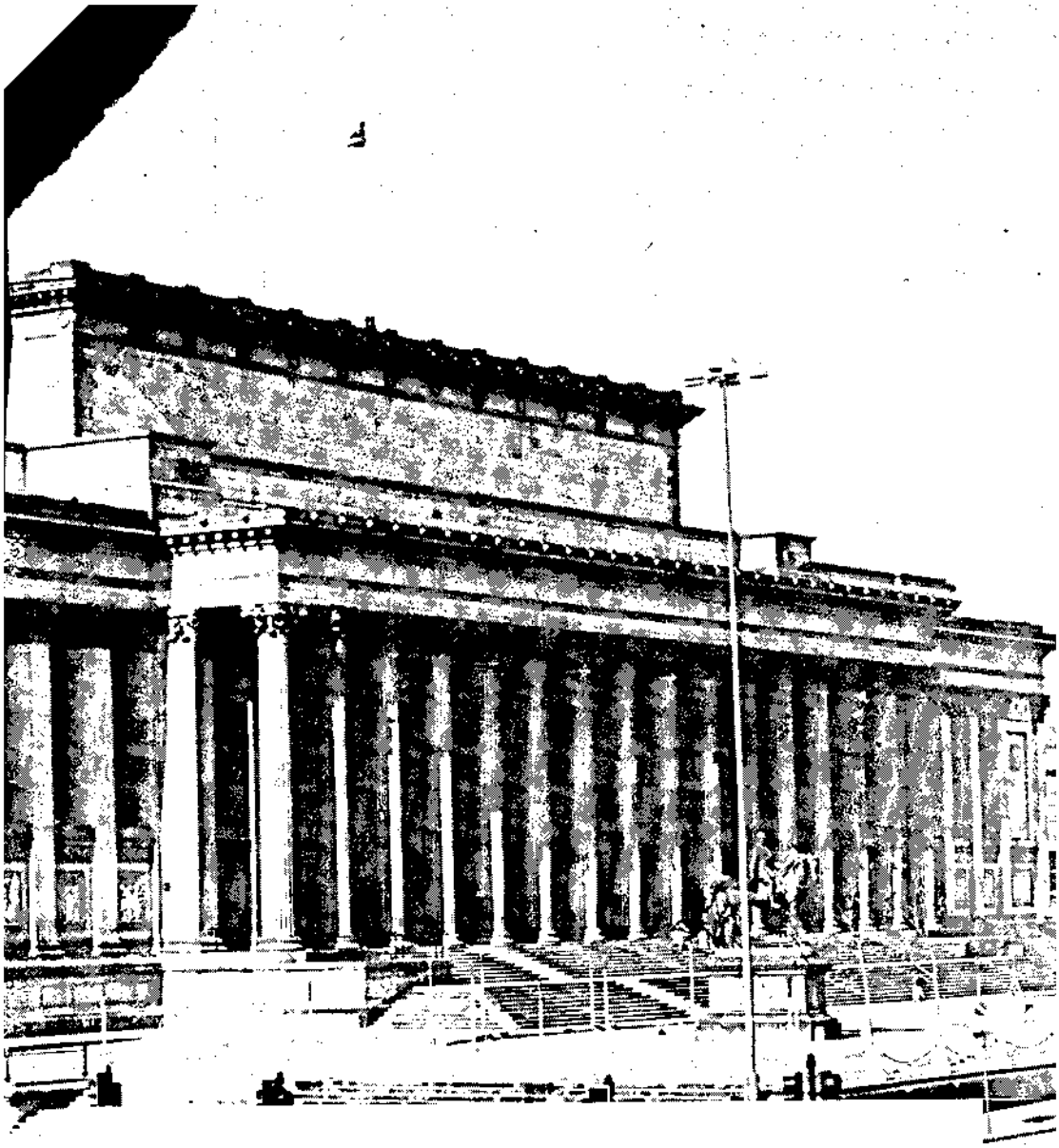

# The Police Surgeon
# SUPPLEMENT

VOL.5 AUTUMN 1978

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# EDITORIAL

## YEAR OF THE BOOK

The history of the Police Surgeon is marked by years of particular significance. 1829 – the Metropolitan Police Act; 1877 – the formation of the Metropolitan Police Surgeon Association; 1951 – the formation of the national Association; 1962 – the start of the Diploma in Medical Jurisprudence.

1978 will surely be recorded as The Year of the Book.

"The New Police Surgeon" may be regarded as the descendant of the Association's first textbook "The Practical Police Surgeon", published in 1969. The new book has evolved beyond recognition from the old. This in itself is evidence of the rapid development of the Police Surgeon and his craft. No doubt in years to come another textbook will be emerging from its chrysalis, documenting further advancement in Police Surgeon skills.

In years gone by, there were no textbooks devoted to clinical forensic medicine. The Police Surgeon developed his skills by practical experience, based on a study of works by forensic pathologists, who ventured from time to time to expound upon the living rather than the dead. A newly appointed divisional Surgeon could expect to spend a number of years acquiring the theoretical and practical knowledge required to master the work in all its aspects.

There are no short cuts to the acquisition of practical experience. But here in one volume are all the short cuts to the acquisition of theoretical knowledge the tyro Police Surgeon can demand. For the experienced Surgeon, the book will be a constant source of reference. It will also be a valuable source for members of the legal profession, particularly those who cross-examine Police Surgeons in defence of their clients.

The Association is rightly proud of its most recent achievement. It reflects great credit on its twenty-two contributors. Particular praise goes to the Editor Stan Burges and his long suffering assistant James Hilton, and the words of Sir Robert Mark in the foreward apply especially to them – "its authors are more concerned with the encouragement of high professional standards than with monetary profit. That is an ideal which they share with the police themselves and its fulfilment can only benefit the public interest".

## A WELCOME FORM

It is a rare occasion indeed when one can regard the appearance of yet another form with pleasure. Form 5331 Sexual Offences Form is one of those items which stimulate the comment: "Why wasn't it thought of before?" It is a single page form, compiled by scientists at the Metropolitan Police Forensic Science Laboratory. The first part is devoted to requesting information regarding the sexual offence under investigation which the medical examiner is best placed to provide, and which is of assistance to the forensic scientist in his assessment of the items he is asked to examine. Part 2 of the form specifies the samples of particular value to the laboratory, and gives some advice on the collection and storage of specimens.

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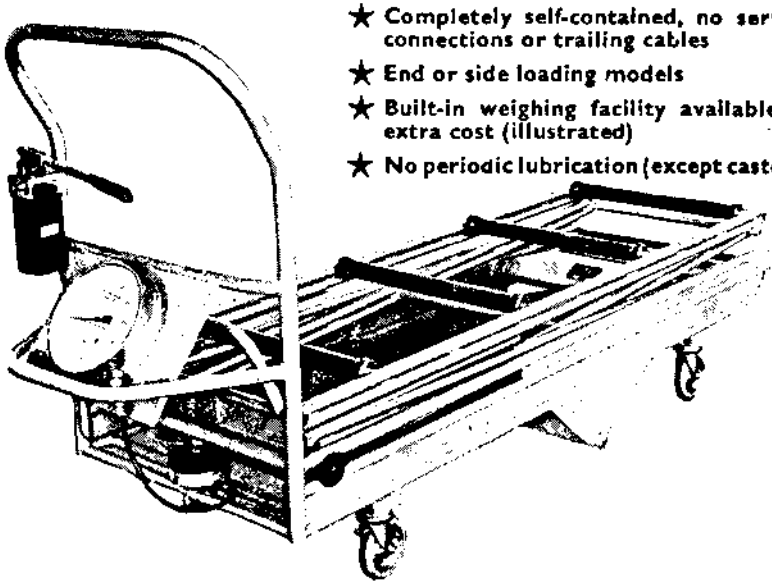

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The form is simple and straightforward. It is concerned only with those items of the Police Surgeon's inquiry which are of particular relevance to the forensic scientist, and is not a proforma for the medical examination. Variations on Form 5331 are starting to appear in other parts of the country, with modifications to suit local laboratory conditions.

In the Metropolitan Laboratory area, the form accompanies a sexual assault examination kit, an inexpensive but comprehensive selection of items which will enable the satisfactory collection of specimens for laboratory use. It is to be hoped that similar kits will be introduced into all parts of the country where the supply of equipment by police authorities is meagre or non-existent. A full report on the introduction of the form, and a description of the kit will be appearing in a future edition of "The Police Surgeon".

There is still a reluctance on the part of many Hospital Medical Authorities to involve Police Surgeons in cases which present at the Hospital. This is partly due to the fact that many Universities give little or no time to the teaching of clinical forensic medicine. The Junior Hospital Staff who are first involved in a case when it presents and who take the initial decisions, may be so ill-informed as to be unaware of the expertise available from the local Divisional Police Surgeon. In addition, Junior Hospital Officers may be totally unaware of the care needed in obtaining forensic samples in a satisfactory manner.

The Police Surgeon should always be involved from the beginning in the examination of any case of suspected sexual assault, whether the case presents at Hospital, Doctor's Surgery or Police Station.

## INJURIES

The difficulties associated with the interpretation of injuries and their medico-legal significance appear to have been illustrated by a case reported in the Daily Telegraph of 8th July, 1978.

A two-year old girl sustained injuries following a fall astride a garden fence and was taken to Burnley Victoria Hospital by her parents. The child was detained.

On the following morning the parents visited her in the Children's Ward. They were then told that their daughter had been sexually assaulted and the Police had been informed.

The child's father went to Burnley Police Station, where he spent six hours in custody. During this time he was questioned by Detectives and stripped. He was seen by a Police Surgeon. Tests by Forensic Science experts were reported as negative and it was then decided that the child's injuries had an innocent explanation.

It was not stated in the article whether the child was examined by a Police Surgeon at the Burnley Victoria Hospital.

## FEES

The first increase in the fees for Police Surgeons for over three years came into effect from 1st July, 1979. Members have received the details of the new fees: non-members of the Association may apply to the Hon. Secretary for this information.

The mileage rate remains at 12.3p per mile (from 9th August 1977).

The fee for attending Crown Court as a Prosecution Witness is now £12.60 per half-day, £25.20 per full day.

## SPECIAL REPORT

'The Practitioner' is at present publishing a series of six articles in the Autumn issues of the magazine, under the heading "Special Report: The Police Surgeon". The articles include a history of the Police Surgeon, Scene of Crime, Battered Babies, Sexual Assualt, and Alcohol, and are written by members of the Association.

# PRESIDENT'S LETTER

## Post-Alcoholism

Those who came to write a history of the Association in years to come will, I think, refer to the present period in our existence as the post-alcoholic era.

At last, when members mention alcohol, it is more likely to be in a social context. No longer are our meetings dominated by references to drinking and driving. The so-called Police Surgeon whose sole claim to fame in the annals of clinical forensic medicine was an uncommon knowledge of white lines and the Leith Police has been respectfully interred.

The title of our manual, The New Police Surgeon, was no random choice but was intended to indicate the abilities of a surprising number of clinical forensic physicians who have "just growed" over the past twenty years or so.

We are for ever indebted to our colleagues in forensic pathology and forensic science who recognised the need for the clinical forensic physician and have assisted our evolution. Our hope is that their trust in us to provide the hitherto missing link between post mortem room and laboratory is justified.

It is no idle boast that the vast majority of the acknowledged forensic physicians in the United Kingdom are members of our Association.

## The Future

The future of the Association — and this is the same as saying the future of clinical forensic medicine in the United Kingdom — looks encouraging. Our ambition? To know that every established member is an expert and every new member a potential expert. We are not ashamed to have pretentions of becoming an elite institution. By having pride in ourselves and our abilities, society is the better served.

## The Means

Education and the exchange of information is one of the more important aims of the Association. Many members agree that this need not be a painful or tiresome exercise. I refer, of course, to those delegates who have attended the annual Spring Conferences and the annual Autumn Symposia. Council and Conference organisers take especial care in providing; an academic programme which is varied in content, speakers of national and international repute, a venue which, over a period of four years or so, is easily accessible to all members wherever they reside, and, not least, a stage for the informal and friendly gathering of old friends, new friends and their spouses.

## A Plea

Wherever you live, whatever your forensic work-load, meet your Council, your fellow members, and distinguished colleagues in associated disciplines at the next Conference or Symposium most convenient for you. All new faces are sought out and welcomed. I can promise you that you will leave the better informed and the richer in friends.

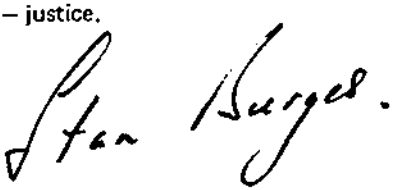
All members, whether able to attend or not, should not have to be reminded that personal contact is but one means

of communication. Our Hon. Secretary, members of Council, the editor of The Police Surgeon, and the editor of Supplement are all possible points of contact by letter or telephone. All are ready to listen and assist. Technical information, difficulties in working conditions, changes in our constitution, research projects, observation on The New Police Surgeon; these are but a few of the subjects which may need to be discussed and which, collectively, nourish and strengthen the Association and its aims.

## Conclusion

I am most fortunate to be your President at a time when it is obvious to all that the Association is a dynamic body, possessing a momentum which increases by the day. Strong links exist between members on a personal level – and this in spite of the geographical strictures; effective channels of communication are a reality with the likes of the Home Office, the Association of Chief Police Officers, Government sponsored working parties, Directors of Forensic Science Laboratories, the Forensic Science Society, the Medico-Legal Society, the British Academy of Forensic Sciences, the British Medical Association, the Society of Apothecaries, the National Society for the Prevention of Cruelty to Children, the National Council for Civil Liberties and Amnesty International.

I ask you all to assist me and the Council to increase that momentum yet further. By so doing, we assist ourselves and – justice.



## ONE IN A HUNDRED – A CAUTIONARY TALE

An alcoholic who spent a night in Liverpool's main Bridewell was suffering from a fractured skull, a city inquest heard yesterday (21.6.78).

Mr. John Rourke, aged 61, was taken to hospital on the morning of May 24 when officers realised something was wrong. He died on arrival.

The Coroner, Mr. Roy Barter, said that Mr. Rourke, a resident at the Springfield Hostel, Islington, seemed to have fallen down steps near St. John's Gardens, where he was found by a passer-by.

He was arrested shortly after 10.30 p.m. on Tuesday, May 23 for being drunk and incapable and placed in a cell for the night. He had been arrested for being drunk on 99 other occasions.

Liverpool Daily Post, 22.6.78.

## TERSE VERSE AND WERSE

Mr. President (to some known as Stan)
Is a happy and fortunate man.
He can turn out good books,
Has a wife with good looks,
And a perfectly splendid old Gran.

The Secretary (his name is Hugh),
Works hard and has much to do.
He'll attend to a smash,
(Battered child or sad crash),
And write a report for us too.

Our Treasurer (could his name be Mendozer?),
Has a terrible twin in G. Fraser.
They joke and they pun.
It's all good clean fun,
And as sharp as a double-edged razor.

The Conference was quite a success.
Will you go again? We all said 'yes',
The talks were all good,
And so was the food.
But the friends that we made were the best.

P.T.

# REALITY IN ULSTER

I am on my way to our local police station to adjudicate on a farmer who is being held on suspicion of being drunk in charge of a tractor. In present-day Ulster nothing is ever humdrum. I drive slowly through a housing estate, ease over tarmacadam security ramps as I near my destination and, as it rises before me, I switch to sidelights only. I approach its heavily reinforced gates. The only human thing about a police station in Ulster today are the men in it. Outside, it is forbidding. Inside, foreboding. Behind its fortress exterior "reality" reigns.

Reality: the death of life, the corpse of humour, the termination of friendship. We cannot bypass it, but we can spit in its face with flair.

I parked under the security arc lamps allowing full exposure of my person, my intentions, my thoughts to the hidden eyes of a tall sentry-box. The gates opened. I handed my official police surgeon identity card to a waiting hand. A grunt. The card was returned to me. Another light and the station opened to receive me. I was in.

The sergeant was stolid but genial.

"Sorry to trouble you, doctor, it's just a DIC. He's a sheep-man. He won't give you any bother. He's agreed to everything".

I wasn't listening to him. Just walking on to my room, although, for all it contains, I could examine a man in the back seat of a coupé as well. Anyway I like mountains, I like sheep, and I like the men who live with them.

The station was busy as usual; men coming, men going, men writing, men reading, men arming, girls typing, girls attracting. Over all, staccato radio reports advised, reported, ordered, revealed. The suspect stood up when I came in. I hoped I could pronounce him sober.

I introduced myself, explained the purpose of my presence, stressed my neutrality, told him to "take a seat" and gave him a cigarette. And took one myself. He fumbled in his pockets for a match but my Ronson lit his for him.

I arranged my papers. Checked the time. Placed my finger on his pulse. It immediately got faster.

"Would you walk to the door, please. Don't worry about a straight line, just amble up ordinarily, turn and come back".

He did so.

"Good. Now, for a few questions while we finish our smoke".

He was suffering from no illness or injury. He wasn't on any medicine. Yes, he'd had a few stouts . . . and . . . a little taste of poteen. No, he hadn't eaten. Temperature. Ability to write. Co-ordination. Pupils, on, on, on. Routine to me; to him disaster. That bloody drop of poteen.

I took his blood sample. He stared at the red flow.

"Have I any chance, doctor?"

"When did you take the poteen?"

"Less than an hour ago".

I couldn't ease his thoughts. He lowered his head on to his clenched fingers.

"Oh God, doctor, is there nothing we can do. I had so very little. I need my tractor . . . my wife . . . my kids. My God what have I done to them?"

I suppose I could have pointed out to him that "Things could've been worse", quickly followed by its pal "Where there's life there's hope", but a man's entitled to his dignity, even that of anguish. I busied myself sealing his blood sample (and his fate) in the jiffy bag. The police returned and with them came "reality". Their emotional reactions and mine and his were of no account.

I chatted to them. I didn't mention the poteen. Why should I? The price of a drink in Ulster makes the still morally justifiable, even essential. Soon we were finished. The sheep farmer was alone once more.

The sergeant called me back as I was leaving.

"I think we'll have another one for you soon, doctor; there's some raving lunatic tearing over the Glenshane Pass on a motorbike".

Twenty minutes later I met Sean. He led the police down the corridor and into my room. He sat down and as the sergeant enunciated the legal requirements, Sean turned his attention to me.

"I'm Sean Mag Flannacada, mister. Are you Irish yourself, or an Ulster-Scot like these gentelmen here?"

The sergeant gulped, and spluttered for a second before speaking again.

"The form, constable, give me the form".

"Form, sarge? What form?"

"The bloody DIC forms. God, doctor, they're hacking them out of the hedge nowadays".

The constable opened the cupboard, rummaged on the white filled shelves, taking out, looking at, putting back forms. The sergeant waited at boiling point.

Sean bent down and picked a form from the floor.

"This is the proforma you require, boys. But check, I could be wrong and I have a damn good solicitor".

The sergeant read the contents to himself. Satisfied, he read them aloud. Sean nodded his compliance. All was well.

It was over to me now.

"Sean, do you give me permission?"

"For God's sake, cut the cackle. I agree to everything, examination, blood, urine, the works, provided you can prove to me you are a doctor'.

I loved him at that moment. The sergeant exploded, the constable gaped. Oh God, how I loved him, his unsmiling "innocent" face.

"Listen here, Mag, Mag whatever the hell you call yourself", said the sergeant. "You needn't try that on here. Of course he's a doctor".

Sean turned to me.

"Hardly an unbiased opinion, mister?"

"Would a prescription with my name and occupation stamped on it be any good to you?"

I wanted to let the hare run. He ran. Sean's lips expressed his scorn for my naivety.

I tried a stethoscope, a driving licence, a sphygmo, a thermometer. He disdained them all. The chase was truly on.

And then he ruined it. I'm a man who enjoys a fight, an argument, a debate, but let my opponent assume the role of conqueror, let him get uppity. Sean did.

"I wouldn't mind betting you sleep with a hot-water bottle from choice".

I nearly rammed my official Police Surgeon identity card (complete with photograph) up his highly arched nostrils. He was lucky he had his trousers on.

"Harry Truman", I said, "put it much better. So let's get on with the stuffing. You've just cooked your goose, my friend".

He disappointed me.

"I want my solicitor", he whined.

I nodded to the sergeant. Sean named a personal friend of mine. The constable dialled. The solicitor was on his way.

Tom came in with a flourish, shook hands with both of us.

"And what can I do for the pair of you?"

"You can prove that boyo's a doctor, Tom".

Tom laughed.

"He's a doctor all right, Sean, and a damned decent one into the bargain. You're bloody lucky. Come on, don't act the ejit. Carry on, Hugh".

Sean turned away but his words rang through the room.

"And why should I listen to you, Tom? Can you prove you're a solicitor?"

I loved him again.

Saliva flowed freely down the outraged face of "reality". I tell you there's no stopping "flair".

**HUGH GLANCY**

Hugh Glancy is a Police Surgeon in Co. Demyr, Northern Ireland. This aritcle first appeared on March 8, 1978 in *World Medicine* and is reproduced by kind permission of the Editor.

# HONORARY SECRETARY'S REPORT FOR 1977/78

## PUBLICATIONS

The work of the Association has been well documented in the Supplement (No's 3 and 4) to the Police Surgeon Journal. My task in preparing this report has been made easier as the results of the efforts of our Hon. Assistant Secretary Dr. Myles Clarke who in a most readable and lucid manner has chronicled the events of the year. In addition he has relieved me of a great volume of administrative work especially in arranging the forthcoming Conference.

The proceedings of our Conferences and Symposia along with other articles of interest continue to be reproduced in "The Police Surgeon". This is becoming more widely read in circles outside our Association as Police training departments and Forensic Science laboratories join the subscription list. Bill Thomas and his team of sub-editors have come a long way since that first issue in March 1972 which replaced the cyclostyled news sheets we received at irregular intervals when contributions could be extracted from a reluctant membership. There is considerable talent among our membership who have collectively and individually a vast experience of matters on which no other branch of the medical profession can speak with authority.

Bill Thomas was the first to successfully harness this talent and in doing so gave a lead to Stan Burges and James Hilton who aided by Ralph Summers have now produced "The New Police Surgeon — A Practical Guide to Clinical Forensic Medicine". It was no mean task for them to persuade all the contributors to produce their articles on time, then tactfully edit and continually keep these contributions up to date with the legal changes which were taking place during the gestational period. Their efforts were well worthwhile and this is yet another landmark in the progress of the Association in advancing medico-legal knowledge in all its aspects as applied to the work of Police Surgeons.

## RESEARCH

We must not be content to rest on our laurels and the motion proposed by the Metropolitan and City Group at this year's AGM — "That a research sub-committee be set up by Council to encourage, initiate and co-ordinate research by members of the Association" is in the view of many, long overdue. Research requires information of which we as individual members have plenty, but it also requires persons who can collect and interpret this information, and those of you with talent in this field or any ideas worthy of consideration, we ask you to come forward.

An article by Laurence Depson in BMA News Review (Volume 3, No. 11 of November 1977) did great credit to the Association and the public relations value was increased when the article was reproduced in its entirety in the December issue of "Police" the widely read magazine of the Police Federation.

## FORENSIC SCIENCE IN SCOTLAND

During the year comments from the Association were sent to the Scottish Home and Health Department (at their request) on the report of the working

party on Forensic Pathology Services in Scotland. Council was in general agreement with the report. It will be remembered Drs. John Clarke, James Hilton, David McLay and Ken Hall gave oral evidence in addition to the written evidence provided by the Association to the working party of which Dr. Peter Jago, Assistant Secretary (Scotland), was a member. We are satisfied with the role of Police Surgeons as defined in the report but expressed reservations that if the Universities assume responsibility for co-ordinating and providing the forensic pathology service this should not exclude the provision of such service without the Universities nor should it prevent any Procurator Fiscal from employing the pathologist of his choice. The Association believes that there should be a representative of Police Surgeons on local as well as national co-ordinating committees.

## ROYAL COMMISSION

The Association has been invited to submit evidence to the Royal Commission on Criminal Procedure and this is now being prepared in respect of the question of photographing, finger printing, and medical examination of suspects or accused persons. The experience of our colleagues in Northern Ireland will give strength to our submissions which will include the principles described in Chapter 5 of "The New Police Surgeon". In respect of photography the Code of Practice in Supplement No. 3 has been accepted by Council as official Association policy.

A consultative document prepared by a special sub-committee on terms of service and remuneration is circulated with this report to members attending the AGM. It is now 10 years since a National Police Surgeon service was established. Your Council is of the opinion that in looking forward to the next ten years we should give the BMA a clear brief as to our aims and objects for the future bearing in mind the changing nature of Police Surgeon practice. The immediate issue of any increase in our fees is currently a matter of intense BMA activity.

In October I presented a paper to the City of London Police Symposium on Major Incident Intervention the subject being the Multiple Accident on the M1 in 1974 involving two hundred and four vehicles. I will be representing the Association at the Ministry of Transport Road Safety Conference in June, and have expressed a preference to be allocated to a working group dealing with "alcohol and accidents"

Dr. S.H. Burges attended the "Poldive" Conference held by the Cleveland Constabulary and has submitted a report to Council which will be of interest to those members who are responsible for the health of personnel in Underwater Search Units especially in respect of legislation arising out of the Health & Safety at Work Act. The subject is to be given attention at future symposia and conferences.

A delegation attended the Home Office prior to the introduction of the trial of breath analysis devices in certain police stations which are the subject of a lecture by Dr. David Filer at this Conference. The delegation expressed its disquiet on certain aspects of the trial and we were promised to be kept fully informed of developments. It is most important that members involved with these machines pass their observations to me, so that we are fully informed for future discussions.

## LIAISON WITH POLICE

With Dr. Havard, Dr. H. Fidler (Chairman of the Private Practice Committee BMA), and Dr. Fisher (Chairman of the Ethical Committee BMA) I attended a meeting with the Chairman and Secretary of the Association of Chief Police Officers. It was reaffirmed that members of A.C.P.O. would be recommended to deal with medico-legal matters through the local Police Surgeon at local level, or through BMA Regional or Divisional secretaries at higher level who in turn would refer to the BMA at National level if it was necessary and that the BMA in turn would consult with this Association as it always has done on matters affecting doctors and police. Members will remember this meeting was the result of suggestions that the Junior Hospital Doctor's Association and the British Hospital Doctor's Federation were

exploring the possibility of entering with discussions with the community relations branch of the Metropolitan Police.

A delegation also attended New Scotland Yard to discuss medical problems at demonstrations such as Lewisham, and various points were clarified in a far ranging discussion. The idea of a mobile first aid unit (manned by Police Surgeons) for treating police personnel was discussed but for various reasons it was unanimously agreed that this was not in general a feasible proposition. It was agreed that as far as possible a reasonable standby notice should be given to Police Surgeons who may be required and that some form of medical planning before the event should be undertaken in conjunction with the Police Surgeons.

## LABORATORY VISITS

I have been asked by the Metropolitan Police laboratory to issue an invitation to any member who wishes to spend a day in the laboratory to contact Dr. Lewington or Chief Inspector Jean Bottel (the Police Liaison Officer at the laboratory). Although this invitation is mainly directed to members in London and the Home Counties I know that other Regional laboratory Directors and staff welcome visits from Police Surgeons. Apart from the pleasure we get in meeting old friends it is a duty on our part to keep up to date with changes at the laboratories so that we are always conversant with laboratory requirements and able to provide adequate and proper specimens for them to work on.

During my visit to Belfast I had discussions with the Secretary of the Police Authority and the Chief Constable of the Royal Ulster Constabulary. Thirty members from all over the Province some of whom had travelled great distances attended their Annual General Meeting and like others from the mainland who have never been before, I was most impressed not only by the way in which these doctors cheerfully carry on their normal day to day work sometimes in very adverse conditions but also by the dedication and the highest professional standards they apply to their role as Forensic Medical Practitioners. I am most grateful to my hosts for their traditional hospitality and for giving me the opportunity to see some of their problems at first hand.

## MEMBERSHIP

The state of the membership is as follows:

| | 1977/1978 | 1976/1977 |
|---|---|---|
| Full members | 468 | 446 |
| Life Associate members | 42 | 38 |
| Associate members | 51 | 50 |
| Corresponding members | 14 | 12 |
| Honorary members | 14 | 13 |
| Total | 589 | 559 |

This represents a net increase of 30 members.

I am grateful for the meticulous attention to detail that our Clerk Ron Taylor displays in his control of the Office and for his willing assistance to myself and the Hon. Treasurer for whom he not only chases up overdue subscritions but also refunds those generous benefactors who pay twice. We shall revert to the use of standing orders in the coming year for those who prefer this method of payment.

## COUNCIL

During the year members of Council have been active on your behalf. Once again my task as Hon. Secretary has been made easier by being able to delegate various tasks to my colleagues on the Council who I thank for readily responding to my requests for aid. We especially thank Drs. J.B. White, S.E. Josse and K.M. Hall who retire from Council this year for their help and support during these past three years. Dr. Fuad Gabbani retires from the Presidency after an active two years, unfortunately marred by a recent spell in hospital but from which he is now recovered. He has travelled all over the United Kingdom attending every Council, sub-committee and numerous other meetings held during his term of office while under his Chairmanship a great deal of Council business has been dealt with in an expeditious manner. We are most grateful to Fuad and Jean for

leading us through an eventful two years and for their cheerful enthusiasm in continuing the friendly tradition of our Conference, by ensuring that the social side remains an important antidote to the more serious and sometimes unpleasant matters we have to deal with because of our interest in clinical forensic medicine.

## ADDITIONAL REPORT BY THE HON. SECRETARY

The summer has been a busy one for the Association, contrary to the usual lack of activity in the months following the AGM.

### NORTHERN IRELAND

In Northern Ireland matters concerning the examination of prisoners and alleged suppression of Police Surgeon's reports once again came to headline news in the National Press. A Press statement was issued to the effect that our members were in no way connected with the medical examination of detained persons in places such as the Holding Centre at Castlereagh, and this also stated that where the Amnesty report refers to "'Police Surgeon's reports" these are in the main reports given by doctors working in these Holding Centres and not Forensic Medical Officers. Drs. Bertie Irwin and John Stewart appeared to give oral evidence before the Commission of Inquiry at the end of August and made all the points considered necessary, spending four hours with the Commission.

The Northern Ireland branch have held three small successful group meetings in different areas of the Province — the Eastern Area (under the care of Gerry Hall) held a meeting in Belfast, Hugh Glancy chaired a meeting of the Northern Area at Ballymoney and Ian Johnston organised the Southern Area meeting at Armagh.

### TWO DAY COURSE

It was decided some time ago to run a two-day Course for deputy and assistant/deputy Police Surgeons which included law, medicine and scientific aspects appertaining to Police Surgeon duties. The first Course, attended by eight students at the Metropolitan Police Laboratory in Lambeth was a great success, and the next Course on the 24th/25th October is already booked. A further Course is planned for Spring 1979 after the meeting on Sexual Offences to be held at the London Hospital on 13th January, 1979 (arranged by Hon. Treasurer). When all the more recently recruited Police Surgeons have had the opportunity to attend, then it is proposed to run one day seminars for established Police Surgeons, which I hope will stimulate interest in the DMJ. The directing staff included the laboratory staff, a senior Police Officer, a Solicitor from Scotland Yard and myself. Our thanks are due to Dr. Frances Lewington for her interest and enthusiasm in organising the Course.

I have attended meetings on obtaining proper medical facilities in the Metropolitan area. Three new stations are to be equipped in accordance with the recommendations of the Association. In some other areas it will be possible to modify existing stations, which may then be used to cover one or more sub-standard adjacent stations, which will cease to function for medical examinations.

### A.C.P.O.

An effective and fruitful liaison has been established with A.C.P.O. (Association of Chief Police Officers), through the good offices of their General Secretary, Brian Morrisey, Q.P.M., to whom I am indebted for his prompt and helpful response to enquiries I have made. Our President has also attended the A.C.P.O. Autumn Conference dinner at Preston, and has several other engagements pending at which he will fly the flag for the Association.

Drs. Fred Shepherd and David Filer have agreed to get the research group going. They have already designed a circular which was distributed with the current issue of "The Police Surgeon".

In June I attended the Conference on Road Safety organised by the Ministry of

Transport and joined the working party on Road Traffic and Alcohol. I had the opportunity to discuss and view the field trial breath analysis machines described by David Filer at Torquay and I agree with his views that it will be a couple of years yet before a safe practical device is found for police station use.

The A.C.P.O. have provided full details of medical arrangements currently in use by all Underwater Search Units who, except for two Forces, rely on their Police Surgeons to carry out medical examinations. In view of this, some attention might need to be paid to the proper instruction of members in special requirements applicable to such examinations, especially in respect of the Health and Safety at Work Act.

**H. DE LA HAYE DAVIES**
Honorary Secretary

## ANNUAL REPORT FROM THE METROPOLITAN AND CITY GROUP — No. 8.

One meeting was held during the year on 22nd February, 1978 at St. Thomas' Hospital at which the Honorary Secretary of the Association Dr. H. de la Haye Davies was present.

The Group were addressed by Dr. Lewington, a Senior Scientific Officer from the Metropolitan Police Laboratory who demonstrated a kit to be used by examining doctors in sexual offence cases. The kit was in the form of a pre-prepared package containing swabs, bottles, etc. and a discussion on the kit followed.

At this meeting it was unanimously decided by the members present that the form HORT/5 would be amended to read as a simple certificate from the 15th May, 1978 by the certifying doctor.

As a result of a discussion at this meeting, a one day Seminar on sexual offences is to be held at the London Hospital on 13th January, 1979, and on the previous evening a Buffet Supper is planned at the Worshipful Company of Innholders Hall.

During the course of the year, our representative on Council, Dr. S.E. Josse, has been active in Council, and as he has now come to the end of his term on Council, the Metropolitan and City Group expressed their thanks to him for the way in which he nas stewarded the affairs of the Group in Council.

**A.H. MENDOZA**
Honorary Secretary

## REPORT OF THE NORTHERN IRELAND BRANCH FOR 1977-78

Northern Ireland Police Surgeons have once again been excessively busy during the last year, but we are glad to say that the pattern of work has changed dramatically. We are no longer seeing the number of murders that occurred during the previous eight years. It is interesting to note that the Secretary of the Northern Ireland Branch has only seen one murder this year to add to his previous total of 309.

Deaths due to bombing have also decreased, in spite of the La Mon horror, and most doctors are now concerned with the increase in traffic offences, and the examination of detained persons in Police Stations.

It is the latter which has concerned us greatly over the last twelve months, and this was particularly so in the summer of 1977, when Police Surgeons began to notice some injuries on prisoners held during police questioning. The Northern Ireland Officers of the Association reported their worries and fears to the Police Authority, and this resulted in complete agreement between Police Surgeons and the Authority that such malpractices should be rooted out.

As it happened Amnesty International began to take interest in allegations of Police brutality in Northern Ireland at the same time; and the Officers of the Association, together with the Officers of the Police Authority, appeared before Amnesty Committee on two occasions in the Fall of 1977.

A full and frank discussion took place, and we felt that the good name of doctors acting on behalf of the Police was not breached.

However, it must be reported that some Police Surgeons in Northern Ireland were subjected to harassment by certain sections of the Press and Television media, as they went to great lengths to obtain the views of a number of doctors.

It was pointed out to these people that the vast majority of cases into which they were enquiring were *sub judice,* and that people detained in Police custody and examined by doctors, were regarded by those doctors as patients, and therefore no comment could be made on any allegations. However, this did not satisfy the sensation-seeking reporters, and what they could not obtain by interview they falsified and invented in order to sensationalise the situation in Northern Ireland. This should be a warning to all Police Surgeons who work in the quieter backwaters of our Association who may find themselves, through no fault of their own, in a similar situation; "Forewarned is forearmed".

As a result of our experience from the media and from the opinion expressed by some of our learned Judges the members in Northern Ireland felt the time had arrived when we could no longer be called Police Surgeons, with all the unpleasant innuendo made on the name. It was decreed that henceforth we be known as the Northern Ireland Association of Forensic Medical Officers. We feel that the name is more appropriate to our situation, and describes more accurately the work in which we are engaged.

The highlights of our year were:— A Conference in Cambridge, when again approximately 10% of the total members present came from Northern Ireland. On the sporting side, the Ulster Cup was returned to its proper resting place, having been won by Dr. Gerry Hall of Dunmurry.

Another important time was our Annual General Meeting held in Craigavon Hospital on 15th November, 1977, when some thirty members of the Northern Ireland Branch attended to hear and learn from a distinguished guest — the Secretary of the Association, Dr. Hugh de la Haye Davies.

The meeting was conducted in business-like fashion (even though it lasted over three hours until after midnight) by the Chairman, Dr. John Stewart, in his usual efficient manner.

No Spring Symposia was held this year in Enniskillen, due to the pressure of work, but we hope to have a Symposia in the Royal Victoria Hospital under the auspices of Professor Marshall, prior to our Annual General Meeting in Torquay in May.

**Dr. R.B. IRWIN**

# HONORARY TREASURER'S REPORT FOR THE YEAR ENDING 31.3.78

It is once again my pleasure to present to the Association the Account to the year ended 31st March, 1978, and you will see that once again we have an excess of income over expenditure of £1,386. Our current assets are £7282 which includes £5,824 in a Building Society. Listed among current assets, we have a Sundry Debtor of £500, and since the completion of the balance sheet this sum has been received and will appear in next year's accounts. This was a contribution from Geigy Limited as their welcome contribution to the cost of the Diary. In general, in spite of a background of inflation over the year of at least 12%, there has been a reduction in both Conference and Symposium expenses, and these events now show a slight profit. The Police Surgeon Supplement continues to show a loss, but your Council feel that the excellence of the publication was such that it should be continued and subsidised out of general funds. Included in this year's expenses are the President's expenses which are expenses over two years, and it is my knowledge that the President's expenses to which he is entitled are considerably more than those claimed.

The main source of our income remains the subscriptions from members, and we are still about £450 short of income in this year due to certain members not having paid their dues. In future, we propose to bring all subscriptions into line at an Anniversary date, so that new members joining will pay a proportion of their subscription ensuring that all subscriptions become due on the same date. During the year, Dr. Stan Burges and Dr. James Hilton represented the Association in Northern Ireland explaining an increase in what appeared in the accounts as "Northern Ireland expenses". A close vigilance is maintained upon the expenses and guide lines have been laid down and minuted in Council as to the quantum of allowable expenses appropriate to certain Officers of the Association, and approval of expenses over £50 must receive the sanction of the President, Honorary Secretary and Treasurer.

I am able to report, therefore, another satisfactory year with a continuing increase in our assets. I do not forsee any major expenditure that is likely to erode our assets, except that of continuing inflation, and I would propose to Council that our assets are left untouched because the time could come when expenses due to rising prices will outstrip income. At that time, it will be possible for us by using accumulated assets to keep the subscription rate at its present level when no doubt other organisations will be raising theirs.

I would like to express my thanks to the retiring President Dr. Fuad A. Gabbani, the Honorary Secretary and members of the Council, for their advice and support in the past year, to our Accountant Maurice Orton of Messrs. Orton, Desborough & Co., Northampton, for his valued advice, and especially to Mr. Ron Taylor our Clerk who has, throughout the year, by virtue of his unstinted efforts particularly in trying to gather in overdue subscriptions, made the office of Treasurer a pleasure rather than a burden. Lastly, I must thank the Auditors, Dr. Stan Lundie and Dr. Ivor Doney.

**A.H. MENDOZA**
Honorary Treasurer

## ASSOCIATION OF POLICE SURGEONS OF GREAT BRITAIN

### INCOME AND EXPENDITURE ACCOUNT
For the year ended 31st March 1978

| 1977 | EXPENDITURE | £ | £ |
|---|---|---|---|
| 385 | Stock of Goods – April 1977 | | 233 |
| 63 | Goods Purchased | | 604 |
| 578 | Diaries | 896 | |
| | Less Grant from Ciba Geigy Ltd. | 500 | |
| | | | 196 |
| 172 | Printing and Stationery etc. | | 106 |
| 256 | Telephone | | 291 |
| 406 | Postage | | 475 |
| 2073 | Conference Expenses | | 1189 |
| 2339 | Symposium Expenses | | 1028 |
| 478 | Council Meetings | | 505 |
| 80 | Northern Ireland Expenses | | 347 |
| 185 | (Conference Facilities Prepaid) | | – |
| 42 | Sundry Publications | | 54 |
| 2851 | Police Surgeon Booklet | | 3116 |
| 543 | Police Surgeon Supplement | | 1066 |
| | Donation – W.G. Johnstone Fund | | 327 |
| 196 | Accountancy | | 239 |
| 140 | Miscellaneous Expenses | | 177 |
| – | Bank Charges | | 27 |
| 94 | Presentations and Tributes | | 103 |
| 37 | (Legal Fees) | | – |
| 107 | Depreciation – Equipment | | 64 |
| 119 | (Mrs. Turners Allowance) | | – |
| 65 | Travelling Expenses etc. (Hon. Treasurer) | | 55 |
| – | Presidents Expenses | | 300 |
| | Expenses – Hon. Secretary | | |
| 325 | Travel and Subsistence | 423 | |
| 37 | Postages and Telephone | 26 | |
| 323 | Locums and Attendance | 143 | |
| | | | 595 |
| 200 | (Typing) | | – |
| | Office Expenses | | |
| 2108 | Assistant's Salary etc. | 2378 | |
| 453 | Rent and Rates | 465 | |
| 38 | (Heat and Light) | – | |
| 45 | (Miscellaneous) | – | |
| | | | 2841 |
| 2801 | Excess of Income over Expenditure | | 1386 |
| 17236 | | | £15308 |

| 1977 | INCOME | £ |
|---|---|---|
| 11976 | Subscriptions | 11342 |
| 100 | Bank Interest | 283 |
| 947 | Conference Receipts | 1190 |
| 2026 | Symposium Receipts | 1318 |
| 273 | Sale of Goods etc. | 322 |
| 1677 | Sale of Police Surgeon Booklets | 303 |
| – | Advertising | 121 |
| 233 | Stock of Goods – March 1978 | 419 |
| 4 | Sundry Receipts | 10 |
| 17236 | | £15308 |

### BALANCE SHEET – AS AT 31st MARCH 1978

| 1977 | GENERAL FUND | | | 1977 | FIXED ASSETS | | |
|---|---|---|---|---|---|---|---|
| | Balance at April 1977 | 6233 | | | Office Equipment | | |
| | Add Excess of Income over Expenditure | 1386 | | | At cost less sales | 814 | |
| | | | | | Less Depreciation to date | 364 | |
| 6233 | | | 7619 | 244 | | | 450 |
| | CURRENT LIABILITIES | | | | Photographic Equipment | | |
| | | | | | At cost | 425 | |
| 185 | Sundry Creditors | 240 | | | Less Depreciation to date | 247 | |
| – | Bank Overdraft | 107 | | | | | 178 |
| | | | 347 | 58 | Medallions – At cost | | 58 |
| | | | | | CURRENT ASSETS | | |
| | | | | 233 | Stocks – at cost | 419 | |
| | | | | – | Sundry Debtor | 500 | |
| | | | | – | Loan – W.G. Johnstone Trust | 500 | |
| | | | | 672 | Cash at Bank and in Hand | 39 | |
| | | | | 5045 | Cash in Building Society | 5824 | |
| | | | | | | | 7282 |
| 6398 | | | £ 7966 | 6398 | | | £ 7966 |

### ACCOUNTANTS REPORT

We have prepared the above Balance Sheet and annexed Income and Expenditure Account from the books and information supplied to us and we certify that they are in accordance therewith.

17 York Road, Northampton
24th April 1978

DRTON GESBOROUGH & CO.
Accountants

### W.G. JOHNSTON TRUST FUND
### COMBINED ACCOUNTS 5th APRIL 1977 – 5th APRIL 1978

| 1976/77 | | |
|---|---|---|
| | Balance as at 5th April 1977 | |
| 1437 | Deposit Account | 1312.44 |
| 39 | Current Account | 8.98 |
| 1 | Covenant | 1.06 |
| 3 | Book Royalties (Practical Police Surgeon) | – |
| 183 | Interest Deposit Account | 61.22 |
| 3 | Cash in Hand | |
| – | Investment interest from A.P.S.G.B | 327.00 |
| – | Loan from A.P.S.G.B. | 500.00 |
| – | Pre-publication sales of 'The New Police Surgeon' | 3684.47 |
| | | £5796.17 |

| 1976/77 | | |
|---|---|---|
| 246 | Editorial Expenses | 51.50 |
| 48 | Entertainment | 55.00 |
| 11 | Travelling | 45.00 |
| – | Stationery | 28.99 |
| – | Bank Charges | 1.20 |
| – | Refund of one book | 12.00 |
| – | Refund of over payment of one book | 2.00 |
| – | Hutchinson Benham Publications (two instalments) | 4512.00 |
| | Balance as at 5th April 1978 | |
| | Deposit account | 1003.18 |
| | Current account | 34.23 |
| | | £5796.17 |

# ALIAS PANJANDRUM

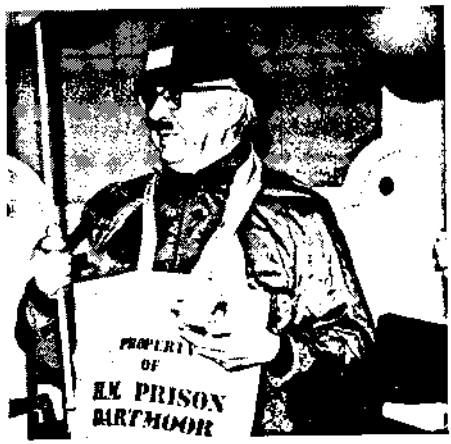
Whilst all right-thinking members of the Association are busy buying and admiring and benefiting from the new book, it is with regret that we have to record that one member of the Association has actively campaigned against the book being successfully brought to fruition. We refer to one William Thomas, alias Panjandrum. This person from Penwortham, Preston, perpetrates persiflage persistently. His freely acknowledged reason for wishing the book's failure was the further achievement of his own literary enterprises — he gazed upon the contributions accumulating in Suffolk with greedy eyes. Fortunately, his map-reading leaves much to be desired, for there is little doubt that otherwise he would have mounted a felonious expedition in the manner of his Celtic ancestors (come back, Offa, all is forgiven).

For many years this comrade of the Picinnies, the Jobililies and the Garyulies has caused dissension and distension within the gatherings of the Association. It is not recorded what happened to the little red button, but there have been rumours. In desperation he was appointed Editor of the Blue Book, an annual which recorded faithfully almost every word uttered at each Annual Conference. This sealed the fate of that epic journal which had appeared without fail for twenty years. No longer may we read of Presidential utterances giving rise to laughter. No more the record of 'applause' or even 'sustained applause'. Crushed by the man from St. Fillans. In its place there appeared a duplicated shadow — a mere twenty pages of flimsy substance.

That shadow survived but one issue, and was replaced in 1972 with a grey jacketed compilation of the words of Burges, Davies, Havard, Brodrick and others. The works of these famous men were hurled to the four corners of the free world, without thought of the disturbance such revelations might cause. And so it has been ever since. The equinoctial dissemination has continued, clothed in many hues. And laterly shamefully coloured prints have appeared within, of a type which have caused many extra copies to be printed to satisfy the whims and fancies of those pleased with such things.

In desperation Thomas, W.M., was elected President one shameful day in darkest Newcastle-upon-Tybe, and those who can still gather the strength to talk about that day will for the price of a pint tell of cabals and intrigue. To the surprise of most, Thomas survived the fate of many foreign Presidents and was not assassinated, and he resigned his appointment some two years later.

It is now said that Thomas has (been?) retired from his appointment with the Lancashire Constabulary, and no doubt that force is now well set to raise its standards to that enjoyed by the country's remaining forces. Be that as it may, there is no doubt many of his cronies and sidekicks have infiltrated the Association. This vicious crew so manipulated the Annual General Meeting, that not one




dissenting voice was heard when it was proposed that Thomas should become an Honorary Member of the Association. It is said that Thomas had perforce to sell his wife into slavery again, to pay for the drink demanded by his supporters.

It is with leaden boots and a heavy heart that we report that this latest disaster inflicted on a long suffering Association will mean that for years to come the yoke of the Penwortham journal will lie heavily on our desks. As we observe the evidence of eccentricity, exhibitionism and transvestism evident in these photographs, we can only fortify ourselves with the thought that it is unlikely Thomas will continue as Editor more than another twenty years.

---

**STOP PRESS** Dr. Collacott of The Orkneys has not yet received his book. Will he please tell us how to get it to him. The Post Office has returned his copy to us and said that he will not go and collect it. If he *has* got a copy, will he please tell us where the hell he got it from?

**WHAT DO YOU THINK OF IT SO FAR?**

Neoburgesism culled from the speech at the Annual Dinner, Torquay.

**GABBANATE** — to welcome any passer-by, particularly a member of the Association, with a generous hospitality without thought of personal inconvenience.

**FUADANATION** — a state of transient poverty brought about by providing pleasure for others.

**FUAJEANOPHOBIA** — the fear of returning Gabbani hospitality, knowing full well it cannot be matched.

---

**STOP PRESS** Do you realise that the 252 books sold through the trade would have meant another £4,500 to The Trust? Please order through James Hilton.

# in narcotic overdosage

## KNOWN

In the emergency treatment of coma, respiratory depression and other signs of narcotic poisoning, Narcan usually acts within 2 minutes of i.v. injection.

## SUSPECTED

Reversal of symptoms by Narcan is diagnostic of narcotic poisoning. If patient fails to respond, a non-narcotic cause should be suspected.

Drugs reversed by Narcan include morphine, heroin, pethidine, fentanyl, dextropropoxyphene, diphenoxylate, etorphine and the non-narcotic analgesic Fortral (pentazocine).

Narcan: 0.4 mg naloxone per ml. 1 ml ampoules.

# Narcan
## (naloxone)
"Pure" narcotic antagonist

Narcan and Fortral are registered trade marks. Full prescribing information available on request from Winthrop Laboratories, Surbiton-upon-Thames, Surrey.

WINTHROP

5549

# EXAMINATION IN SEXUAL OFFENCES

**A full day Symposium to be held at**
**The London Hospital Medical School, Turner Street, Whitechapel, London, E.1**
**on Saturday 13th January, 1979, 10.00 a.m. – 4.00 p.m.**

This meeting is being organised by Dr. Arnold Mendoza, Association Treasurer and Hon. Secretary of the Metropolitan Group, and Professor J.M. Cameron, Professor in Forensic Medicine at the London Hospital. Speakers will include Dr. S. Burges, Dr. David Jenkins, Dr. David Paul, Mr. Bernard Sims and Dr. Frances Lewington.

Lunch on Saturday will be held in the Bleazard Club, London Hospital Medical School. Accommodation in the Bleazard Club is limited to 40, and places will be allocated on a first come-first served basis. Those unable to be accommodated in the Bleazard Club will make their own arrangements for lunch, and will receive a refund. Symposium Fee (including lunch) £8.50. This meeting has been approved under Section 63 requirements.

Metropolitan members of the Association are holding a Buffet Reception at 8.00 p.m. on Friday 12th January, 1979, at the Innholders Hall, College Street, London, EC4, to which they cordially invite visiting members of the Assosication (and their spouses) who are planning to attend the Symposium – cost £9.00 per person. The Buffet Reception will be preceeded by a short business meeting at 7.50 p.m. for Metropolitan members only. Mr. Nevin, the recently retired Chief Medical Officer, will be a guest at this meeting.

Applications for the Buffet Reception and the Symposium are to be made on the form below by all wishing to attend (including Metropolitan members). Full details of the Sympsoium and the Buffet Reception will be sent to each applicant in due course.

---

To: Dr. Arnold Mendoza, H.M. Coroner's Office, Civic Centre, St. Albans.

I wish to attend the Buffet Reception at Innholders Hall on Friday 12th January, 1979. I will be accompanied by guests (cost £9.00 per person) £ .....

I wish to attend the Full Day Symposium at the London Hospital Medical School on Saturday 13th January, 1979 £8.50

Please make cheques payable to APSGB TOTAL

IMPORTANT: COMPLETE IN BLOCK CAPITALS

Your Name ..... Surgery address (if different)

Address ..... .....

..... .....

..... .....

Tel. No. ..... Tel. No. .....

Responsible Family Practitioner Committee/Health Board Cipher .....

Prescription Pad Number .....

Date Received ..... No: .....

Confirmation Sent .....

## 15 good reasons why we're sure you'll be giving us a ring any second now . . .

- 25 acres of woodland grounds
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- 9 hole 'short' golf course
- Squash courts
- Indoor and outdoor swimming pools with sauna
- 5 resident professionals
- Rooms for table tennis, billiards and cards
- Children's playroom and resident nanny
- Resident band
- Ladies' and Gentlemen's hairdressing salon
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- Four star luxury
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**Let us cater for you this year and enjoy yourself at:**

# The Palace Hotel

**Torquay TQ1 3TG**
Tel: 0803 22271

# NOTTINGHAM 78

The Spring Symposium of the Forensic Science Society was held in the depths of the Nottingham University campus early in April 1978. Like all meetings arranged by the Forensic Science Society, it was well attended but there were only four members of the Association of Police Surgeons present. Association members, who are also members of the Forensic Science Society, may have thought, incorrectly, that the subject for the principal group of papers "Crime and Television" would not be of sufficient interest to warrant them attending.

Dr. Alan Usher, a speaker well known to the Association, took us on a guided tour of the new Medico-Legal Centre in Sheffield (see Supplement No. 3 Autumn 1977). This outstanding building is a shining example of what can be done with flair, imagination and a willingness to seek and adopt the best ideas from other establishments throughout the world. No Police Surgeon should pass up the opportunity to visit the Sheffield Medico-Legal Centre.

The Saturday Symposium was preceded by six short papers given by members of the Forensic Science Society. Papers of particular interest included a frightening film demonstration on the instability of motor cycles at high speed, particularly with light riders, a new technique for detection of indented impressions on paper and a film on easily identifiable paints for the marking of mobile property.

Two of the speakers on the Symposium "Crime and Television" were professional television reporters, one from the BBC and the other from Tyne Tees Television. Their professionalism in presentation was apparent but many of the other speakers were of the same calibre.

*Mr. Arthur Chapman*
*President Forensic Science Society*

Three aspects of the Symposium were of particular interest to Police Surgeons. The first was a demonstration by Chief Inspector J. Waghorn of the Technical Support Group, Nottinghamshire Constabulary, of video-tape equipment. He showed scenes of the investigation of a murder and of a post mortem examination. It is evident that this type of recording has great teaching potential and it is hoped that video-tape material will be used at future Police Surgeon Conferences.

Dr. A. Minto, Consultant Psychiatrist at Mapperley Hospital, Nottingham discussed forensic psychiatry aspects of television and its influence on members of the community.

The programme closed with video-tape recordings of observations made at the Spaghetti House seige, using fibre optics and video-tape recordings. Using this equipment, the Police were able to monitor all that was going on between the hostages and their captors.

In an adjacent room there was an exhibition and demonstration of special surveillance equipment and a variety of television and video-tape equipment. In addition there was a stand displaying "The New Police Surgeon", the first public airing of this remarkable new text-book.


# THE NEW POLICE SURGEON — WHAT THE CRITICS SAY

Every chapter of this book is written with the refreshing candour of men used to making decisions and aware of the pitfalls that beset their professional work. They write from practical experience, and with humour, and are not afraid to ride a hobby-horse or two, here and there.

The chapters range from the work of the police and the courts, through forensic medicine and pathology, to legal medicine in all its aspects. The clinical subjects such as sexual offenders and the effects of alcohol are fully explained from a practical point of view, while the more legal sections of the book are clearly outlined with a welcome lack of verbosity.

It would be invidious to congratulate individual contributors, but the Editor deserves special praise for producing a handbook in which the separate essays form a coherent whole, with a minimum of repetition. The format is excellent, and I particularly liked the way that each chapter is given a list of contents. With its comprehensive index the guide makes a perfect work of reference.

It is often said that a particular book should be on every doctor's bookshelf. 'The New Police Surgeon' truly deserves this claim.

*The Practitioner*

The whole book is eminently readable, in particular those contributions dealing with such situations as how to deal with drunken drivers or drug addicts; the Police Surgeon's role vis-a-vis a sexual offender or in the case of non-accidental injury (for example, baby battering); sudden death; and how to exclude foul play.

Not only is the book a useful introduction to young Police Surgeons, but it is also an essential reference book for those who are experienced in this field. All Police Surgeons should buy a copy if for no other reason than that it will surely appear on the desk of every defence council in court during cross-examination of a medical expert.

*Journal of the Royal College of General Practitioners*

*Professor Alan Usher and Dr. James Hilton*

There is certainly more factual information about the work of a Police Surgeon in this book than has ever been assembled in one place before – – – – – – it is clearly going to be the definitive work in English on the subject for many years to come.

*Alan Usher,*
*MB, BS, FRCPath., DMJ (Clin et Path)*
*Professor in Forensic Pathology,*
*University of Sheffield.*
*Home Office Pathologist.*

---

# BUY ONE TODAY!

The gradual filling of the order book pages bears witness to the fact that I have not been idle these lazy, hazy, rainy days of summer. Things are going well, and although we are not yet out of the wood, daylight is clearly visible. Nearly 700 copies sold within four months of publication, and that before any reviews have appeared, is some achievement.

Waiting for reviews feels just like waiting for the exam results. I am fearful of asking, and yet have become weary of waiting. How about members doing their own reviews? Your editors would welcome your comments – the good ones with open arms, the bad ones with shocked disbelief! Seriously, we would appreciate some feed-back from you, our readers.

It is rather exciting to think that "our book" is now being read in seven different countries, apart from places all over the British Isles. It really does make delightful reading, and although I have been through every page many, many times, I still pick it up and discover something I have missed.

My arithmetic is poor, but is easily compensated for by the handy calculator. So long as one presses the right button and in the right order, the answer is swift and sure. My calculator and I now reckon that we can pay for our book by selling another 160 copies. That is if they are bought direct from the W.G. Johnstone Trust. Can we all make one more big effort? Talk to your colleagues, many of whom are not members of the Association. Approach your Chief Constable – 11 Forces and three Police Training Departments (including Bramshill) have already purchased copies. Approach your post-graduate centre – only a handful have obtained the book. Speak to your Casualty Consultant – again only a few A.H.A's have ordered. Ask your lawyer, or write to the local Law Society, and point out the advantages of keeping abreast. Just a bit of canvassing by the 350 members who have so far purchased copies will see us home and dry.

AND REMEMBER – Order through me.

Since taking overall charge of distribution, for every order that has been received a book has been posted back by 10 a.m. that same morning. There will be no delay at my end – GET CRACKING and see that there is no delay at yours.

**JAMES HILTON**

**LIVING WITH THE OPPOSITION —**
**(Or — If you can't beat them — join them)**

For the past three years I have been living with a pipe dream, which has now materialised in the form of a book known to you all as "The New Police Surgeon". To buy a book is one thing, but to be involved in the actual production of one is a revelation.

There are days when all goes well and the atmosphere is all sunshine and light, and then, for no reason apparent to me, my better half is in the utmost depths of depression and almost unapproachable. He shuts himself away in his study and once again I become a "book widow". We all have to creep around for fear of disturbing the genius as he ploughs through the various articles which arrive from all parts through the post.

At last they have all arrived and a meeting with the publisher eventually arranged. A sigh of relief from all members of the household — little did we know that our troubles were only just beginning.

Delays, phone calls, last minute alterations, checking and re-checking, and finally a real body blow. Due to all these problems the publishing costs have doubled, truly a very depressing and disheartening occasion.

Now it is a true state of emergency. "To be or not to be" — More phone calls, more meetings, and at last a most welcome offer (with tongue in cheek) from the A.P.S.G.B., and so the finished product emerges. An outstanding book which could never have been produced without the skill of the various contributors and the understanding and help of so many people too numerous to mention.

We now have a study with one corner piled high with books and boxes. The problems are not yet fully resolved; we need to sell many more books to clear the debt, so please help to increase sales.

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M.H.

READERS — Save this family from its manic-depressive father. Return the kitchen table to its rightful owner! Guard this young boy's sexual development from the pernicuous effects of Chapters 9-11! Buy another copy for Christmas. Ed.

**STOP PRESS** Orders have been received from the following Police Forces:— Bedford, Durham, Hampshire, Metropolitan, Merseyside, Norfolk, Northants, Northumberland, Northern Ireland, Suffolk and Tayside. Do you realise that this means 47 Police Forces HAVE NOT ordered copies. That is a lot of books, and a lot of Police Surgeons who have not been to see their Chief Constable. ACT NOW.

# THE NEW POLICE SURGEON

## A PRACTICAL GUIDE TO CLINICAL FORENSIC MEDICINE

**Editor: Stanley H. Burges, M.B., B.S., M.R.C.G.P., D.M.J.**

**Assistant Editor: James Hilton, M.B., Ch.B., M.R.C.G.P., D.M.J.**

**Foreward by Sir Robert Mark, Q.P.M., late Commissioner of Police of the Metropolis**

### CONTENTS

The Police Surgeon: Police Organisation; Examination of Police Personnel; Examination Room and Equipment; Examination of the Living; Scene of Incident; Examination of Injured Persons; Injuries due to Firearms, Explosives and Fire; Sexual Offences and Allied Subjects; Non-Accidental Injury in Children; Sudden Death; Management of Drug Problems; Alcohol Intoxication; Examination of Mental Abnormalities; Poisoning; Forensic Pathology; Judiciary Systems in the United Kingdom; Legal Responsibility; The Police Surgeon in Court.

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# EVIDENCE TO THE ROYAL COMMISSION ON CRIMINAL PROCEDURE

1. Having regard to the terms of reference of the Royal Commission on Criminal Procedure, it is the considered opinion of the Association of Police Surgeons of Great Britain that at the present time many police investigations and prosecutions are prejudiced by the absence of an expert in clinical forensic medicine.

2. We estimate that there are no more than 150 medical practitioners of acceptable merit in the field of clinical forensic medicine in England and Wales at the present time. (We are aware that the number of 'Police Surgeons' may be ten-fold that figure).

3. We consider that an acceptable clinical forensic physician shall be Competent, Impartial and Available. A discussion of these attributes is, in our view, by no means irrelevant to the terms of reference of the Royal Commission.

4. **Competent:**

   4.1 - Competence requires knowledge of medicine, law and police procedure to a degree quite exceptional for normal medical practice and not required as a qualification for initial inclusion on the medical register.

   4.2. - It therefore follows that post graduate study and experience are an absolute necessity for any pretentions of expertise. At the present time, there is only one post graduate qualification available to those seeking recognition, viz. the Diploma of Medical Jurisprudence (Clinical).
   We readily accept that experience, per se, is often more valuable than a post graduate qualification alone.

   4.3. - The principal motivating factor of those practising clinical forensic medicine is an enthusiasm and sense of vocation for the speciality. The income derived from the work does, of course, play a part but scrutiny of the remuneration received shows the period 1969-1975 to be the only time ever that payment has been at all commensurate with work performed.

   4-4. - For all practical purposes, no agency employing the services of a clinical forensic physician shows any real desire to either recognise or demonstrate recognition of competence. This is, in our opinion, due to two main factors. Firstly, lawyers and courts appear to be easily satisfied with whatever medical opinions are offered and, secondly, the number of competent specialists is so small that police authorities are usually obliged to enlist the aid of any practitioner offering his services, whether competent or not.

   4.5. - A measure of the competence of any clinical forensic physician is to some extent dictated by the facilities he has available to conduct any necessary examination. Regrettably the overall standard of examination facilities in England and Wales is low.

5. **Impartiality:**

   5.1. - In our view no clinical forensic physician is competent unless he is impartial. It is, of course, possible to have an impartial medical examiner who is otherwise incompetent.

   5.2. - The very existence of the clinical forensic physician is almost entirely dependent upon police authorities since they represent the only realistic employing agency.

   5.3. - It is rare for the police to inhibit the professional honesty and integrity of the examining medical practitioner but there are many recorded instances when the examinee has had misgivings about the impartiality of the medical examiner by virtue of the known contractual arrangement

between the police and the medical examiner. The title "Police Surgeon" tends to compound these fears.

5.4. - The Association has considered on many occasions a more suitable title but no acceptable alternative has been found. It is pertinent to mention that the Northern Ireland branch of the Association has recently decided to delete reference to the police in their designation and since 1st July 1978 doctors assisting the Royal Ulster Constabulary are designated as Forensic Medical Officers.

5.5. - The Association cannot visualise any realistic alternative means of being employed other than by the police authorities. A possible but unlikely solution may be for the clinical forensic physician to be a part of the establishment of the National Health Service hospitals and thereby be available to the community in general, and, the hospital, the police and courts in particular.

5.6. - The Association considers the advantages of the police employing a full time clinical forensic physician is outweighed by the obvious disadvantages of implied partiality.

5.7. - Similar shortcomings would apply to any other non-medical departments of the State.

5.8. - An exception to this general rule can be visualised in the appointment of a clinical forensic physician as part of the permanent establishment of the courts that they may be the better informed in assessing and interpreting medico-legal evidence.

5.9. - The Association is of the firm view that all clinical forensic physicians whether employed by the police or not should make their expertise available to any bona fide claimant. It is aware that abuses may occur in the practice of this principle but this disadvantage should be accommodated in the pursuance of justice at least being seen to be done. Persons abusing their expertise may be likened to a form of court mercenary and in our opinion should be discredited by the profession and the Courts. (The assistance of a court medical adviser mentioned above (5.8) would also be of assistance in such cases).

5.10 - Experience in Northern Ireland (and elsewhere in the world, particularly South Africa) has shown that the availability of a competent impartial clinical forensic physician is vital for the preservation of the rights of accused and suspected persons.

5.11. - It is considered imperative that the conduct and form of any medical examination shall be governed only by the requirements of criminal law, ethical code and not conditioned upon any strictures by lawyers, police or any other third party.

5.12. - It is pertinent to mention that the Association believes in and practices the code of conduct known as the Tokyo Declaration initiated by the B.M.A. in 1972 and endorsed by the World Medical Association in 1975. (The Declaration makes particular reference to torture or any other form of cruel inhuman or degrading treatment).

6. **Availability:**

6.1. - The Association believes that in the interests of all parties in a criminal investigation whether the aggrieved, accused or suspected, any infirm person shall be examined as soon as possible.

6.2. - In those cases where the health and well-being of a patient are at risk by reason of any injury or infirmity, treatment should be instituted with expedition.

6.3. - The appearance or presence of informative contact trace evidence may become lost or valueless with the passage of time.

6.4. - Where treatment has been instituted, it is imperative that a clinical forensic physician is able to use his

expertise before that treatment has altered or destroyed clinical findings of evidential value, provided of course that there is no risk to the well-being of the person.

6.5. - In cases where a transient mental abnormality is present (either mental per se, or induced by drugs and/or alcohol) the condition may be either unsubstantiated or unsuspected unless seen as soon as possible by a competent medical witness aware of the legal implications.

6.6. - Conversely any physical or mental condition alleged to have been present at the material time may be rebutted by a competent clinical forensic physician.

7. We accept that the majority of medico-legal examinations are conducted by non-specialist practitioners without prejudice to either the police investigation of the prosecution system.

8. The examination most likely to be prejudiced are the unusual or the serious.

9. Regrettably, the unusual or serious are often not recognised in the initial stages except by an expert. Thus we have a situation where the non expert has been employed to no avail and with vexatious results to; the investigation, the aggrieved, the suspected and the accused.

10. We consider that a serious defect in the present system is when an injured subject is taken to a hospital or a casualty department without reference to an expert and is then examined by a newly qualified and perhaps unregistered medical practitioner who makes no claim to have knowledge of forensic medicine or the associated disciplines of e.g. forensic pathology, forensic psychaitry or criminal law and, who concerns himself, quite properly, solely with the diagnosis and treatment of the injured person.

11. This undesirable situation is often compounded by the misjudged attentions of a nurse or other auxiliary who has no knowledge whatsoever of the special nature of the form and conduct of a medico-legal examination.

12. Experience has shown that the following specific types of case are the most likely to be mis-handled.
    (a) Child abuse.
    (b) Impaired driving through drink and/or drugs.
    (c) Drug misuse.
    (d) Assault by police.
    (e) Injured persons later the subject of examination by the Criminal Injuries Compensation Board.
    (f) Sexual offences.
    (g) Mental disorders associated with criminal offences.

13. The special qualities required for the proper presentation of medical evidence for the benefit of police, lawyers and the courts is not a qualification of the medical profession.

14. A certain increase in personal assault, mob violence, and terrorist activities will necessarily mean an increase in those cases deserving the expertise of the clinical forensic physician.

15. However important the role of the clinical forensic physician as a witness to fact, perhaps even more important is the credibility of any expressed opinion in relation to assumed or claimed expertise.

16. An increase in the numbers of clinical forensic physicians may be achieved in two ways:

    Firstly, by the encouragement of post graduate educational facilities in the speciality, either by University Departments or bona fide institutions, e.g. The Association of Police Surgeons of Great Britain.

    Secondly, by the assurance of a realistic scale of remuneration.

17. Those employing the services of a medical practitioner should be more discerning than hitherto and recognise the usefulness of the true expert.

18. Though fully cognisant (perhaps more than most) of the need for the efficient and economical use of resources, we are unable to give more than generalisations about the likely increase cost (if any) in providing a better clinical forensic medicine service.

19. We are certain that at the present time there are anomalies in that similar fees are paid to widely differing degrees of expertise.

20. It may be argued that expertise properly used may result in increased efficiency and at no extra cost. Certainly a medical examination by the non expert may result in purposeless police deployment and increased litigation costs.

21. We recommend to the Commission perusal of "The New Police Surgeon — A Practical Guide to Clinical Forensic Medicine" edited by S.H. Burges. Hutchinson Benham. London, 1978 for a more definitive appraisal of the qualifications of a clinical forensic physician. (Copies may be readily obtainable from the Association).

**H. DE LA HAYE DAVIES**
*Hon. Secretary*

# COVER PHOTO COMPETITION

There are many members of the Association skilled in the use of a camera, as exhibitions at past conferences have shown. Others are equally talented, but are diffident when it comes to showing the end results to the critical eyes of colleagues.

Now is the chance to exhibit your craft to the whole Association. The competition is for black and white prints only, suitable for use as a cover for the Police Surgeon Supplement, and is open to members of the Association and their immediate families.

The subject — any theme with medico-legal connections, suitable for the cover of the Supplement, whether it be the scene of a long-forgotten murder, the local Crown Court, a disused prison, or a montage of weapons removed from the visiting team's supporters!

There is no limit to the number of prints which may be submitted. Each print must be marked on the back with the competitor's name, address, title of print, and a brief note of the medico-legal connection of the print, if not evident in the title. Prints should be well packed to prevent damage in the post.

Prints — black and white only — should measure not less than

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A succinct and compendious Description of such Tokens in the Human Body as are requisite to determine the Judgment of a Coroner, and of Courts of Law, in Cases of Divorce, Rape, Murder, etc.

SAMUEL FARR – Published 1788.

## CHAP. IV

## ON RAPES

In the consideration of rapes, three objects of attention present themselves.

1st Whether a rape, strictly so called, be possible?

2nd Whether a woman, upon a rape being committed, can become pregnant?

3rd What are the signs of a rape being perpetrated?

1st. In answer to the first question, whether a rape be possible, meaning upon a grown person, it may be necessary to divide it into two parts, as it is distinguished into the attempt and the consummation of a rape. The attempt, under which is to be understood a great force exercised over a woman to violate her chastity, but where a compleat coition is prevented, may be possible. But the consummation of a rape, by which is meant a compleat, full, and entire coition, which is made without any consent or permission of the woman, seems to be impossible, unless some very extraordinary circumstances occur: for a woman always possesses sufficient power, by drawing back her limbs, and by the force of her hands, to prevent the insertion of the penis into her body, whilst she can keep her resolution entire. Besides it is evident that a lesser resistance can prevail against the motion of any body which acts against the weight; and that is the case here; the penis, in attempting an immission into the vagina, moves a body against the weight.

2nd. With respect to the next question, whether a woman, upon whom rape hath been committed, can become pregnant? It may be necessary to enquire how far her lust was excited, or if she experienced any enjoyment. For without an excitation of lust, or the enjoyment of pleasure in the venereal act, no conception can probably take place. So that if an absolute rape were to be perpetrated, it is not likely she would become pregnant.

3rd. The signs of a rape having been perpetrated, or rather attempted, are taken from the evacuation of blood from the injured parts, and great swelling and inflammation. But as these may be induced by other means, or are not inconsistent with consent having been obtained, they can only be considered as corroborating, but not as certain proofs.

As rapes however are sometimes committed upon young children, who may have the signs of their virginity obliterated by them, it may be necessary to consider what are those signs and what are the marks of their being destroyed. The signs of virginity then, may be allowed to be the following.

1st The lips of the pudendum are more prominent, and close together.

2nd The nymphae are small, endued with a light rose colour, and do not extent out of their place.

3rd The prepuce of the clitoris is small, and does not cover the glans.

4th The orifice of the urethra, or urinary passage, is entirely covered.

5th The wrinkles of the vagina are considerable, and raised above the surface.

6th A bridle or froenulum appears before the lips of the pudendum.

7th The hymen is likewise present, by which is meant a thin tense membrane situated at the entrance into the vagina, being sometimes of an oval figure, sometimes circular, and sometimes semilunar, and shutting up greatest part of the passage. This hymen hath been esteemed a certain mark of virginity, when other circumstances concur to give it authority. It is not, however, by any means absolute, even in the youngest subjects; for it may be so concealed in

the back of the vagina, as not to be perceptible at first sight, or it may be destroyed or obliterated by a variety of causes, besides a connection with a male. A fresh rupture of it, however, may be perceived, and some remains of it will continue evident for some time.

The marks by which it is most probable that a female hath accustomed herself to venereal habits, and of consequence is less to be believed upon a deposition for a rape, are the following.

1st The lips of the pudendum are flaccid and distended more than in a maiden.
2nd The clitoris is enlarged and hath a prepuce which covers the glans arising from constant friction and is produced to defend it from injuries in proportion as it is exposed to them.
3rd The nymphae are likewise enlarged, and are of a lighter and more obscure colour.
4th The orifice into the urinary passage is more open and exposed. This is owing to the flaccidity of the labiae.
5th The hymen is wanting, as may naturally be supposed, but it is not to stand as a test by itself, where the other circumstances do not occur.
6th Some small excrescences arise in the shape of the berries of the myrtle (called from thence carunculae myrtiformes) at the entrance into the vagina.
7th The vagina is enlarged and spacious, and this even where there has been no parturition.
8th The wrinkles are less prominent, and in length of time are quite obliterated.
9th The orifice of the uterus approaches nearer than before to the orifice of the vagina. This, however, must be entirely relative, as the extent of the vagina must differ in every subject; and besides, it presumes upon an acquaintance with the person pervious to the habit she is engaged in, which is not easily to be acquired.

*The assistance of Mr. Derek Crook, Librarian of the Liverpool Medical Jurisprudence Institution is gratefully acknowledged.*

## THE GRAPHIC FEBRUARY 4th, 1883

The most merciful mode of inflicting the death-penalty has been carefully studied by a State Commission in New York, who have now reported to the Legislature. Their report is a most ghastly record of the different methods of putting to death, from the days of Moses and the early Chinese down to the present time, when in civilised countries the sword and the guillotine are the most frequent means of execution. Beheading is almost general on the European Continent, the guillotine being used in France, Belgium, Denmark and several German States, the sword in Prussia and Italy, both sword and guillotine in Switzerland, while shooting is generally reserved for military cases, except in some parts of Germany and South America. Great Britain, the United States, Holland and Portugal prefer the gallows, which are also used in Russia as often as the sword, while Spain uses the garrotte. The American Commissioners condemn all these modes of execution alike as barbarous and revolting, and recommend the infliction of death by electricity. This method is certain, painless and instantaneous, nor does its carrying out depend on the skill of the executioner. The condemned culprit is seated in a chair with a head-rest and a footrest. A button is touched, and he is dead immediately. The object of capital punishment is to remove the criminal, and electricity affords the means most in keeping with the civilisation and scientific achievements of today.

## WALL SHIELD

A wall shield bearing the insignia of the Association of Police Surgeons is now available, and may be purchased at £5.55 including postage direct from the suppliers.

Montague Jeffery, St. Giles Street, Northampton, NN1 1JB.
Time between receipt of order and delivery will be approximately 12 weeks.

# DEATH AND LIFE

What do we understand of life and death? Dictionaries state that death is the opposite of life, and life the opposite of death. The way life has evolved is probably clearer. We are reasonably sure that living matter first appeared a long time after the world came into being. Then, probably by random changes, over a longer period, we developed to the stage of man, the only animal aware of himself and his life and death.

A simple way to look at human life is as a continuous flow from the beginning, running through man today, and on into the future. Human life in this constant stream is everlasting, without end, immortal, as it passes from individual to individual through the process of reproduction. The individuals are mortal, only passing on the torch of immortal human life to their children.

Those of us who have religious belief in a creator, can also see in modern scientific style, the life of each new individual man starting on earth, as ongoing creation, at each genetic interchange of sexual fertilisation of a human ovum: the moment of conception. The individual man goes on living on earth, briefly or long, until the cessation of living matter in him: the moment of death. Whether there is existence before conception, or after death, is not our concern here.

What directly matters to man, and has done in recorded time, is his need to fix artificially recognisable limits of the span of individual human life on earth. This has always been accepted legally for secular purposes as from birth with the onset of breathing, till death the complete cessation of breathing. The differences between these latter long established views and the modern religious model cited, have caused misunderstandings.

The long time interval between the two views, that a human life starts at conception, or that it starts at birth is the battleground between those against and those for abortion. We shall not consider this here, either.

Till recently there was no doubt that the end of individual human life on earth was evident by complete cessation of breathing. Mistakes were made, and still will be, but for secular legal purpose it was sufficient that individual human life on earth extended from the first to the last breath. But this has now been complicated by the coining of a new notion of death, "brain death", which either precedes or possibly coincides with legal death. This term has emerged from the use of artificial respirators to ensure oxygen supply to the tissues. It is now possible for an individual unable to breathe normally to have his respiration artificially maintained for long periods, and even after he is deemed dead. A new jargon has arisen to mislead many.

The main aim of this article is to suggest that in these matters only a single term is needed, death, meaning cessation of all vital function in the individual.

The circumstances which have occasioned present confusion are interesting. When patients for a variety of reasons are no longer able to breathe normally, they are often "supported" by a mechanical respirator, so that there can be a supply of oxygen to the tissues. If this is not done, there is very soon failure of the pulsating heart, and death ensues. However, in serious brain damage it is possible that a respirator will merely maintain other organs, while the extensively damaged brain fails to show activity of recovery and may degenerate, and this can go on a long time, to no purpose, but respiration and heart-beat still go on, while the brain has reached irreversible coma.

It is thus essential to determine a point of no return, when the respirator no longer serves a purpose and so can be removed. The patient then is back to "square one" in his original state before use of the respirator, and goes on naturally and unaided to his death, soon after.

This issue, however, is complicated by another. The organ transplant surgeons quickly recognised that these dying patients, often young victims of traffic accidents, could be a valuable source of essential organs. So if it was possible to make adequate arrangements, the organs were taken as soon as the patient

had died, after his respirator had been disconnected. Dying is rarely an instantaneous process of the whole body and some organs last longer through the continuing activity of their cells, and so if removed quickly are still functioning and can be suitable for transplanting. The individuals from whom the organs were taken after death were wrongly called donors though "donation" is not possible after death. Soon it was realised that there would be better transplant results if the organs were taken not after the respirator was switched off, but before, and so before death, the organs would be better oxygenated, function better, and be better able to take on the needs of the receiver. So some transplant surgeons did take organs, while the respirator was still running, the heart was still beating and the patient had not died, though the brain was deemed beyond the point of no return, that is in irreversible coma. What the status of these organ removals was is questionable.

Were the relatives agreeing to removal of organs before death? If both of paired organs, or one non-paired organ, were taken at this point before death, could this procedure have been considered technically as homicide? Be that as it may, when organ removal happened before switching off the respirator, they were said to be taken from a "beating heart cadaver". As death had not yet arrived it was not a cadaver; so again this was a misleading term. The seal was set on the procedure when the authoritative view was expressed that it was unethical to transplant organs other than from a "beating heart cadaver".

A worried priest did write to the press asking which of his colleagues would be prepared to officiate at the burial of a "beating heart cadaver?"

Further confusion arose in the lay mind, when the point of no return, the diagnosis of irreversible coma, at which the respirator might be disconnected was inappropriately termed "brain death", though the patient was not yet dead. To lay public and press this term "brain death" implied death of the (whole) individual via some cerebral process. Then, even stranger, at least two state legislatures in the USA enacted laws approving "brain" definition of death. This may be convenient, but still has to pass the test of time and experience.

However, "BRAIN DEATH" is now part of official medical jargon, and has been sanctified by an *ad hoc* committee of Harvard Medical School in 1968, and then in 1976 a special committee representative of the British Royal Colleges; each determined and reported on definition and diagnosis of (so called) brain death. If the medical profession wished justice to be done and to be seen to be done, it might have been wiser to invite a responsible lay authority to set up its own committee to reach decisions on death in any of its aspects which are the concern of all of us, and not only of doctors.

Certainly, laymen, press and many doctors are mightily confused; two examples will illustrate. Recently the press reported that a man with serious head injuries, dead on arrival at hospital had been revived, but a few days later his life had been switched off. In another case: "On Sunday tests showed he was clinically dead . . . The life support system was disconnected and the patient died on Monday night". Some lay people understandably believe doctors do kill patients, intentionally.

I want to suggest that the confusion lies in the use of the word, death, in two different ways: first, meaning wrongly the irreversible destruction of the brain; second, meaning rightly the end of the individuals life on earth.

It should be sufficient to explain that the severely brain damaged patient unable to breathe was temporarily helped by a respirator. When he reached the point of irreversible coma as diagnosed by the standards of Harvard and the Royal Colleges, and thus there was no hope of recovery, it was considered reasonable to disconnect the respirator, which no longer served its original temporary holding purpose. Had the respirator not been used at all, the patient would have passed quickly along the path to his death, for lack of oxygen – as he could not breathe. The respirator when used delayed this outcome, but once it was

From

Our Ref. Date

To H. de la Haye Davies
CREATON HOUSE
CREATON
NORTHAMPTON

Your Ref.

disconnected, the patient still unable to breathe, continued unaided on his original course, and reached the finish of his life on earth, his death, naturally. Thus, in the same way as if the respirator had not been used, the criterion of cessation of breathing as evidence of death still holds, and there is no need for such a misleading term as brain death.

Some may consider this academic and that the interval from diagnosis of irreversible coma to death is only theoretical and very short. This need not be so. The "beating heart cadaver" routine has shown that the time between diagnosis of irreversible coma and occurrence of death can be prolonged artificially at will by keeping the respirator working, to provide sufficient opportunity to make all arrangements, and then to take the organs which thus have been kept well oxygenated.

Indeed this interval from irreversible coma to death could be vastly expanded over years, if the ideas of Willard Gaylin, an American Psychiatrist are valid. These were set out fully in an article entitled "Harvesting the Dead" published in a Harper's magazine in USA in September 1974, for all to read. This was followed by a brilliant resume in a feature article in World Medicine in March 1977 in this country, under the title "A Consummation devoutly to be wished?" During the interval between diagnosis of irreversible coma and occurrence of death, in its state of continuing living, the "beating heart cadaver" is said to have a surprising potential. Dr. Gaylin has wrongly, in my view, renamed the "beating heart cadaver" a "neo-mort", as though the still living individual were already dead. He suggests that "heating heart cadavers" alias "neo-morts" could be used (literally in vivo, as I see it) over long periods if efficiently handled (i.e. I assume, nursed), for many purposes. These purposes include:— medical education on the live body, teaching techniques of examination, of diagnostic procedures, of operative surgery; testing out new drugs and new treatments; experimenting on living functioning human bodies, not those of animals; then again, organ banking, harvesting periodically blood and other products; and also the manufacture of anti-bodies. I can see no reason why pregnancies and live births could not also possibly be produced by AID. It has even been suggested by others that decorticates, the so called cabbages of chronic hospitals, might be used. These examples suggest that the interval from irreversible coma diagnosis to occurrence of death need not be theoretical and short, and might be vastly expandable. The diagnosis of irreversible coma and occurrence of death are quite separate points of time in the life span, they are not of comparable quality and certainly are not the same.

This present situation probably arises from doctors unwisely making decisions outside their own field. The warnings and clear thinking of non-medical experts could have been heeded. I go all the way with one, Hans Jonas, when he wrote, "Nothing less than the maximum definition of death will do — brain death, plus heart death, plus any other indication that may be pertinent, before final violence is allowed to be done"..

Some of the present confusion has also arisen from the lack of openness and honesty over death — a conspiracy of silence — a taboo strictly observed by our Victorian ancestors, and still much in existence. It is remarkable that though we now teach preparation for marriage, pregnancy, birth, parenthood, retirement, old age and bereavement, we never do anything about preparing for death. We try to ignore death, we do not want to know, the public are just not interested. Yet, it has been sagely written by Thomas Filler, "Dying is as natural as living", and by Dietrich Bonhoeffer, "Death is the supreme festival on the road to freedom".

During our lifetime on earth, we may never fully understand life and death, the ultimate mysteries. But, we should try at least to appreciate correctly our point of exit. Until there is adequate preparation for death we shall not be able to say with Pope John, when he learned he was dying, "Don't worry about me. My bags are packed. I am ready to leave".

The last word surely goes to Dag Hammerskjold, he wrote, "In the last analysis it is our conception of death

which decides our answers to all the questions that life puts to us".

**REVEREND WALTER HEDGCOCK, M.D., F.R.C.G.P.**

*The Reverend Walter Hedgcock was in General Practice in Cambridge 1933-51 (excluding years of war service in the R.A.F.). He was a Police Surgeon for a short period.*

*He then served at B.M.A. Headquarters on the Medical Secretariate between 1951 and 1973, retiring as Principal Deputy Secretary.*

*In the early 1950's he was concerned with Drs. Ralph Summers, Charles Johnson, Francis Camps and others, with the conception, gestation and delivery of the Police Surgeons Association and especially its relationship with the B.M.A. Committee structure.*

*In 1972 he was ordained as a New Anglican Priest in the Norwich Diocese. He was Priest-in-Charge of two Norfolk Parishes between 1973 and 1976.*

*He is now adviser to the Bishop of Norwich on scientific responsibilities. He writes and lectures extensively on subjects of scientific and religious relationships, particularly on "Respect for Human Life" and its medical problems.*

*He is an Honorary Member of the Association.*

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# ASSOCIATION OFFICE

Office Address:
**CREATON HOUSE, CREATON, NORTHAMPTON, NN6 8ND.**
Office Hours: 2 – 6 p.m. Monday– Friday

Telephone: (Creaton) **060-124 722**

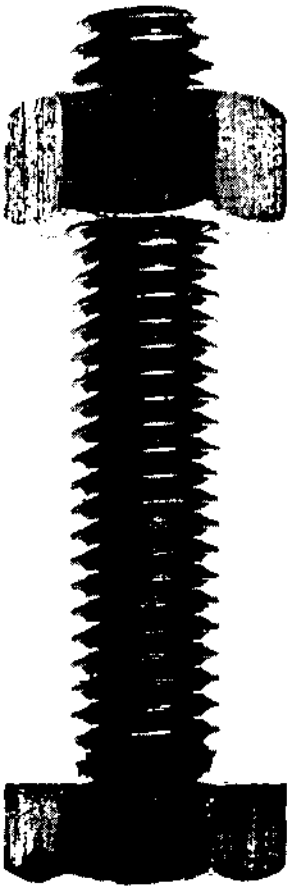
## ASSOCIATION EMBLEMS

The following articles bearing the Association motif may be obtained from the Hon. Secretary at the Association Office:

1. **Aide-Memoires** — documents for recording notes made at the time of forensic medical incidents ..... packets of 50 ..... £2.00

   Postage Charge on Aide-Memoires 55p (one packet), 75p (two packets).

2. **Key Fob** with the crest in chrome and blue enamelled metal ..... £1.00
3. **Terylene Ties.** Silver motif on blue ..... £3.00
4. **Metal Car Badges,** chrome and blue enamel (for hire only) ..... £5.00
5. **Car Stickers** for the windscreen (plastic) ..... each 50p



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# SOME THOUGHTS ON SEXUAL ASSUALT

NESTA H. WILLIAMS

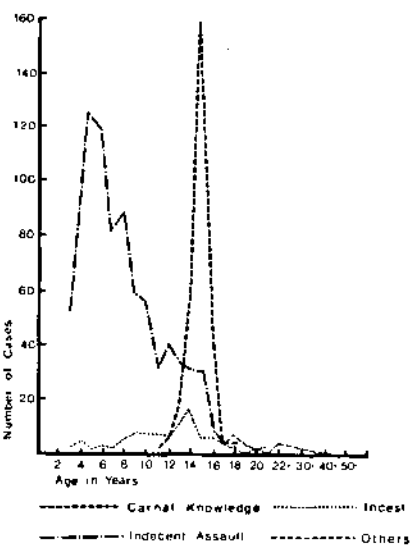
*1933*

The report in the BMA News of the 25 years of the Police Surgeons' Association led me to write to Forum that it was 50 years last year since I was appointed the first Woman Police Surgeon to the City of Manchester, and your Editor has asked me to enlarge on it.

In the early years of this century, before the 1st World War, people were beginning to realise the bad state of the inhabitants of the poorer parts of our cities, and in Manchester groups were formed to do Social Welfare work, such as the University Settlement, the Schools for Mothers, Women Citizens, etc. By the 1920's a woman councillor was put on the Watch Committee. She knew at first hand of the numerous assault cases that occurred and by 1927 had persuaded the Committee to appoint a woman doctor to examine the women and chiildren, and I was appointed.

Conditions at first were primitive, but the Committee was gradually waking up to see the need for the expansion of their work though it was 1938 before the four district G.P. Police Surgeons were replaced by a full-time surgeon (Dr. Blench) and the forensic laboratory was formed. After some public protest it was agreed that I should continue to see the women and children. In order to support demands by facts I made a survey of the cases examined during the previous 10 years, to 1937. Of the 583 cases seen there were 10 under 3 years old, 78 of 4 years and 5 years and 189 of 6 to 10 years and 169 of 11 to 15 years. 124 were 16 years and over. This meant that 277 (about half) were under 11 years of age and 446 under 16, and they ranged from 40 to 96 per annum.

*Fig. 1. Cases by Age 1927-1954*



The striking point was the large number of little girls assaulted, and this was confirmed when I surveyed the total (nearly 2000) cases seen between 1927 and 1954. (Fig: 1).

In an early series of 274 cases most came from the poorer parts of the city but few from the real slums, probably because the lower moral standards led to fewer being reported. 156 occurred in houses, 77 in streets or entries and 39 in open places, fields or crofts, including 11 in parks. This rather emphasises the need for foot patrols where car patrols cannot reach.

Fig: 2 shows the annual totals of each type of case as well as the total of all cases. Those of indecent assault are by far the highest, between 40 and 60 per annum.

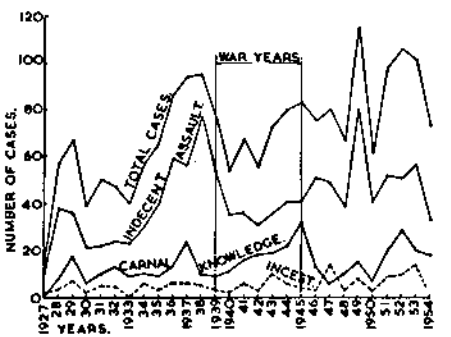



*Fig. 2. Total of all cases 1927-1954*

The number increased considerably in the late 1930's but fell during the war, when the carnal knowledge cases were more numerous. After the war the proportions were much as pre-war but the totals of both were higher. Still more than half were on girls of under 11 years of age.

These latter children in particular have often been very frightened as well as hurt, so it is important to gain their confidence and reduce as far as possible any further psychological trauma. Better statements are obtained if taken by police women experienced in dealing with children and of course the medical examination should be made as little unpleasant as possible (preferably by a woman).

In the courts efforts were made to improve the conditions to meet the special problems of the child witness in these assault cases. After-care had to be thought about and likely cases referred to the Diocesan Moral Welfare Officer or similar worker. Many cases were dismissed through lack of sworn corroboration. Particularly worrying were those concerning the 5 or 6 years olds who, being under 7 years, could not be sworn nor their evidence accepted unless their complaint had been made at the "earliest possible moment". Too often this was not interpreted with common sense and the case fell through.

Concern for the older child arose when the more serious cases had to be referred to the Sessions or Assizes. This meant delay of weeks or even several months before the case was tried, and also involved further repetition of her statements to the police. This put much strain emotionally on the girl, and her memory for details became more blurred, resulting in less convincing evidence, especially as many were "a bit slow on the uptake" or actually mentally retarded.

As many of the men were old, mentally slow and suffering from various perversions, a medico-psychiatric report might have helped in deciding how best to deal with them. These and other problems were discussed with some of the magistrates and various women's societies in Manchester and gradually the idea of the need for change spread to other regions.

Nothing very much was done until after the war. Since 1949 the BMA, the Medical Women's Federation and the Magistrates' Association have issued various reports* and in 1961 correspondence in the Times on Sexual Assaults led the BMJ to print a triple report by a Legal Correspondent, a Magistrate (Sir Basil Henriques) and a Doctor (myself). In 1967 there was correspondence with the Home Office, but since then I have lost touch. However, I expect that although improvements have been made there probably remains much to be done, as I hear from one of your members that still over half the little girls assaulted are under 11 years.

Justice should be seen to be done to the person assaulted as well as to the accused.


JUDITH SMALLSHAW

Comparisons may well be odious but, on listening to the radio broadcasts from the House of Commons (which sound like a cross between a pre-school play-group and the Goon Show) and comparing the goings-on at Westminster with the way in which the affairs of the Association of Police Surgeons of Great Britain are handled, one can only regret that there are not more people of the calibre of members of the Association in Parliament.

This analogy was consolidated at the 27th Annual Conference which was held at the Palace Hotel, Torquay, in May 1978.

On the afternoon of the first day, the gate to the lectures was flung wide by the first speaker, Mr. John C. Alderson, Chief Constable of the Devon and Cornwall Constabulary who read a paper on 'Law and Authority', a subject of formidable dimensions.

He was followed by Professor C.F. Parker of the University of Exeter who spoke, to our edification and satisfaction, on the effect of drink and drugs on other offences.

*Mr. J.C. Alderson* *Prof. C.F. Parker*

Fortified by tea, the eighty-three delegates then heard Mr. Henry Sykes-Balls, HM Coroner for Torbay and District, give an amusing resumé on 'The Coroner's Jurisdiction' and its importance to present-day anomalies coupled with an entertaining abbreviated history of the vocation of the Coroner and the function of his Office as a whole.

*Mr. H. Sykes-Balls* *Dr. D. Filer*

Dr. David Filer, an Association member and well known to us all as a medical journalist, kicked off on the second day with his paper, 'The Intoximeter Comes To Town'. In this he dealt with the apparent need to provide a precise breath test to determine blood alcohol levels which would preclude the present blood samples for laboratory testing which Police Surgeons are required to take from drunk-in-charge suspects.

Dr. Filer pointed out that most of the various machines which were on trial were considered to be unsatisfactory, being only relatively accurate where the lower blood alcohol levels were concerned; the higher the level, the more inexact the readings appeared to become.

In any case, the use of these machines could not pre-empt the attendance of the Police Surgeon on these cases. He would still have to go to the station to ascertain whether or not the suspect were ill or under the influence of drugs. Also, some drivers may be too drunk to use the machine or may be hospitalised due to injury (the machines are not portable). It takes time for the intoximeter to be recalibrated after use – evidence of which will have to be produced in Court – and could not, for instance, be used three times within 20 minutes, whereas three blood samples can easily be taken in this time.

Taking into account the fact that only 1,000 machines would cost in the region of £2,000,000 – and there are over 5,500 police stations in Great Britain – the scheme would appear to be unfeasible, especially as the intoximeter breaks down all too easily and is not 'police-proof'. Each station would therefore need a back-up machine and staff to man, repair and calibrate. The machine is still in the experimental stage and there is no indication when, or if, legislation for its general use may be passed.

These facts, coupled with the enormous initial and running costs of the intoximeter, would seem to forestall its general use for some time. In the future, the Police may be trained to use this glorified Alcotest apparatus but, in the meantime, the Police Surgeon continues to remain the official Police blood-sucker.

This was followed by an interesting and very amusing lecture by Detective Chief Superintendent P.J. Sharpe of the Devon and Cornwall CID and Dr. A.C. Hunt, Home Office Pathologist – or was it a West Country staging of the Morecambe and Wise Show? A superbly entertaining joint paper in which examples of local homicide cases were given – some of which were still sub-judice – and their attendant forensic pathology explained.

*Dr. Hugh Davies, Dr. Stan Burges, Dr. H.C. Hunt & Det. Supt. Sharpe*

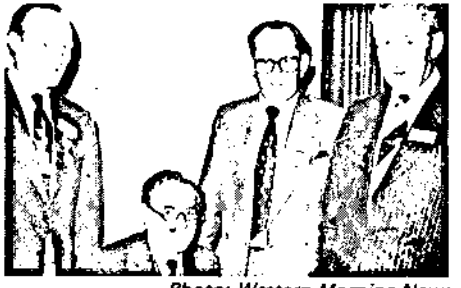


*Photo: Western Morning News*

Put before us were a crime of passion, an instance of baby-battering resulting in death and a case of filicide; the first murder reported from the Scilly Isles in 400 years.

One rather alarming fact which emerged from this lecture was that, in 1976, there were more murders in the Torbay district than in the whole of the Metropolitan area.

*Mr. T.C. Crewe*

*Mr. A.S. Davies*

A commentary on the subject of forensic odontology and the presentation of three cases was included in the next address given by Mr. T.S. Crewe and Mr. A.S. Davies, both Forensic Odontologists, in a joint paper entitled 'Bite Marks and Knocked-out Teeth'. In another hilarious double act we were assured that the title was not chosen by either Mr. Crewe or Mr. Davies as neither of them had 'actually met an unconscious tooth!'

The serious part of their talk covered proof of bite identification in homicide cases with photographic examples of suspects' tooth impressions matching actual indentations in flesh and also evidence of slipping dentures showing clearly in the bruise marks on a cadaver.

At this juncture the delegates went to lunch, no doubt with their teeth aching from what had been heard and seen – and their sides in the same state from the

laughter induced by Messrs. Crewe and Davies.

Later, members were given the opportunity to air general problems appertaining to the everyday work of the Police Surgeon which were discussed spontaneously with senior members of the Association from the floor of the Conference.

This useful addition to the proceedings was followed by a comprehensive and entirely fascinating history of The Police Surgeon from the inception of the rôle in the early 19th century to the present day. This was given by Dr. R.D. Summers, OBE, who is well-known in the Association and is a founder member and past-President.

The work of the Prison Officer within the Prison Service was the title of the next paper read by Mr. B. Wallace, Senior Prison Hospital Officer of HM Prison, Dartmoor. He told us that, after an all-embracing training in most aspects of medicine, which is covered in an incredibly intensive three months, the Prison Hospital Officer has not only to be a Jack of all trades but also a virtual master of them all.

Such diverse problems as assisting in theatre, coping with psychiatric cases, reading X-rays and separating fighting homosexuals are not exactly dealt with simultaneously but are all in the order of the day.

The Prison Officer was again in the spotlight when Dr. P.A. Trafford, Senior Medical Officer, HM Prison, Bristol, took his place at the microphone. His topic was 'Homicide in Acute Porphyria' and his lecture covered the whole spectrum of this rare disease.

He also gave an interesting and detailed example of the case history, from both the physical and psychiatric angles, of one of his own patients who had suffered from this 'purple disease' or, in the American idiom, 'the coco-cola syndrome!'

The last day of the Conference was resumed with seven Association members presenting short papers on their own subjects: a new innovation which we all hope will be used again in future Conferences.

*Dr. P.A. Trafford* *Dr. M.J. Jardine*

These included Dr. Hugh de la Haye Davies, Hon. Secretary of the Association and Dr. Hubert Cremers, Principal Police Surgeon, Rotterdam, a regular Conference delegate.

Dr. Davies held our close attention with his talk on attempted child poisoning in hospital in which he quoted extensively from one of his own horrifying cases, while Dr. Cremers came near to revealing chauvanist porcine tendencies in his amusing lecture entitled 'Sexual Equality — for all police duties?'

Adding to this plethora of talent from within our own ranks, Dr. Ivor Doney, member of Council for the Association, gave a very interesting talk: 'Intersex and the Medico-Legal Aspects'. Intriguing slides jostled with gonadal diagrams and chromosomic symbols to illustrate some of the cases in which sex defies differentiation.

Last on this full programme of lectures, but by no means least, came Mr. M.J. Jardine, Deputy Director in the Department of Public Prosecutions, who gave us a generous and enlightening insight into the way in which this all-important Office really works.

The public image of the Police Surgeon is usually that of a general leech or duty dracula, having little else to do but take blood samples from captive drunken drivers.

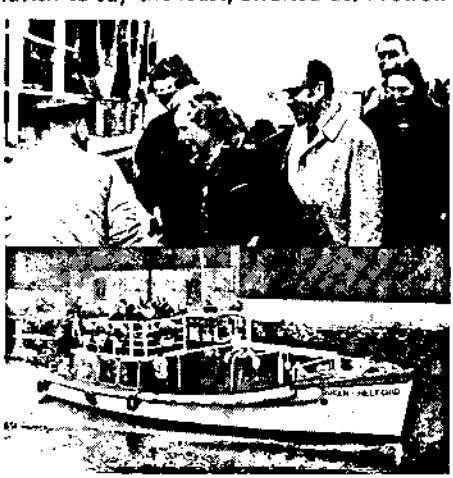
If only the general public could have heard the proceedings from the platform at the Torquay Conference, they would certainly have gone home with a very different impression: that of a man with a multiplicity of talent, knowledge and dedication to a difficult, demanding and sometimes Herculean task.

# KEANLY OBSERVED

GILLIAN KEAN

The "social whirl" of the 27th Annual Conference began on Monday when the first of the delegates arrived. Between lunch and dinner many old friendships were renewed and new ones were established.

On Tuesday immediately after breakfast a party of 40+ left the hotel by coach for a day's tour. After crossing the River Dart by car ferry we stopped for coffee at the Dart Marina Hotel and although 'Gran' lost her shoe down the staircase she managed to climb the stairs admirably. We left the hotel and boarded the launch to enjoy a very pleasant cruise up river. Wildlife was plentiful and in particular a great number of herons were to be seen. Our rendezvous with Ann and Myles on one of the banks did not materialise but they were waiting to greet us (yet again!) at Totnes. The coach then took us to the Cott Inn at Dartington (the oldest pub in Devon) where a lunch, lavish to say the least, awaited us. A stroll down to the Cider Press Craft Centre helped to ease the digestion and a pleasant half hour was spent browsing amongst the crafts exhibition. Back on the road again we set off for Castle Drogo at Drewsteingnton. By this time the weather had become considerably warmer and the sun was shining brightly. The pseudo-medieval surroundings of the castle created a strange atmosphere as the building was only completed in 1930. We returned to the hotel in plenty of time for dinner after a pleasant and interesting day.



*'Gran' — Mrs. K.E. Smith*

*Assistant Ed.*

On Wednesday afternoon (while the men got down to the business of the conference) a party of ladies (and one lucky gent!) set off for an afternoon tour to Saltram House. Here, marvellous examples of Robert Adams' interior design and some of Joshua Reynolds' works of art could be seen. Although the coach broke down when we arrived a replacement was soon sent to the "ladies in distress". It was interesting to note the increased volume of "chatter" on the coach compared with the day before!

*Lectures are so exhausting*

Prior to dinner at the hotel Mrs. Burges very kindly entertained the ladies to a sherry reception which was much enjoyed by all.

On Thursday evening we boarded the "double-deckers" to visit the Mayor and Mayoress of Torbay and the Torre Abbey Mansion. They entertained us to cocktails and we were invited to take a stroll around the Mansion to see some of its treasures.

On Friday morning Mrs. Turney gave us a splendid demonstration of her floral arrangements. Everyone learned something (even if it was about the birds!) and it is hoped she has since been able to put it into practice.

Each evening after dinner there was dancing to the music of the hotel's excellent resident group. The hotel's facilities were very good indeed and the available activities included swimming, tennis, squash, golf and billiards. The extensive grounds were beautifully maintained and a pleasant stroll through them was most relaxing. The food and service were equally good, with plenty of variety and a high standard of cuisine each day.

However, the highlight of the social activities was the banquet on Friday evening. After a very good meal there followed four of the most entertaining after-dinner speeches most of us had ever heard. They were all really superb and after each speech we thought "follow that" and they did! Dr. and Mrs. Hunt literally "sang for their supper" much to everyone's surprise and delight. We then adjourned to the ballroom and danced until the early hours of the morning — sorry to have to say goodnight!


*WINNER: Dr. J.K. Smallshaw*
*RUNNER-UP: Dr. G.E. Crawford*
*WOODEN SPOON: Dr. J.F.M. Newman*

## HIRING SONG

**As sung by Bill and Ann Hunt, Torquay, 1978.**

In the 19th Century workers were engaged at "Hiring Fairs". They stood wearing a mark of their trade and potential employers chose the ones they liked the look of.

**Ann**
Where be you going to, my Boy Billy?
Where be you going to Billy my Boy?

**Chorus**
Where be you going for ever more
yer below,
down in the meadows so gay so gay.

**Billy**
I do be seeking employment Missis, this new Consultant's Contract ain't no good for us whole-timers.

**Ann**
Then come with me Oh my Boy Billy
Then come with me Oh Billy my Boy

**Chorus**

**Billy**
How much will you pay me Missis? I don't want none of this N.H.S. nonsense, that's why I left that Mr. Ennals.

**Ann**
£3 a year Oh my Boy Billy
£3 a year Oh Billy my Boy

**Chorus**

**Billy**
Why, even Radiologists' get more than that under yon New Contract. But if I come here, where will I sleep, Missis?

**Ann**
You will sleep with the Beasts
Oh my Boy Billy
You will sleep with the Beasts
Oh Billy my Boy

**Chorus**

**Billy**
Just because I've been working in Cornwall doesn't mean I'm like that. It won't do.

**Ann**
Then sleep with the men
Oh my Boy Billy
Sleep with the men Billy my Boy

**Chorus**

**Billy**
You shouldn't say things like that in front of all these Police Surgeons.

**Ann**
Well sleep with me Oh my Boy Billy
Sleep with me Billy my Boy

**Chorus**

**Billy**
That's all very well Missis, but what about the Maister?

**Ann**
Maister be dead Oh my Boy Billy
Maister be dead Oh Billy my Boy

**Chorus**

**Billy**
As I used to say in my last job, what did he die from?

**Ann**
I poisoned his Paaasty, my Boy Billy
I poisoned his Paaasty, Billy my Boy

**Billy**
If you poisoned his Paaasty what is he doing sitting at that table right over there wearing a Dinner Jacket?

**Ann**
Oh dear .....
Oh, come back tomorrow
Oh my Boy Billy,
Come back tomorrow,
Billy my Boy
Come back tomorrow
for evermore yer below
Down in the meadow so gay so gay.

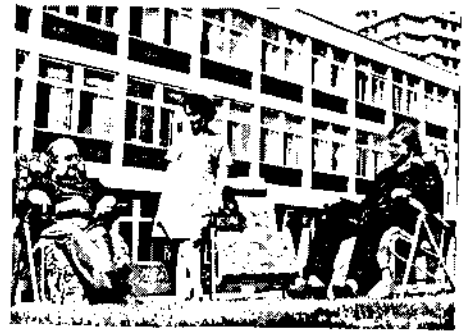
*Entertaining first attenders at Conference*

*Presidents:*
*Outgoing Dr. Fuad Gabbani. Incoming Dr. Stan Burges. Pending Dr. Henry Rosenberg*

*Above: The Hunts strike a serious note. Decanter presented to Fuad Gabbani*

*Right Visitors to Conference*
*(L to R)*
*Dr. Frances Levington (Met. Lab.)*
*Dr. P.R. Wilson (B.M.A.)*
*Dr. Paul Day (Australia)*

# METROPOLITAN POLICE MEDICAL CENTRE HENDON



Earlier this year Ralph Summers and I were invited to visit the Metropolitan Police Medical Centre in the Police complex at Hendon. My first impression on approaching this area was that the complex reminded me of a University campus. Apart from the Recruits Training Centre it houses the world famous Driving School, and other training departments to which Officers come not only from the Metropolitan Police but from other Forces in the United Kingdom and abroad.

The Medical Centre on the edge of the campus serves as a Health Centre for the large number of policemen and families on the site. I have never seen a more comfortable or modern Health Centre in my travels. The main part of the building is a mini-hospital which would be the envy of any private nursing home for comfort and service. Although there is a minor operating theatre the surgical patients are mainly early discharges from the London hospitals at the stage of pre-convalescence. Other patients include single members of the Force who live in 'digs' or section houses and also married men perhaps with chronic illness needing ongoing treatment and general nursing care who are admitted to give their wives and families a break.

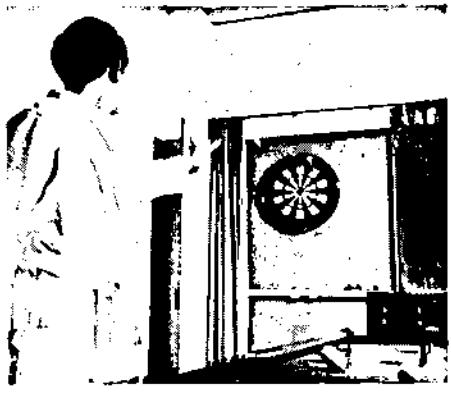
Surprisingly these excellent facilities which by regulation are available only to serving members of the Metropolitan Police or Officers of other Forces taken ill while on duty or on Courses in the Metropolitan area, are for the most part under-used! *Members of this Association with patients on their list who qualify for admission are reminded of these facilities.* Admission can be arranged at any time of the day or night, for example when Officers are injured or taken ill on duty and are unfit to be returned to single accommodation.

To quote from the brochure, "The medical officer visits the Centre every morning and is available at all times. The full-time qualified nursing staff is led by the Matron and a Sister, supported

by up to five State Registered and three State Enrolled Nurses, together with a small army of catering and domestic staff. The Chief Surgeon to the Force visits at regular intervals and the Consulting Physician is on call to provide specialist advice to the staff if they need it. There are a total of 38 beds in single, 2-bedded or 4-bedded wards and a fully equipped treatment room on every floor. Each bed has its own control console incorporating a bell and graduated lighting. There are also earphones which can be switched to a variety of radio channels and television. There is a good choice of food at every meal prepared in ultra-modern kitchens. Special diets can be provided. Patients who are allowed up for meals eat in the dining room. You won't be cut off from your family and friends. Visiting hours are generous and flexible by prior arrangement with Matron. Between times you can make or receive calls using the bedside plug-in telephone system. For those up and about there is plenty to do. There are comfortable lounges, a library, a radiogram and several colour TV sets, darts, bar billiards and other games. Or perhaps you would just like to sun yourself in the garden or on the balcony". These facilities are available without charge to the patient.

Those of us who are responsible for the health of Police families in the provinces are rightly envious of such an excellent facility being available for our Metropolitan colleagues and it would be a tragedy if because of under use the powers that be were to consider closing it as an economy measure. Apart from exhorting those who can take advantage to make full use of the Medical Centre — I would suggest the authorities consider opening it up to neighbouring Forces so that some of the running costs can be recouped to the mutual advantage of patients and Establishment.

**HUGH DAVIES**



*Photographs: Metropolitan Police*

## THE MEDICO-LEGAL SOCIETY

**Thursday 11th January, 1979**
"Sexual Violence – Fact and Fantasy"
Mrs. Margaret Puxon, MD, FRCOG, Barrister.

**Thursday 8th February, 1979**
"The Flixborough Disaster"
Dr. Alan Usher, MB, BS, FRCPath, DMJ (Clin et Path), Senior Lecturer in Forensic Pathology in the University of Sheffield and Consultant Pathologist to the Home Office.

**Thursday 8th March, 1979**
"Problems of Long Term Care"
Dr. Maureen A. Tudor, MB, BS, Principal Medical Officer, The Royal Hospital and Homes for Incurables.

**Thursday 5th April, 1979**
"The Hadgkiss Case – Wife in the Bath"
Professor A. Keith Mant, Professor of Forensic Medicine at Guy's Hospital in the University of London.

**April/May**
Annual Dinner/Buffet Supper
(Date to be announced)

**Thursday 10th May, 1979**
"The Problems of Identification in Criminal Trials"
His Honour Judge C. Lewis Hawser, QC

**Thursday 14th June, 1979**
8.00 Annual General Meeting
8.15 "Keeping the Peace"
John C. Alderson QPM, FBIM, Barrister.

All meetings are held at The Royal Society of Medicine, Wimpole Street, London, W1, at 8.15 p.m. unless otherwise stated.

Enquiries about membership should be directed to:
The Honorary Secretary,
The Medico-Legal Society,
71 Great Russell Street,
London, SC1B 3BZ.

## THE NORTH OF ENGLAND MEDICO-LEGAL SOCIETY

**Monday 4th December, 1978**
"The historical development of the legal and medical professions"
Professor Norman McCord.

**Friday 5th February, 1979**
"The Black Panther"
Mr. Gilbert Gray.

**Monday 2nd April, 1979**
"Social Security Law and Medicine"
Professor Harry Calvert.

**All meetings commence at 8.15 p.m. in** the New Lecture Theatre, Royal Victoria Infirmary, Newcastle upon Tyne.

Further details from:
The Hon. Secretary (Medical),
The North of England Medico-Legal Society,
Dental School,
Northumberland Road,
Newcastle upon Tyne, NE1 8TA.

## NORTHERN IRELAND MEDICO-LEGAL SOCIETY

**Tuesday 7th November, 1978**
"Sex and Sudden Death"
Dr. Alan Usher, Home Office Pathologist and Senior Lecturer in charge of Department of Forensic Pathology, Sheffield University.

This meeting will be held in the Ulster Medical Rooms, Medical Biology Centre, Belfast City Hospital at 8.00 p.m.

For further information please write to:
Dr. Elizabeth McClatchey,
Honorary Secretary,
Northern Ireland Medico-Legal Society,
40 Green Road,
Belfast, BT5 6JA,
Northern Ireland.

## THE FORENSIC SCIENCE SOCIETY

**6th/7th April, 1979**
Spring Symposium: "Fire and Arson"
Venue: Fire Service Technical College, Moreton-in-Marsh, Gloucestershire.

Limited overnight accommodation will be available.

For further information please write to:
The Hon. Secretary,
The Forensic Science Society,
P.O. Box 41,
Harrogate,
North Yorkshire,
England, HG1 1QL.

## MERSEYSIDE MEDICO-LEGAL SOCIETY

**Thursday 16th November, 1978**
"The Butler Report: Regional Secure Units and Mentally Abnormal Offenders"
Dr. James Higgins,
Forensic Psychiatrist.

**Wednesday 14th February, 1979**
Dr. T. Marshall,
State Pathologist, N. Ireland.

**Wednesday 28th March, 1979**
"The Hanratty Case",
Mr. Berkson, Solicitor.

**Wednesday 2nd May, 1979**
Annual Dinner.

Meetings 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.

## MANCHESTER & DISTRICT MEDICO-LEGAL SOCIETY

**Thursday 23rd November, 1978**
"The Wallace Case"
Mr. Leslie Walsh.

**Thursday 14th December, 1978.**
"Some Observations on Medical Malpractice"
Mr. Alan Glass, FRCS.

**Thursday 25th January, 1979**
"The Magistracy in the Modern World"
Mr. J.N. Coffey

**Thursday 22nd February 1979**
"Food and Drugs Legislation — Its development and future"
Mr. E.W. Foskett, Director of Environmental Health, Manchester.

**Tuesday 14th March, 1979**
Annual Dinner.

Meetings are held at 7.30 p.m. on Thursdays at the Courts of Justice, Crown Square, Manchester.

For further information please write to:
Dr. T. Dinsdale,
Hon. Secretary,
Manchester & District Medico-Legal Society,
25 Queens Drive,
Heaton Mersey,
Stockport, SK4 3JN.

**Please note that attendance at Medico-Legal Society meetings is usually restricted to members and their guests.**

Requests for past issues of 'The Police Surgeon' and the 'Police Surgeon Supplement' are received from time to time. If you have old copies of either publication which you no longer require, please return them to the editors.

# BIRD'S EYE VIEW

I wrote an article some months ago for "The Police Surgeon Supplement", in which I gave a tongue in cheek description of some hang gliding enthusiasts helping the Police to round up a rapist in the Australian bush. I did not realise at the time that what had partly been written in jest would now have to be written in earnest. I now predict that hang gliders will be used by Police and other bodies engaged in search or rescue.

To begin with it is necessary to describe what a hang glider is in its simplest form and to explain how it flies and is controlled.

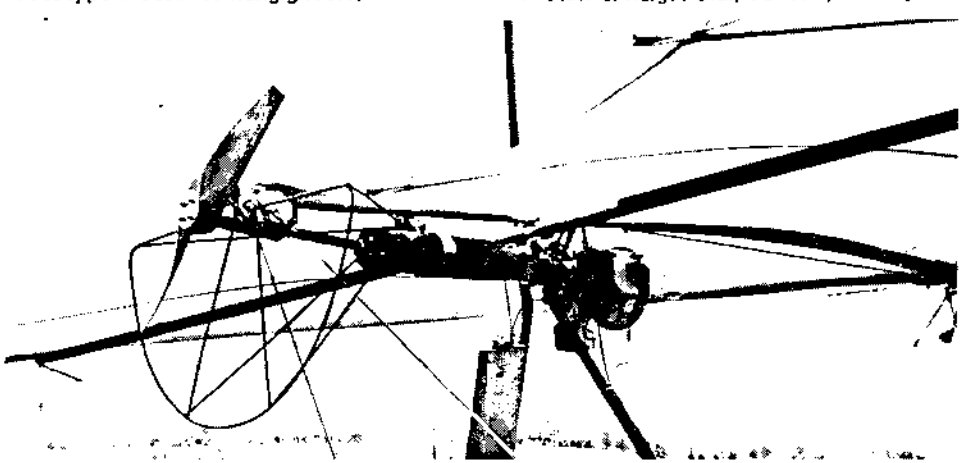
The hang glider is a flexible wing aircraft. It was invented by Dr. Francis Rogallo and his wife in the 1960's in the hope of helping the NASA space programme in solving the problem of guiding a space capsule after its re-entry into the earth's atmosphere. The plan never came to fruition but in 1972 patents were taken out by Rogallo to get earth bound men airborne. Prior to Rogallo's invention hang gliders of a different type had been flown by Otto Lillianthal in Austria in 1848 and Sir George Gayley in this country in 1852.

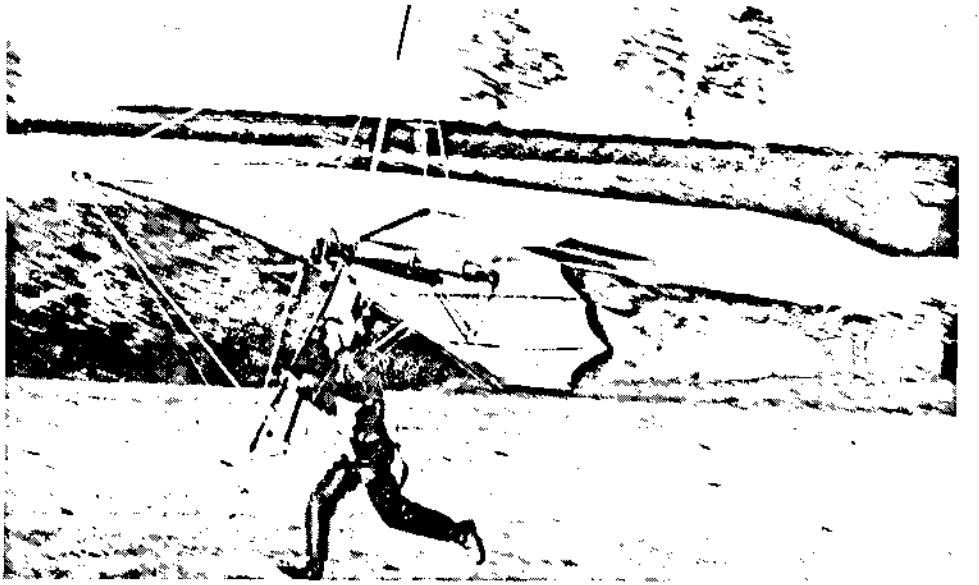
Control of the hang glider in its simplest form is achieved by weight transference. To turn to the right you move your weight to the right of the control frame and similarly to the left. To increase speed you transfer your weight forward by pulling the control bar in to your body. To decrease speed or 'flare-out' you push the bar outwards away from your body.

Ideally, a hang glider should be flown from the top of a rounded hill or ridge (e.g. from a gigantic breast!). Take off has to be into the wind, with a slope of not less than 45%, with a wind speed of 18-20 mph. The ground below the hill should be clear of buildings, trees, powerlines, etc., because such obstructions are liable to set up turbulent conditions and make flying more hazardous. Modern hang gliders of high performance are less demanding as regards conditions of wind speed. During flight a hang glider is confined to a 'lift band' that comes over the hill and is, therefore, able to do little more than soar the ridge for the distance it extends. On coastal sites the distance soared may be quite considerable. By making use of thermal activity the pilot can leave the ridge band and go further

Prototype Motor for hang gliders.

*Photos: C. Hargus Ltd., Gawcott, Buckingham.*





*World's first flat land, foot launched, motorised flight? Pilot: Simon Wooton*

afield. Thermals are bubbles of hot air which give the pilot lift, but the direction and height will be dictated by the "thermal" whilst the pilot concentrates on his flying to make the most of the thermal activity. Although the glider may cover a large area whilst flying in a thermal, the pilot cannot know exactly where it will take him. Where there is little or no wind the best the pilot can hope for is a flight from the top to bottom of a hill.

From what has been said so far, the possibility of using a hang glider for any purpose other than sporting activity would seem to be remote. The only advantage over any other aircraft is its ease of transport, as a kite such as I have described can be carried on the top of a small car.

All the problems mentioned can be obviated by using a powered unit, which can now be attached to a hang glider. It does not detract from its ease of transport by car. It can take off from virtually anywhere, in nil wind conditions. It can climb rapidly to 1,000 feet or more, or fly at a very low level. It is more manoeuverable than a conventional aircraft and the only unsuitable flying conditions would be very high winds, when other aircraft used for flying at low level would also be grounded.

I foresee the powered hang glider being used by the police to search for lost people or vehicles; capturing escapees over moorland or hills; or looking for disturbed earth, etc. What could be simpler for the police than to have several powered hang gliders put on top of their vehicles to transport to a search scene. Radio communications can be used and are already used for training purposes. The cost of using hang gliders would be minimal compared to conventional aircraft, such as helicopters or light aircraft. Maintenance would be negligible.

My critics may think I have my 'head in the clouds'! But I invite them to recall that it was not until the introduction of the aqualung that police divers were used for searches, when air hoses, life-lines, etc. used with standard diving equipment were no longer a necessity.

MICHAEL GLANVILL

*For further information on hang gliding see "Hang Gliding" by Bob Mackay, published by Thornhill Press Ltd.*

# INTERNATIONAL ASSOCIATION OF FORENSIC SCIENCES WICHITA 1978

## OUR POLICE SURGEONS LECTURE WITH THE TOP MEN

**Reporter: IVOR DONEY**

You might imagine that Wichita, being in the mid-West of America, would abound with rodeos, cow punchers, cattle auctions and cavorting bullocks. It certainly abounds with all the history of the cowboys and Indians that the motion picture industry has made us associate with it. Years ago there might have been some truth in the story that a man walking down a road in the midwest and a down and out cowboy stopped him and said, "Buddy, can you spare a dime for a poor old cowboy who has nothing left in the world but this six-gun pointing straight at your heart" — but it doesn't happen any longer.

This clean, sunny, delightful city of Wichita was the venue for the Congress. And what a great Congress it was.

Ever been to an International Meeting of Forensic Sciences? If not, you've missed something. At one time there are something like 600 delegates, plus wives, and you have a chance to meet many of the top people in the forensic field in the world — scientists, doctors, chemists, dentists, lawyers, University academicians.

### FORENSIC MENU

Various meetings are held at the same time in different lecture rooms under the same roof and you are free to wander in and out as you please. You are issued with a combined programme of all the forensic sessions and you have to treat it like a menu in an hotel. Pick out what you want to hear, note the time and arrange your day. Perhaps you would start off with a 15-minute talk on bite marks, nip next door to hear the latest on abnormalities in the pancreas in cot deaths, then off to hear a Japanese professor talking about carbon monoxide and exhaust fume inhalation (all in English incidentally) and so on to the end of the day. If you don't think you get tired — try it!

After a super day of interesting academic titbits at the Wichita Conference you got no chance to kip down because that's when the jollity began. Every night there was food and drink and a mammoth party. Everybody turned out so after the release of a few inhibitions you could go right up to Professor X and ask what he really meant in his talk on marijuhana by "nannograms per ml of cross reacting cannaboids!" They were buccholic evenings. Next day if you recalled that "the wages of gin is breath" the local liquor laws didn't help you to find the hair of the dog!

### THE AMAZING DR. ECKHERT

The man behind this amazing Congress was Dr. William Eckhert. He organised it and got the whole thing swinging, though he'd be the first to acknowledge the assistance of many other doctors and scientists who helped on the academic side, his wife and the long suffering wives and lady helpers on the social side, the

*Dr. & Mrs. Eckhert (centre) flanked by helpers.*

police of Wichita and, I suspect, his own partners holding the fort for his routine day's work! Just everybody in Wichita knows Bill Eckhert. You could hardly miss him — over 16 stones of jovial, cheerful bonhomie, but when his eyes turn on you they tell you more about him, he's thoughtful, shrewd, erudite and you know at once he's a real intellectual.

**FAMILIAR FACES**

Don't think that if you went to a Congress like this that you wouldn't know anybody there. It was nice to see Dr. Ann Robinson again (now living and working in Canada). Professor David Bowen, from Charing Cross Hospital, gave a talk on the effect the Abortion Act has had in bringing down death rates from septic abortions and pushing all the back-street abortionists off the High Street and

*Dr. Elizabeth McClatchey gracing the meeting, whilst Drs. Knight and Marshall take their medicine.*


forcing them on to Social Security. David Filer, from the Met., gave a witty and entertaining talk on International Terrorism, which he had been invited to present. He had plenty to tell them and it went down well. Off the rostrum he sported a cowboy hat to fit in with the locals. Genial Dr. Harry Morgan, Forensic Scientist from Northern Ireland was there, friendly as always. Our own Dr. Elizabeth McClatchey was there too.

*Dr. Harry Morgan (Belfast) with Dr. & Mrs. R.L. Williams (Met. Forensic Lab.)*

She'd grace any gathering. She had been invited to give a talk on the Police Surgeon's role in Northern Ireland and did it well, precisely, modestly non-partisan. Her picture of the violence made a big American cop next to me gasp. Professor Tom Marshall, also from Belfast, impeccable as always, gave a superb lecture and John Harbison, Dublin Pathologist, seemingly tamed for once, told us about life south of the border.

Liverpool Dental Surgeon, John Furness, talking on Bite Marks, gave them all plenty to think about though some felt he was a bit dogmatic. He was also over there for a trial in which a 17-year old youth was accused of murdering a girl of 14. John was in the witness box for 4 hours at one stage. There were some tough questions too. A previous dentist had been asked "Could you say that only one person in the whole world could have made this bite mark?" Takes some answering. John Furness himself, after saying the teeth of the person from whom the casts were made inflicted the wound, was asked, "If it develops that the accused had no opportunity to perpetrate the bite mark on the girl, then would you say you are totally wrong in your opinion?" Tricky questions but not for an old campaigner like John Furness.

One of the most interesting presentations was from Dr. Oksanen of Finland, concerning a suicide which was filmed and tape-recorded. After the man shot himself and collapsed he later appeared to wake up and move again. Indeed two shot gun holes were found in his skull. It prompted Dr. Bernard Knight from Cardiff (who had earlier given a talk on histology in myocardial damage) to surprise the audience by quoting a case of a man who shot himself through the roof of the mouth, spattered brain on the ceiling above him, got up and walked home, went upstairs and kicked the people downstairs who had come to help him: it was several hours before he succumbed.

Dr. Julius Grant, unchallengeable as always, showed how when you make an X the intrepid questioned examiner can still make something of it. Ever thought how often you make an X? Not just if you're illiterate but on football pools, filling in questionnaires, voting at elections, etc.

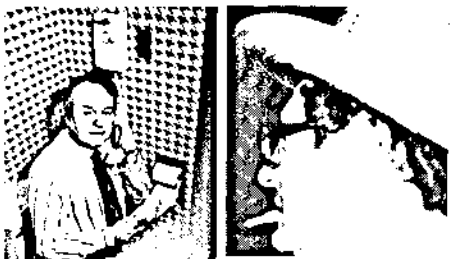
## PARTIES

And what about the parties? Oddly enough Wichita is one of the many 'dry' cities around Kansas. It sounded hard to hear there were no pubs, no liquor, no wine with meals. But you'd never have noticed. There was plenty to be had, thanks to the organiser and man's determination to poison himself even when everything else seems against him.

The first night of the festivities sent you around meeting people. There were delegates from Japan, Australia, Czechoslovakia and about 30 other countries.

Another night introduced us to the colourful plains Indians. It's a sad story the way they got pushed off their land many years ago.

A visit to Cowtown the following night with beer flowing in enormous barrels showed us how the old Wild West really was. The Wichita police mocked up a bank robbery and a jail break for us (Wyatt Earp really did live in Wichita). Thrills all round. Not so strange that, while the Conference was on, in next door



*David Filer* ▲
◀ *John Furness*

Oklahoma three policemen and two escapers were shot dead in one day.

Banquet night — what anyone could remember of it — was held in the Freemasons' magnificent Shrine Temple, dripping with lush candelabras, beautiful carpets, a superb Egyptian room complete with palms and sphinx statues. Speeches and presentations were made.

The last night was a wow of a party at the house of Dr. Bill Eckhert and his wife. Plenty of pleasant hangovers next day to remember it. What generosity from these two delightful people! Can you imagine a few hundred people trampling over your own house, beating your carpets, flouncing past your nicest pieces of china? The Eckherts didn't move a hair. One can only hope that next day they didn't come downstairs to find burnt holes in the carpets, cracks in their favourite crystal, smudges on the wallpaper, their best garden plants trampled on. But my guess is that they did.

## DAY TRIPS

There were day trips to forensic establishments in Oklahoma, Topeka. The motion picture industry had already made us familiar with these romantic names and after all the Santa Fe trail was only next door.

Ever thought that pre-employment examinations don't change? They do! At the Federal Aviation Centre in Oklahoma the pressure is on to accept people with contact lenses for pilots and red filter lenses for colour blind pilots. Times change!

The ladies were not forgotten. There were fashion shows, porcelain exhibits,

a tour to Eisenhower's house, and interviews on T.V. None of the ladies could grumble at the prices of things in Wichita. Food and utility goods rather less than British prices; a good English breakfast for instance at our Broadview Hotel about £1.40.

Amongst the usual trade exhibits at the Congress was a bookstall. One of the exhibits was 'The New Police Surgeon'. Plenty of people were seen loooking at it and at least that one copy was sold to a Chicago doctor.

So what came out of the Congress? What's the message?

I'd say we do well with our Annual Police Surgeons' meetings and our Symposia. We are on the right lines. We do them well. Those who don't go to meetings might ask themselves whether they do their job properly. How do you know whether what you are doing is right? The only true test is to discuss with your peers of equal standing and experience and see if they support you. How much better then if you go to the experts and get teaching as well. That is how you progress. That is what an international Congress does. That is where you can mix with the greats, hear what they are saying. When you hear experts saying "I don't know", it teaches you not to be cocky about what you think you know yourself. Furthermore they are humble enough to share their knowledge with you.

The next International meeting (every third year) is in Bergen, Norway, in 1981. Make a note of it. After the Zurich meeting in 1975 it was argued that our Association should send speakers. It was good to see two members, David Filer and Elizabeth McClatchey, giving personal papers this time. Perhaps we can contribute, corporately, in Bergen in 1981.

Wichita gave us a tremendous Congress, the kindness and generosity were overwhelming. Wichita has never staged an International Congress before. It is making its name. After us at the hotel came a religious convention of priests. As someone said to the elevator attendant on the last trip down with the baggage — "Looks as if this week you'll be having a change of background conversation from violence and rape".

## ASSOCIATION OF POLICE SURGEONS OF GREAT BRITAIN

### MEETINGS FOR 1979 and 1980

**Annual Conference 1979**
14th-19th May 1979
Hotel Majestic, Harrogate

**Autumn Symposium 1979**
7th-9th September, 1979
Nene College, Northampton

**Annual Conference 1980**
19th-24th May 1980
Peebles Hotel Hydro,
Peebles, Scotland

**Autumn Symposium 1980**
Bristol (dates to be announced)

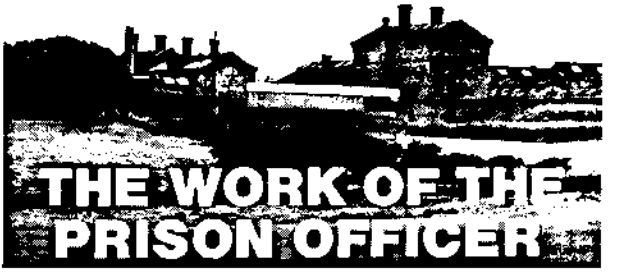
## LONDON HOSPITAL MEDICAL SCHOOL DEPARTMENT OF FORENSIC MEDICINE

**December 8th-19th, 1978**
"Recent Advances in Forensic Medicine"

**March 5th-16th, 1979**
"Diploma in Medical Jurisprudence" Course.

Further details of these meetings may be obtained from:

Professor J.M. Cameron,
Department of Forensic Medicine,
London Hospital Medical College,
Turner Street,
London, E1 2AD.



# THE WORK OF THE PRISON OFFICER

B. WALLACE

A few months ago the staff of the Prison Service was informed that Her Majesty, The Queen, would be visiting one of our training schools in the summer. The visit was in honour of our centenary year as the modern Prison Service.

During the hundred years the role of the Prison Officer has changed enormously, I believe for the better. In the old days staff were forbidden to talk with the prisoners. Now, staff talk freely with the inmates and, if possible, help them with any problems they may have. It is the policy of my Association for the Prison Officer to be involved in welfare work within the prison service.

In 1921 the title "Warder" was changed to Prison Officer. Modern Prison Officers are people of integrity, interested in working with others, capable of being leaders yet responsive to orders. They must be tactful, firm but fair, and capable of being flexible when the occasion demands it. They must accept the abnormal life within the prison as normal. They must cope with any emergency which may arise and treat it as part of the day's work. For instance – separate two men fighting in the toilet and then unlock a cell door and find a prisoner has committed suicide, all before breakfast.

A sense of humour is essential in a Prison Officer. On separating two homosexuals who were fighting, I asked one of them how the fight started. He said that he had thumped the other one because he kept calling him a queer.

On another occasion, when an inmate complained to me that he was constipated, I gave him a suppository. He looked at it a bit oddly and asked me if it would work and I said it would. With this assurance, he popped it in his mouth and swallowed it. The next day he came up to me and said, "That depository you gave me yesterday Gov. It worked!"

A Prison Officer may remain on purely discipline duties, such jobs as reception officer or censoring letters, manning shops with a party of inmates or assisting in the running of a wing. However, there are specialist posts within the prison and Officers are trained within the service to perform these duties, e.g. as a cook and baker. Some of the specialists can, in a practical way, assist the inmate in making a fresh start when he leaves the prison.

A few years ago, my Association held its Conference in the North of England, close to our Training College, and the trainees prepared the pre-Conference Buffet. To satisfy 100 delegates with some wives and observers, is no mean achievement but no fault could be found. This standard is taught to the inmates who cook the food in the prison kitchens, thus ensuring, we hope, that there will be no complaints about the food. In addition to supervising the kitchen, the cook and baker will train the inmate who wants to continue cooking on leaving prison. An inmate can be trained to City and Guild standard within the prison, and provision is made for the exams to be taken while they are inside.

Another specialist is the Trade Officer. This is a man who has learned a trade before coming into the service and wants to continue with it. Electricians, plumbers, painters and joiners are usefully employed within the service. Inmates can ask to work with a Trade Officer and later take exams in some trades, which will assist in making a fresh start outside.

The Physical Education Instructor is another specialist. Ask this Officer what his two hands are for, he will probably tell you it is for weight lifting or press-ups. Ask me and I would say they were for carrying a pint and a short of my favourite brew.

The P.E. Instructor has two important functions within the service. The first is to organise the physical education programme of the prison. Many prisoners like to keep fit and the gym is always used to the full. In fact there is usually a waiting list for keep fit classes. Circuit training and weight lifting are high on the priority of many inmates. There is an inter-prison weight lifting operation between interested prisons. The inmates cannot travel so there are no away matches, but the P.E. Instructor in each prison organises his part of the competition and the results are forwarded to the other prisons.

On some Bank Holidays, the P.E. Instructor organises a sports day for the inmates. There are the usual races from 100 yards up to three miles. One event not in the programme is pole vaulting. Some cynics will say that the P.E. Instructor builds up the prisoner so that he can attack the staff, but the Instructors claim that if an inmate vents his spleen on the equipment in the gym instead of the staff, then the Instructor has contributed to the smooth running of the prison as well as keeping the prisoner fit.

The second function of the P.E. Instructor is to work with the medical section of the prison. He is trained to carry out remedial work prescribed by the Medical Officer. If the Medical Officer thinks that an inmate would benefit from remedial exercises, for example after an operation, rather than send him to an already overloaded Physiotherapist at the local hospital and taking up prison staffs' time, the inmate is referred to the P.E. Instructor for the appropriate treatment.

Others posts for the Prison Officer include postman, librarian, gardener, telephonist, receptionist and in administration. I was going to mention the dog handler and his job, but in the past when they have been entered in competition against the police dogs, the prison dogs win more than they lose so I will draw a diplomatic silence over that part of the service.

Finally, I wish to discuss the role of the Hospital Officer. He is a man who has the minimum of training to do the maximum of work within the nursing side of the service. He is taught first aid, anatomy and physiology, medicine, medical nursing, surgical nursing including post-operative care, psychology and psychiatry. The exams include written, practical and oral tests. The course lasts three months and then he is posted to any hospital in the service. At the hospital there is always an experienced hospital officer to help the newly trained hospital officer to find his feet. In a large prison with a large staff the work is shared out and the paper work usually goes with seniority, but in smaller stations, two or three officers all take their share of nursing duties and paper work. The Hospital Officer finds that a pen is just as important as a thermometer.

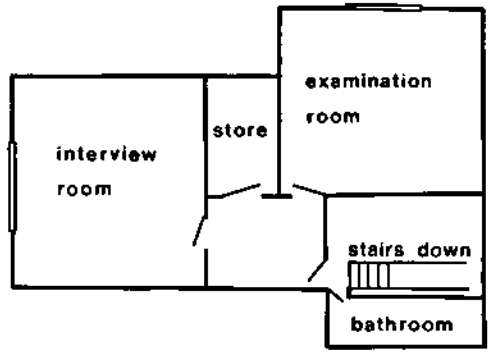
What is the nursing scope of the Hospital Officer within the service? Compared with our nursing colleagues elsewhere our scope is greater. From treating a graze to suturing a cut, we take the place of the casualty nurse. Assisting the surgeon in the theatre and sterilising the equipment afterwards, we take the place of the theatre nurse. Being in charge of a medical, surgical or psychiatric ward or landing, we take the place of a charge nurse.

The Hospital Officer may be trained to take and develop X-rays. The X-rays are usually referred to the local hospital to be read. The Hospital Officer may also train to be a compounder, taking on the duties of the pharmacist. We also serve as dentist's or optician's assistant if required. Thus no inmate can say that he or she is deprived of any form of treatment while in prison.

I believe it is in the field of psychiatric nursing that the Hospital Officer excels. We may not have the facilities our colleagues have in the special hospitals to deal with the mentally disturbed, nor do we have the special training that is needed,

*Continued on page 65*

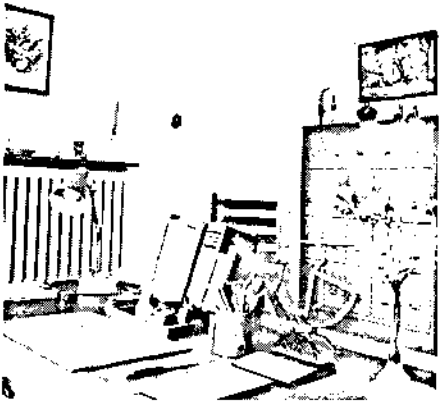
# A POLICE SURGEON'S SUITE IN KENT



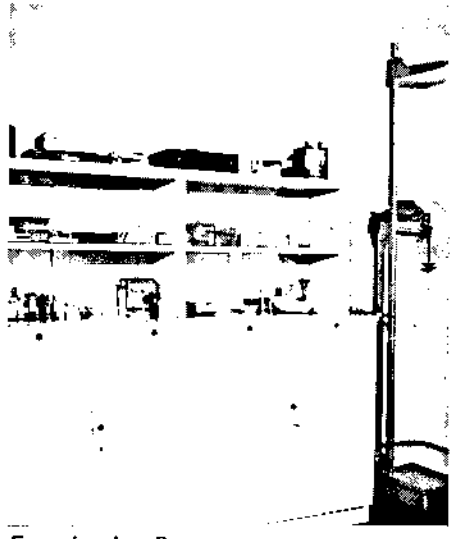

Until the end of 1977 it had been my practice to examine major forensic cases at my Surgery. It had more space and more specialised equipment than that provided at the Police Stations. Each Police Station in my area has a small room suitable for the examination of drinking drivers, fitness for custody cases, and so on, but inadequate for the needs of sexual assault examinations and other serious cases.

At the end of 1977 I retired from General Practice but continue with my work as a Police Surgeon. I also undertake work for the Social Services, chiefly concerning non-accidental injuries and neglect of children. I also examine mental health cases, as I am at present one of only two non-Consultants in the district approved under Section 28 of the Mental Health Act.

*Interview Room*

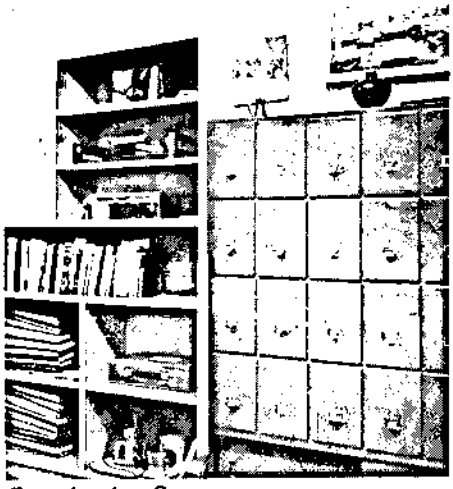


I suggested to the Divisional Chief Superintendent that if he could find me suitable space, I would take my Surgery furniture and equipment there, and when I ultimately retire I will bequeath them to the Police for the benefit of my successor. The old Gillingham Police Station is no longer operational as such, but is still

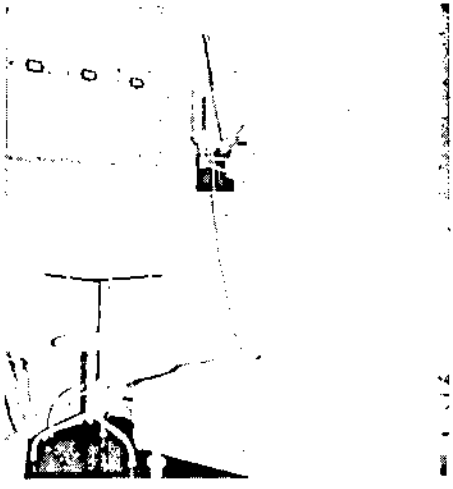


*Examination Room*

used for various offices and to provide a base for a small number of Constables patrolling the town centre. The new Police Station is in Rainham. Part of the old Police Station is now given over for a Police Surgeon's Suite. One room is furnished as an interview and waiting



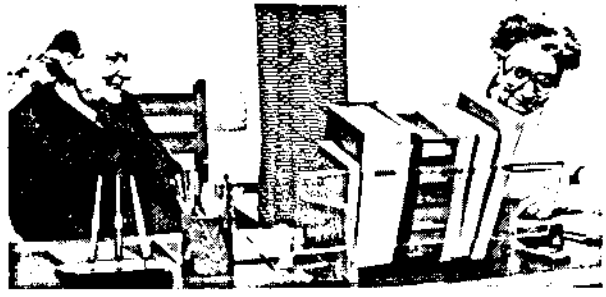
*Examination Room*



room, another room is equipped as an examination room and there is separate adequate secure storage for confidential files, drugs, instruments, bandaging materials, etc. Washing and toilet facilities are provided. Much of the furnishing and equipment is what I used in General Practice over many years. Additional equipment — ultra-violet lamp, scales, a second anglepoise lamp, etc. — was provided by the Kent Police.

I always use a low couch rather than the standard one. I have never understood why one should make people climb up onto a high couch and examine them standing, whilst it is much more comfortable for the patient and the examiner is more relaxed if he can do the examination sitting by the examinee.

**K.F.M. POLE**



*Dr. Pole's Secretary does reports at any time between 8 a.m. to 10 p.m.*

*Photos: Kent Constabulary*

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*Continued from page 63*

but what we do have is experience and plenty of it.

The Prison Officer has to be a Jack of all trades, and a master of any job he undertakes. He makes a positive contribution to the running of the prison. He contributes actively to the welfare of the prison inmate and plays a major part in the rehabilitation of the prisoner.

From a paper given by Mr. B. Wallace, Senior Prison Officer (Hospital), H.M. Prison, Dartmoor at the Annual Conference, Torquay, 1978.

# CORRESPONDENCE

## CARE OF POLICE DIVERS

Police Headquarters,
Strathclyde Police,
Glasgow.

Perhaps unfortunately, the short papers delivered at the Annual Conference were so placed that not a great deal of time was available for discussion about the topics raised. Five members put their names on a list as expressing interest in the care of divers and one has been added since. Drs. Cosgrave, Fairclough, Glanvill, McFayden, Nelson and Smeeton represent parts of North-East England, East Anglia, the South-West, East Midlands and Central Scotland. No less than twenty-nine underwater search units are detailed on a recent list published by the A.C.P.O. Training Committee! This list shows the strength as: Inspectors and Chief Inspectors 12; Sergeants 37; Constables 232. That implies a substantial medical work load over the whole country in any one year.

The question of statutory control of police divers is not yet settled. There is no doubt that, as with any employee, the provisions of the Health and Safety at Work Act apply, but specific diving regulations made under the Act may not. It is expected, nevertheless, that A.C.P.O. and A.C.P.O.(S.) will insist that standards be no lower than required for commercial divers.

The latest draft regulations available to the Employment Medical Advisory Service suggest criteria not very different from those stated at the Annual Conference but are, of course, subject to alteration. Simply because a statutory instrument does not cover our work, we should still be prepared to review current practices. Those responsible for diving training in the Royal Navy have indicated their willingness to help. I appeal, therefore, to any member concerned to indicate to me readiness to participate in a training session.

**Dr. W.D.S. McLAY**
Chief Medical Officer
Strathclyde Police

## RUPTURED HYMEN AND THE DMJ

Jocelyn House Mews,
18a High Street,
Chard,
Somerset.

Dear Sir,

May I enter the lists on two subjects which have arisen, one in the "Police Surgeon" and the other in the "Supplement".

In the "Police Surgeon" there has been discussion on rupture of the hymen and rape; positions of the tear, etc. Surely the point whether a hymen is torn laterally, anteriorly or posteriorly is of little significance, because only one thing is proven (in the absence of other evidence) and this is that a hymen has been torn.

I support Dr. Paul's contention in the "Police Surgeon Supplement" that the DMJ examination has significance and that questions are asked about this qualification — under cross examination I have been questioned on this subject by a young barrister. He attempted to "needle" me concerning my qualifications. I had refused to be drawn on a point and gave that valuable answer, "I don't know".

It is a pity more General Practitioners who are eligible do not take it. It has certainly made me more conscientious in the records I keep and the reports I send

to Solicitors. I have found that the DMJ (Clinical) is an extremely useful qualification. In working for it I have disciplined myself forensically, so to speak, to be more suspicious and to develop a more enquiring mind about all kinds of injury.

Dr. Filer might suggest that the DMJ (Clinical) was easier when I took it, although I would not agree. Certainly I studied more Pathology than was necessary, including a trip to the London Hospital to study specimens. I was at an advantage when a question concerning exceptions to the hear-say rules was set in one of the papers. I had had the same question in my Bar Finals and was able to reel off most of those mentioned in Phipson's Manual of Evidence.

Barristers are now receiving lectures in forensic medicine. It will not be long before Members are cross examined as to whether they have the DMJ.

**MICHAEL GLANVILL**

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# PRESENTATION TO DR. R.W. NEVIN

At the end of 1977, the Chief Surgeon of the Metropolitan Police, Mr. R.W. Nevin, T.D., retired and the Metropolitan Group of the Police Surgeons of Great Britain raised a subscription fund to make him a presentation. Mr. Nevin was presented with an engraved decanter and matching glasses, the decanter being engraved with the Crest of the Association.

The Old Forge,
Greywell,
Basingstoke.

Dear Dr. Mendoza,

I am writing to thank you and the Metropolitan Group of the Association of Police Surgeons of Great Britain for the most generous and useful present that you have given to me.

The decanter has a most attractive design and the tumblers are splendid. The engraving has been done beautifully.

I was Chief Surgeon to the Metropolitan Police for over 20 years, so had many pleasant contacts with the members of the Metropolitan Group and have to thank them for their kind co-operation at all times.

This delightful present will be a constant reminder to me of these happy years.

I wish the Group every good fortune in the future.

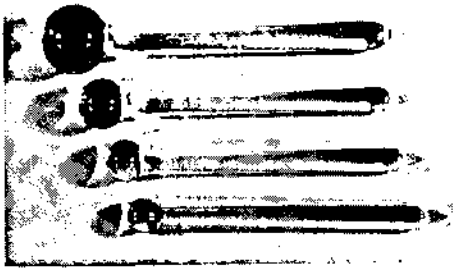
Thank you all again for being so kind and generous.

Yours sincrely,

**R.W. NEVIN**

# GLAISTER'S GLOBES

The use of Glaister's Globes for the examination of the hymen and vaginal introitus has been established for some years. Obtaining a set of globes may present difficulty for the newly appointed Police Surgeon. The set illustrated here were made in Pyrex glass at the local University glass instrument laboratory, and inquiry at such establishments, or any concern connected with the manufacture of glassware in small amounts, may produce results.



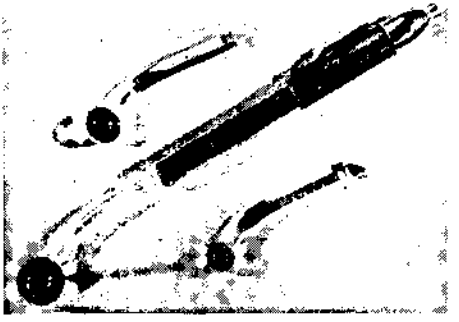
*Glaister's Globes*

Suitable dimensions are 1/4-inch diameter pyrex rods, four inches long, with globes of 3/8-inch, 1/2-inch, 3/4-inch and 1-inch diameters. If any surgeon has difficulty in procuring a set of Glaister's Globes, drop a line to the Editor.

A modification of the Glaister's Globe is the Glaister Keen Rod. This is made of perspex, and fits onto a Twinlite diagnostic torch. Sets of Glaister Keen rods and Twinlite diagnostic sets are available from the following suppliers:—

James L. Hatrick & Co. (London) Ltd.
170 Archway Road,
London, N6 5BE.
Twinlite Diagnostic Set £6.56 complete
Glaister Keen Rod Set £18.07complete

**Please note that the prices quoted do not include postage or VAT, and are subject to alteration without notice.**



*Glaister Keen Rods*

Philip Harris Medical Ltd.,
Hazelwell Lane,
Birmingham, B30 2PS.
Twinlite Diagnostic Set £6.60 per set
Glaister Keen Rod Set £21.64 per set

Another instrument of value in local examinations, particularly of children, is the Hoyt Flexible Examination light, obtainable with either 5-inch or 3-inch stems. These disposable lightweight instruments last a year or more in regular use, and are cold sterilizable. The stem is flexible. The Hoyt Flexible Examination Light costs £7.50, and is obtainable from:—

Colgate-Palmolive Ltd.,
76 Oxford Street,
London, W1A 1EN.

*Hoyt Flexible Examination Light*

# MEMBERSHIP LIST

Owing to the difficulty in keeping up with changes of address, it is suggested that if members are unable to contact other members at the address shown in the Medical Directory contact may be made through police channels.

The Hon. Secretary requests prompt notification of change of address and ex-directory phone numbers. The Hon. Secretary would also appreciate if any case of serious illness or death of a member would be brought to his notice by neighbouring members.

F = Founder Member.

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| J.B. James | Pontypridd | Glenna Thomas | Cardiff |
| H.W. James, D.M.J. | Wrexham | W.C.T. Thomas | Llanelli |
| D.R. Jones | Pontypridd | H.T. Thompson | Risca |
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| C.D. May | London, S.E.9 | J.F.L. Watson | Wanstead |
| M.V. Meyer | London, E.9 | I.E. West | London |
| I. Muir | London, N. | D.M. Wilks | Chiswick |
| R.J.R. Moffat | South Croydon | M. Woodliff | Ealing |
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| R.R. Hamilton | Hawick | A. Roy, M.B.E. | Balfron |
| T. Hannah | Edinburgh | R.G. Sinclair | Falkirk |
| A.S. Harper | Alexandria | A.M. Tait | Hamilton |
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