
tracking Injecting intravenously
travelling kite Stolen cheque
trip Experiencing the effects of L.S.D.
turd burglar Homosexual
turkey See cold turkey
turn on To introduce a person to drugs or to use drugs for the first time
turned off Withdrawal from drugs
turned on Under the influence of drugs
turned over House searched
twirls Keys
two moons Two months imprisonment

up the steps Sent for trial
user A person taking drugs

W Warrant
washed up Withdrawn from drugs
wasted Under the influence of drugs
weed Cannabis
weedhead Cannabis user
weedhead habit A small irregular drug habit
weight 1 lb. weight of cannabis
whistle and flute Suit
white lightening L.S.D.
white stuff Heroin or morphine (not cocaine)
wick Penis
wino One who drinks excess cheap wine or methylated spirits
woollie back County or rural policeman
works The equipment for injecting drugs
wrap up Small amount of cannabis in brown paper

Zen L.S.D.