Historical Development and Contemporary Dilemmas of a Police Surgeon

by

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Student Declaration

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution.

I declare that no material contained in this thesis has been used in any other submission for an academic award and is solely my own work.

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Abstract

The requirement for investigation into death has been present since the mists of time. From the process of identification of the person and determination of the cause of death the Coroner's service that operates in England today has slowly emerged. Along the evolutionary path of death investigation the concept of Clinical Forensic Medicine became established.

The formation of the Faculty of Forensic and Legal Medicine in 2006 with the objectives of promoting the advancement of education and knowledge in forensic and legal medicine and ensuring the highest professional standards of competence and ethical integrity of it's practitioners was initially met with enthusiastic support but growth of the membership appears to be stalling. The Police Surgeon is the main clinician working in Clinical Forensic Medicine, a role that is undertaken by generalist forensic physicians and other healthcare professionals, who manage the medical aspects of custody, assault and death.

It is now pertinent to consider whether, the development of Clinical Forensic Medicine has reached the point where it can be regarded as a clinical specialty and whether those practicing in this field are specialists. This question is central to the thesis and is answered in terms of history and a discussion of the elements of the practice of Custody Medicine, a subset of Clinical Forensic Medicine, and a review of the mechanisms that exist to determine specialty status. There is a degree of urgency to resolve this issue because Police Surgeons are increasingly being employed by private providers of forensic medical services, who constricted by budgetary control may not be able to support the development of a specialty hierarchy. If Clinical Forensic Medicine does not develop then the Criminal Justice System risks losing the services of trained collectors and evaluator of forensic medical evidence.

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The farther backward you can look, the farther forward you are likely to see.

W.S.Churchill

Chapter 1

Introduction

The Police Surgeon was formally established in 1829 by the Metropolitan Police Act[1]. Since then the focus of the Police Surgeon has changed from that of a doctor caring for police officers and their families and the investigation of death and carrying out autopsies, to the Police Surgeon of today, variously termed a forensic medical examiner or forensic physician. There are generalist forensic physicians who deal with the medical aspects of custody, assault and death to specialist forensic healthcare workers, doctors and nurses who act as examiners in cases of adult and child sexual assault.

1.1 Aims

Some research theses are designed to answer primary and secondary questions and the thesis is written around those questions. Such an approach can be particularly useful when a subject has previously been researched and even the primary question is in effect subsidiary to questions that have been addressed in other work.

This thesis has a broad aim, that of placing Clinical Forensic Medicine in the context of clinical practice. By tracing the historical development back from earliest of times

[1]Metropolitan Police Act 1829

there was an opportunity to discuss the role of the coroner showing how little the fundamentals of death investigation have changed since the middle ages. Perhaps of greater importance to the Police Surgeon is the emergence of the medical witness, from those witnesses that gathered at an inquest, to the professional and expert witnesses that assist the courts of the twenty-first century.

An important element of the thesis was to illustrate some of the conflicts that permeate the work of the Police Surgeon. Although the central conflict is the tension between the doctor's duty to the patient and the doctor's responsibility to the Criminal Justice System. Chapter 3 will also point to other issues such as the diverse approach of the courts in cases of drink driving and the problem of differentiating between victim and assailant in cases of assault.

By the end of Chapter 2 it becomes clear that modern Clinical Forensic Medicine has started to be organised by the formation of a Faculty within the Royal College of Physicians. With this development, the central research question also emerges whether Clinical Forensic Medicine is a specialty. This question is addressed from a technical perspective in greater depth in Chapter 4, when the steps that are requited to be taken to achieve specialty status are outlined.

Secondary research questions arise and are addressed as the thesis progresses. These questions concern the health of the Faculty and are answered by a review of membership data; the scale of Clinical Forensic Medicine is illustrated by the numbers of custody suites and detainees in the Inner London Boroughs and there is a pointer to the qualifications of doctors caring for those detainees, with information provided by the Metropolitan Police; referrals to the professional conduct process of the General Medical Council show the relatively new phenomenon of the actions of Police Surgeons being scrutinised by their professional regulator. Whilst Chapter 3 outlines some of the dilemmas facing the Police Surgeon, from the perspective of the legal and ethical base, the question of whether all complainants are victims is addressed with reference to the analysis of case notes.

1.2 Methods

The history of the Police Surgeon is in part documented in the standard textbooks[2], or in historical topics of forensic medicine[3]. Others have written research theses[4] but a complete historical account does not appear to have been produced. A complete historical account would not have been appropriate in this piece of work.

Perhaps it is appropriate in a thesis that examines the dilemmas facing the Police Surgeon that there should also be a dilemma about the best methodology to research the issues. A humanities researcher would naturally favour a qualitative approach, whereas a researcher with the bias of a forensic scientist would favour the rigour of a quantitative approach, with the construction of a null hypothesis and the derivation of a value for probability. This thesis adopts a pragmatic approach[5] to address the central question of whether Police Surgeons are specialist clinicians working in a clinical specialty. This question is addressed using a mixture of qualitative and quantitative reasoning. Such a mixed approach is recognised[6], but there is a risk that the quality of the research is compromised.The techniques of qualitative research are not applied and in this case the quantitative elements have not been analysed statistically, more of out consideration for assessment than difficulty designing the relevant question or applying a suitable statistical test.

Central research question

In addressing the central question of whether Clinical Forensic Medicine should be considered a specialty, one obvious element to the answer was to establish the size and composition of the Faculty. Rather surprisingly for an organisation composed

[2]J. Payne-James & A Busuttil, Forensic Medicine, Clinical and Pathological Aspects,Payne-James, Busuttil and Smock. Greenwich Medical Media. 2003, pp.3-13

[3]Catherine Crawford, Legal medicine in history Legalizing medicine: early modern legal systems and the growth of medico-legal knowledge. Cambridge University Press, 1994.

[4]Jennifer Ward, "Origins and Development of Forensic Medicine and Forensic Science in England 1823-1946" Ph.d Thesis Open University 1993.

[5]M Q Patton, Qualitative evaluation and research methods (Sage, 1990) p13.

[6]T D Jick, "Mixing qualitative and Quantative methods: Triangulation in action", Administrative Science Quarterly 24 (1979), pp. 602-611.

of doctors and others working in an area of medicine where identification of facts is important, the Faculty was unable or unwilling to release the data. It was possible to obtain a proxy from the financial balance sheet that contained subscription information and when clarification was requested the Faculty provided spreadsheets from which the tabulated information in Chapter 2 was derived.

Scale of Clinical Forensic Medicine

A more formal approach, a Freedom of Information Request[7], was used to obtain the information from the Metropolitan Police with respect to the numbers of custody suites in the Inner London Borough and the numbers of detainees passing though those custody suites, as well as the proportion of Police Surgeons working in the Metropolitan Police who possess a qualification in Forensic Medicine. These findings indicate the scale of Clinical Forensic Medicine,or at least Custody Medicine in London.

Professional accountability

One question was serendipitous, that of doctors entering the Professional Conduct process of the General Medical Council, the regulatory body of the the medical profession, this question arising from a parallel stream of work. Following a formal request for information, the General Medical Council helpfully provided information about the new phenomenon of Police Surgeons entering the disciplinary process, the data being tabulated in Chapter 2.

Victims and assailants

Personal data collected from 99 consecutive assault cases is used to provide some notion of scale of the discrepancies and tensions inherent in Clinical Forensic Medicine. This data demonstrates for example the blurring of the distinction between victim

[7]Freedom of Information Act 2000

and assailant. The significance of this data could have been measured using statistical techniques for example using a null hypothesis or matching victims with controls, but the use of statistical methods has been deliberately avoided. However, this data can be presented in a more appropriate forum where it can be evaluated by peer review.

Rationale for the thesis.

Having defined the role of Police Surgeon in Chapter 1, Chapter 2 identifies those elements of the medical examination that are required by the Criminal Justice System, as opposed to those elements of the examination that are required to satisfy the notion of Good Medical Practice demanded by the General Medical Council and so defines the functions of the Police Surgeon. The subject area is limited to the work of a Police Surgeon in a custody suite so sexual offences and the examination of children for evidence of abuse, sexual or otherwise is excluded from this discussion. As appropriate in an LLM this Chapter explores the legal basis of Forensic Medicine or at least Custody Medicine.

The increasing use of Healthcare Professionals, for example nurses or paramedics undertaking the role of the Police Surgeon can be used to support the notion that Clinical Forensic Medicine is essentially general medical practice operating within the restricted environment of police custody. The working relationships between Police Surgeons and other Healthcare Professionals employed in custody suites has not been examined and this could be a fruitful area for more research, both in terms of training required by doctors and others in managing the clinical needs of the detainees and the requirement to collect forensic evidence.

The mechanism of specialty accreditation and the alternative of credentialing Police Surgeons working in Clinical Forensic Medicine is outlined in Chapter 4, building on the role and function of the Police Surgeon established in Chapters 2 and 3.

The resolution of the problem of balancing the clinical needs of the detainee against the requirements of the Criminal Justice System for reliable forensic medical evi-

dence is one of the main challenges that the Faculty of Forensic and Legal Medicine has to overcome if it is to deliver the dual aim of advancing education and knowledge and ensuring that practitioners operate to the highest of professional standards and integrity. The goal of course is that if successful Clinical Forensic Medicine will be recognised as a specialty.

Chapter 2

The Historical Development of Forensic Medicine

Introduction

The same four basic questions are asked on finding a body; who was the deceased, when did the deceased die, where did the death occur and what was the mechanism of death. Answers to these basic questions resulted in the development the inquest official. Not surprisingly given the four questions the system that developed in medieval England, the Coroner was remarkably similar to ancient civilisations such as those of China.

The role of Coroner preceded the formation of the courts. The legal system that developed later was remarkably stable until the melting pot of the industrial revolution and the consequent urbanisation when the Metropolitan Police Force was inaugurated and with it Police Surgeons. At this time medicine was being organised with the establishment of the Royal Colleges.

It was not until post World War II that Clinical Forensic Medicine broke free of the professional self interest of the various groupings of medical practice. Now at the beginning of the 21st century Clinical Forensic Medicine is gaining recognition, if not specialty status, with the formation of the Faculty of Forensic and Legal Medicine[1].

[1]Med Leg J 74 (2006) p.1-2; *Editorial: A Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London Neville Davis: How the first attempt to join with the physicians failed as did an attempt to found an independent College of Forensic Medicine. Efforts were spearheaded by members of the Association of Police Surgeons, renamed for reasons of political correctness to the Association of Forensic Physicians. The need for change caused medical academia to become more receptive to the notion that forensic and legal medicine is intrinsically important and should be supported. In September 2005, the RCP invited specialist doctors, significantly from three groups, to apply for Foundation Fellowship to kick start a new Faculty of Forensic and Legal Medicine. These groups were forensic physicians, a term now coined for police surgeons or those who were police surgeons and now accept instructions from defence lawyers, medically qualified coroners and medically qualified advisers to the medical defence organisations.*

2.1 Ancient civilisations

Sydney Smith, Professor of Forensic Medicine[2], postulated the practice of forensic medicine by the ancient civilisations. Today this is a well-trod path with many specialties dating the birth of their craft to descriptions deciphered from ancient Egyptian papyri[3]. Professor Smith referenced his assertions to the writings of Sir William Osler. Osler, in his lectures to the Silliman Foundation delivered at Yale University in 1913[4], appears to have been influenced by the then recent deciphering of the Edwin Smith Papyri.

Osler declared the Ancient Egyptian, Imhotep to be the Father of Medicine. If Leonardo Da Vinci was the renaissance man then surely Imhotep was the naissance man. The range of Imhotep's abilities was collated by Forbes[5] and included the titles "*Inspector of the Buildings of the Upper and Lower Egypt*", "*Inspector of the (pyramid-) town", "Vizier", "Chief Ritualist of the King of Upper and Lower Egypt", "Chief Scribe of the Grain of the King of Upper and Lower Egypt*". Care needs to be taken because the source materials are inscriptions on the bases of statues or other buildings and make no reference to Imhotep's medical knowledge. It might have been the veneration with which Imhotep was held that led to the tradition that Imhotep practiced the medical arts directly rather than just being their patron.

Forensic medical principles were used in Athenian courts and other public bodies where the testimony of physicians in medical matters was given particular credence, although this use of physicians as expert witnesses was not particularly structured.

In the Roman Republic, the *Lex Duodecim Tabularum,* the twelve tablets of laws, were finally published in B.C 449 and resulted from an attempt to limit the Imperium of the Consuls[6]. These Laws had references to medico-legal matters covering such topics as determining the length of gestation and thus legitimacy, poisoning, disposal

[2]Sydney Smith, History and development of forensic medicine, Br Med J (1951), pp. 599-607
[3]E. F. Frey, The Earliest Medical Texts, Clio Med (1985), pp. 79-90
[4]William Osler, The Evolution of Modern Medicine Yale University Press (1923) pp.10-17
[5]R J Forbes, Imhotep, Proc R Soc Med (1940), pp. 769-773
[6]George Long in William Smith's, A dictionary of Greek and Roman Antiquities, John Murray (1875), pp. 688-690

of bodies and punishments dependent on the degree of injury caused by an assailant. Interestingly, in some jurisdictions nowadays the doctor is still asked to classify the degree of injury to determine punishment. Papyri relating to Roman Egypt dating from the latter part of the first to the fourth century AD contain information about forensic medical examinations or investigations.

Paul Knapman refers to Bernard Knight's work of 1975 researching the Yunmeng tomb's bamboo slips of 475-221 B.C[7]. These slips gave instructions to judges on how to detect bruises, wounds and general post-mortem changes. In the Tang and Song dynasties 681 AD "coroners" existed in China. According to Hsi Yuan Chi Lu, "The Washing Away of Wrongs", translated by McKnight[8] but written by Sung T'zu in 1247, is a handbook of instructions for the investigation of sudden death. This documents the legal and medical procedures to be followed in an inquisitorial judicial system with reference to a traveling inquest official and in part, concerned hangings and death in custody.

Records in Europe appear much later. Medical jurists were first acknowledged and their services formally required in the criminal code of Charles 5th at the Diet of Rastaban in 1532, where the *Consititutio Criminalis Carolina* ordered:

> *that medical men shall be consulted whenever death has been occasioned by violent means, whether criminal or accidental, by wounds, poisons, hanging, drowning or the like; as well as in cases of concealed pregnancy, procured abortion and child murder*[9].

The addition of this law to the criminal code in Europe was instrumental to the advancement of Forensic Medicine on the continent that led England for many years.

[7]P Knapman, The Crowner's Quest, Proceedings of the Royal Society of Medicine (1992) p716
[8]Brian McKnight, Hsi Yuan Lu (Washing Away of Wrongs), University of Michigan (1981)
[9]J A Paris and J S M Fonblanque, Medical jurisprudence (1823), pp x

2.2 Justice in early England

The received understanding of the development of English Common Law was developed by Maitland[10]. He argued that the *Tractatus de legibus et consuetudinibus regni Angliae*, a treatise on the laws and customs of the Kingdom of England attributed to Glanvill[11], was the earliest treatise on English law and that the period of 1154 to 1189 saw the creation of the Common Law. This notion was challenged by Hurnard[12] and later by Milsom[13] who re-evaluated the innovatory nature of the reforms of Henry II and proposed that the development of common law was an evolutionary process arising from the pressures from suitors and devices rather than the construction of a centralising government. John Hudson[14] acknowledges Maitland's analysis but prefers to see history in the wider context of "*society.*" That society operated within a hierarchy, families, hamlet, village, hundreds and shires that led to the organisation of a system of justices and courts. There were four main type of justices; resident justices with jurisdiction throughout one or more shires, minor local officials dealing with the King's Pleas, appointed individuals that heard particular cases as royal justices and itinerant justices who went on circuit.

It seems that one man became singled out who might be responsible for one or more hundreds[15]. Hudson refers to Benjamin mentioned in an 1130 Pipe Roll[16], who was paid to keep the King's Pleas. The keeping of the King's Pleas involved the viewing of wounds and the victims of unnatural death.

The organisation of the courts was also based on the units of civil administration. Shire courts were a meeting place for the major figures of a district. Shire courts might be convened outside or in the hall of a castle or a monastery and by the

[10]Frederic William Maitland, The Collected Papers of Frederic William Maitland, (Cambridge University Press, (1911) Vol 2, 266-290

[11]*Ranulf de Glanvill, Chief Jusiticiar of England during the reign of Henry II, died 1190*

[12]N.D. Hurnard, "The Anglo-Norman Franchises", English Historical Review LXIV (1949), pp. 289-327.

[13]S.F.C..Milsom, The legal framework of English feudalism: the Maitland lectures given in 1972 (Cambridge University Press, 1972).

[14]John Hudson, The formation of the English Common Law, Law and Society in England from the Norman Conquest to Magna Carta, Longman (1966)

[15]*A division of administration where 100 men could be recruited to fight for the crown.*

[16]*A collection of financial records maintained by the English Exchequer.*

thirteenth century were held every four weeks. The court would be summonsed seven days in advance and heard pleas for one day only. In the thirteenth and fifteenth century, most of the shire or county courts would have involved 150 men. Bishops, Earls, Sheriffs, Deputies, Hundredmen, Aldermen, Stewards, Reeves, Barons, Village Reeves and other Lords of the Land or their nominees all attended court. The court heard land claims, offences of violence and some ecclesiastical cases but serious cases required a royal representative.

Hundred courts were typically held monthly although by the end of the thirteenth century the frequency of sitting may have increased to fortnightly. Most sittings lasted a single day and the court dealt with less serious cases than the shire court[17]. In 1270 there were 628 hundreds and wapentakes, the Danelaw equivalent. The number of hundreds per shire varied from thirty five in Devon to fourteen in Oxfordshire. The number of villages per hundred could vary from two to twenty or so.

Just as the King was available to petition so the Lord of the Manor would be available to hear pleas from tenants in seignorial courts. These courts were open to residents outside the immediate manor. Probity was predicated on the Lord of the Manor's honour, who dealt with offences against the person and disputes over goods.

2.3 The origin of the coroner

Some[18] attribute the origin of the coroner to the controller or "*coronator*" who maintained order at Saxon tribunals, where suitors sought resolution of disagreement. It was King Aethelstan who granted the office of "*keeper of the pleas*" to John of Beveley. However, Davis[19] places the origin of the role to the Norman influence and in particular Henry II. The court of Henry II migrated across Henry's realm which extended from the Tweed to the Pyrenees.

[17]http://historymedren.about.com/od/hterms/g/hundred.htm

[18]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press (2006) p.5

[19]H. W. C. Davis, England under the Normans and Angevins, 1066-1272, Methuen (1905)

In 1178 or thereabouts, Henry II separated the judicial from the administrative department of the *Curia Regis*[20], selecting experienced and trusty servants to act in his Council in affairs of state and appointed five justices to deal with judicial matters, the *Curia Regis in Banco.* With the succession to the throne of Richard I on the 3rd September 1189, time immemorial[21] ended. Richard's commitment to the crusades and his lands in France required a greater reliance on administrators to manage affairs in England. One such administrator was Hubert Walter, Archbishop of Canterbury, regarded by some as the creator of the role of Coroner[22].

Hubert Walter's policy to raise funds was contained in the instructions to the Itinerant Justices of 1194 and 1198 and his ordinance of 1195 for the conservation of the peace, and in his scheme of 1198 for the assessment of the carucage, a form of land tax.

The visitation by the Itinerant Justice was called an Eyre[23]. There was scepticism of the Itinerant Justices because they wandered from the path of equity in fulfillment of their finance raising function. Turner cites Roger of Howden who referred to the 1198 Eyre in the following terms:

> *by there and other vexations the whole of England was reduced to poverty from sea to sea*[24].

These visiting justices brought with them a list of articles, some of which concerned royal financial interests and other issues concerning political events such as the unrest associated with Prince John whilst Richard was away on crusade. The sheriff and his bailiff in preparation for the Eyre's visit would ensure that litigants to an action were present and in cases of death that neighbours of the deceased were present.

The Itinerant Justices of 1194 were directed to provide in each shire the election of four coroners. Article 20 of the Articles of Eyre, promulgated that in every county

[20] *Royal Council*

[21] *Time extending beyond the reach of memory*

[22] http://www.britannia.com/history/articles/coroner1.html

[23] *Journey circuit, or justices in circuit. Justices were usually members of the superior court, although the sheriffs sometimes performed this duty.*

[24] Ralph V. Turner, Judges, administrators and the common law in Angevin England. Hambledon Press, (1994) p 107.

there should be an election of three knights and one clerk to act as *keepers of the pleas of the crown*, the *Custos Placitorum Coronas*[25]. These individuals were chosen by the suitors of the shire-court from their own number. These officers were to decide what matters arising in their shire should be regarded as Pleas of the Crown and reserved for the hearing of the Justices.

This was an important transition because opportunities to levy blackmail by the sheriff and the suitors was increased along with their share in the administration of criminal justice. The Articles for the Eyres of 1194 and 1198 introduced the representative principle into the spheres of fiscal business and private law.

The knights acting as custodians of the peace, foreshadowed the Justices of the Peace into whose hands the whole work of county government was to pass in the course of the fifteenth and sixteenth centuries. The custodians of the peace, as appointed in 1194 and for a long time afterward, were not invested with judicial powers. Their chief duty was to control the Hue and Cry, a rough machinery for the apprehension of criminals, which had descended almost unchanged from the days of the Heptarchic Kingdoms[26] and was still the only form of police in rural districts[27].

Hubert Walter would have been most interested in collecting revenue and by choosing knights there was the expectation that their probity would be guaranteed by the threat of loss of social position if the administration of justice was corrupted. Consequently, amercements[28] collected from felons or the estate of suicides were more likely to pass to the crown than be retained locally. Felons who chose the sanctuary of the church to confess his or her crime could choose to *"abjure the realm"* leaving the jurisdiction of the crown[29]. The Coroner documented the abjurations[30] and col-

[25]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 6

[26]*The seven kingdoms,Wessex, Sussex, Essex, Kent, East Anglia, Mercia & Northumbria*

[27]*In areas where feudalism has only just given way to democracy, such as Sark in the Channel Islands, the Seigneur heard petitions from parishioners in the Chief Pleas until 2009. In Jersey, each parish still elects a centenier who acts as a police officer and to this day are the only persons who can charge and bring persons to court, although the policing role was largely supplanted by the formation of the States of Jersey Police in 1974 when the Police Force (Jersey) Law, was passed.*

[28]*A financial penalty*

[29]Carro, Jorge L, "Sanctuary: The Resurgence of an Age-Old Right or Dangerous Misinterpretation of an Abandoned Ancient Privilege", U. Cin. L. Rev. 54 (1986), p. 747.

[30]*Acts of renouncing upon oath*

lected the felons property that would have been forfeited to the crown by the act of abjuration[31].

The twelve miles surrounding the King's court had its own Coroner. The Coroner of Marchelsea or coroner of the verge, a post that is extant and came to prominence when the body of Diana, Princess of Wales was brought back to England after her fatal accident in Paris.

On finding a dead body it was the duty of the nearest four neighbours to raise the hue and cry and to notify the bailiff who would call the Coroner. If the first finder of the body did not initiate this process an amercement was due[32]. A jury would be gathered from the local hundred to examine the body that would have been laid on a table for inspection. The jury members were in effect medical examiners. The Coroner had a duty to investigate death in prison, the *Statute de Officion Coronatoris* in 1276[33]. It is interesting to note *en passant* that this duty was cited in Regina v. Secretary of State for the Home Department (Respondent) ex parte Amin (FC) (Appellant), a case of a murder in a Young Offenders Institution.

This state of affairs was to continue for hundreds of years. Writers supporting the notion that William Shakespeare was a lawyer or at least had legal training, cite the graveyard scene in Hamlet[34] in support of their arguments[35]. The clowns arguing

[31]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 8

[32]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 8 & 9

[33]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 9

[34]Hamlet Act V. Sc. 1. 1-22

[35]*Grave.* Is she to be buried in Christian burial, when willfully seeks her own salvation? Other. I tell you she is, therefore make her grave straight. The crowner hath sat on her, and finds it Christian burial.

Grave. How can that be, unless she drowned herself in her own defence?

Other. Why, 'tis found so.

Grave. It must be *se offendendo*; it cannot be else. For here lies the point: if I drown myself wittingly, it argues an act; and an act hath three branches—it is to act, to do, to perform; argal, she drowned herself wittingly.

Other. Nay, but hear you, Goodman Delver—

Grave. Give me leave. Here lies the water—good: here stands the man—good. If the man go to this water and drown himself, it is, will he, nill he, he goes; mark you that. But if the water come to him and drown him, he drowns not himself. Argal, he that is not guilty of his own death shortens not his own life.

Other. But is this law?

Grave. Ay' marry is't, crowner's quest law

over Ophelia's burial are parodying the *ratio decidendi*[36] of the case of Hales v. Petit[37]. Hales v. Petit had been decided 40 years before Hamlet had been published and the case would have been written in Norman Law, a language used by lawyers. In the case of Hales v. Petit, Sir James Hales, a judge of the common pleas was ruled to have killed himself, *felo de se*[38]. Drowning in a river after failing to open his veins with a knife. Hales had been forced to renounce his protestant principles in order to earn his release from custody after being involved in a conspiracy to make the Lady Jane Grey, Queen. Being a suicide, the inquest ruled that all his lands were forfeit to the crown and that his body be buried at a crossroads. His widow argued that the property which had been given to him and his wife jointly, was not forfeit because suicide could not occur during that person's lifetime, an interesting argument that was not upheld.

2.4 The development of the coroner

The first Coroners Act 1751[39] increased the coroner's remuneration to 20 shillings per case and provided a travel expense of 9 pence per mile[40]. This was the first increase since 1487 when the coroner was reimbursed 1 mark per inquest into a homicide plus fourpence from the goods and chattels of the guilty man. The coroner was subject to punishment by fine for failing to hold an inquest where one should have been conducted, but no fee was allowed where the death was accidental[41]. Fees under the 1751 Coroners Act, required authorisation by the Justices of the Peace who had financial control of the coroners. This arrangement led to a conflict between the two offices and resulted in the restriction of inquests to violent deaths.

Statute increasingly placed duties onto the coroner. The Births and Death Reg-

[36] *The rationale for the decision*
[37] Hales v. Petit [1561] 75 E.R 387
[38] *A self-murderer*
[39] Coroners Act 1751
[40] Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 15
[41] Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 13

istration Act 1836[42] obliged the coroner to inform local registrars of death within eight days of holding the inquest. Typically at that time, inquests were opened and conducted close to the place of death, commonly being held in a hostelry[43].

Matthew Hale[44] stated that the Coroner's Court is to inquire truly *quomodo ad mortem devenit*[45] in an effort to find the truth of the facts as near as the jury could ascertain and not to accept lay accusations.

With the coming of the Industrial Revolution, coroners such as Thomas Wakely caused much annoyance by extending the role of the coroner from matters dealing with death to matters dealing with the compensation of the families of the deceased[46]. Wakely's practice concerning the use of Deodand[47], to compensate the families of the victims of accidents, typically those occurring on the railways, led to pressure from industrialists that deodands for fatal accidents be abolished[48] as they were in the 1846 Deodands Act[49] [50]

The forfeiture of the property of suicides and convicted felons was abolished in 1870. This removed personal injury and death compensation from the remit of coroners, curtailing the action most notably of Thomas Wakely.

The Coroner's Act of 1887[51] removed from the coroner the duty to protect the financial interests of the crown. The coroner was the mechanism for the investigation of death due to violence and also sudden or unnatural deaths where the cause was

[42]Births and Death Registration Act 1836 (UK) 6&7 Wm IV, c 86.

[43]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 15

[44]History of the pleas of the crown Mathew Hale Vol I, p60 1736

[45]*In what manner of death*

[46]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, Pg. 16

[47]*An instrument for compensation / an object that becomes forfeit because it has caused a person's death*

[48]Ian Frecklton & David Ranson, Death Investigation and the Coroner's Inquest, Oxford University Press, 2006, p. 21

[49]Deodands Act 1846

[50]*....there shall be no Forfeiture of any chattel for or in respect of the same having moved to or caused the Death of Man; and no Coroner's jury sworn to inquire, upon sight of any dead body, how the deceased came by his death, shall find any forfeiture of any Chattel which may have moved to or caused the Death of the Deceased, or any Deodand whatsoever; and it shall not be necessary in any Indictment or Inquisition for Homicide to allege the Value of the instrument which caused the Death of the Deceased, or to allege that the same has value...*

[51]The Coroner's Act 1887 (UK)

not clear. The Coroner still held inquests into treasure trove and could still act in place of the sheriff. The Coroner was able to summons between 12 and 23 men to appear before him and inquire as jurors into the cause of death.

In 1827 Thomas Wakely writing in the Lancet[52], argued that the depth of medical knowledge exceeded the depth of legal knowledge required to operate as a coroner. *"The legal knowledge required of the Coroner may be comprised in a nut-shell".* This argument has been promoted through the following 180 years and appears finally lost in the 2009 Coroners and Justice Act[53]. This act institutes line management from a Chief Coroner to a service that is led by legally qualified coroners, with medical input being provided by a new cadre of doctor, the Medical Examiner. When Wakely was electioneering for the post of the Middlesex Coroner in 1830 he cited the case of Catherine Cashin upon whom Alexander Thomson had carried out a post-mortem examination[54]. Catherine Cashin had been treated for consumption by John St John Long, a Harley Street quack, but Thomson had been prevented by directions from the legally qualified coroner not to open the head or the spine and consequently was unable to comment whether the injury to Ms. Cashin's back had any bearing on her demise. In a speech Wakely detailed the failings of the the current system that lead to miscarriages of justice. Wakely used this case to present himself to the electorate as a man well qualified in the "*investigation of all subjects connected with medical jurisprudence*"[55].

The Local Government Act 1888[56] saw the appointment of coroners by Boroughs or Counties and the election of the coroner by freeholders ceased. However, when John Troutbeck was appointed Coroner for the City and Liberty of Westminster in 1888 a report was published that recommended the appointment of a skilled pathologist to carry out post-mortem examinations in special cases, or cases where the coroner was not satisfied that the efforts of the General Practitioner would be adequate. It was

[52]Necessity of a medical education to coroners Lancet 1827-8 1:267-9

[53]Coroners and Justice Act 2009

[54]A Thomson Lancet 28 August 1830, pp.867-876

[55]Ward, Jennifer Origins and Development of Forensic Medicine in England, 1823-1946, Ph.D thesis. The Open University.(1993), p.33

[56]Local Government Act 1888

envisaged that such a skilled pathologist would be appointed to each district. The London County Council duly sought nominations. Troutbeck chose Ludwig Freyburger, who had been practicing as a forensic pathologist and toxicologist for several years and was a fellow member of the Medico-Legal Society. Coroner Troutbeck employed the services of his skilled pathologist, Ludwig Freyburger enthusiastically. In his only paper presented to the London Medico-Legal Society, Freyburger reported on 74 cases of death while under the influence of an anaesthetic[57]. Significantly, 73 of those cases occurred in the district of HM Coroner for Westminster and Southwest London during 1902 and 1908. This bias is accounted by the large number of hospitals in the area and Troutbeck's preference for reports from a specialist pathologist. General Practitioners in the area saw a corresponding fall in the number of post-mortem examinations they were asked to carry-out and perhaps more importantly, a fall in their income. The arguments marshalled against the new order attacked the legality of Coroner Troutbeck's authority to use a specialist pathologist, the economy of doing so, and Ludwig Freyberger's position. Leonard McManus in a letter[58] was at pains to point out that the Medical Practitioner who was in attendance should be consulted and paid the appropriate fee. When Coroner Troutbeck died in 1912 the number of post-mortem examination requests fell, and in particular the number of cases carried out by Dr. Freyberger fell sharply[59].

At this time it was found that the quality of post-mortem examinations carried out by *"gentleman who was a medical practitioner and was not generally employed in that work*" might as be expected, fell below the quality of those carried out by "*specialists*" in carrying out post-mortem examinations. A recommendation had been made in 1893[60] by a Select Committee for the appointment of medical investigators or assessors for each Coroner's Court, a notion that was finally written into statute in the 2009 Coroner and Justice Act[61] however, at the time of writing fiscal restrictions have led to the postponement of introducing a Chief Coroner. Coroners from now

[57]Transactions of the Medico-Legal Society Vol V, p.21

[58]Zuck, D. Mr Troutbeck as the surgeon's friend: The Coroner and the Doctors - An Edwardian Comedy. Medical History: 1995, Vol 39, pp. 259-287.

[59]Ludwig Freyberger The Crisis in the Coroner's Courts 1902-1913

[60]Select Committee on Death Registration 1893

[61]The Coroners and Justice Act 2009

onwards will need to be legally qualified, the transition from mix of medically or legally trained post holders to a legally qualified services will occur through natural wastage.

One of the advances of the 2009 Act was the change to death certification with the introduction of Medical Examiners to review all deaths in a developed process, akin to the existing process whereby two doctors reviewed cremations. It is likely that such a system will eventually become part of the National Health Service, because there is a perception that the new procedure could lead to the reduction in claims for medical negligence. If that does occur it would be an opportune moment to bring all forensic services under the mantle of the National Health Service so achieving one of the aspirations of police forces in 1948.

The Coroner service has been subject to adverse criticism. The autonomy of each coroner may have resulted in the development of practices that in modern times are unacceptable in terms of sensitivities to the relatives. These include the delay in holding, finalising inquests and in issues concerning tissue retention. Coroner Knapman retained the hands of some of the victims of the Bow Belle tragedy to aid identification[62]. Nowadays members of the public rarely see a dead body and set against rising sentimentality, tissue retention whether to aid identification or for research, or educational purposes is anathema to the public. The issues raised by the debacles at Bristol Royal Infirmary[63], the Royal Liverpool Children's Hospital (Alder Hey)[64] together with the Isaacs Report[65], which focused on the retention of the brain by the coroner, were some of the drivers for the Human Tissue Act 2004[66].

Before this hysteria coroners had come under fire in the 1971 Broderick Report which addressed the most important function of the coroner, to produce a certificate

[62]Lord Justice Clark, "Thames Safety Inquiry"(2000) s12.

[63]Learning from Bristol: The Report into Children's Heart Surgery at Bristol Royal Infirmary (July 2001)

[64]The Royal Liverpool Children's Hospital Inquiry Report (January 2001)

[65]Dept of Health (May 2003) The Investigation of Events that followed the death of Cyril Mark Isaacs

[66]Human Tissue Act 2004

regarding the cause of death. The United Kingdom has an obligation to supply mortality data to the World Health Organisation[67] additionally the Broderick Report concluded that the coroner should:

> *make enquiries in order to decide whether a post-mortem examination or an inquest or some other action is required;*
>
> *ensure that "properly interested persons" are be given an "absolute" right to participate in an inquest, and legal aid should be made available to enable them to be legally represented;*
>
> *have discretion to hold a "short" inquest based exclusively on documentary evidence;*
>
> *the duty of a coroner's jury to name the person responsible for causing a death and the coroner's obligation to commit a named person for trial be abolished*
>
> *abandon the term "verdict" and replace it with the term "findings"* [68]

The Luce Report 2003 stated:

> *"There is, indeed, a general lack of evidence about the utility and justification for coroner's autopsies on the scale on which they are practised in England and Wales. If the 121,000 autopsies a year that are now performed were surgical procedures carried out on living people there would long ago have been an evidence base compiled to assess the utility and justification for the scale of intervention*[69]"

and paved the way for the 2009 Coroners and Justice Act[70].

[67] 29th World Health assembly Meeting in Geneva May 1976, adopted the 9thRevision of the International Classification of Disease. WHO, International Classification of Diseases (World Health Organisation, 1977), p. xiii-xv

[68] http://www.proni.gov.uk/index/search_the_archives/proninames/about_the_coroners__service.htm

[69] Death Certification in England, Wales and Northern Ireland, Report of a Fundamental Review, Cm 5831 (2003), 173.

[70] Coroners and Justice Act 2009

2.5 Organisation of Medicine

Alongside the development of the role of the coroner medical practice was evolving so that by the nineteenth century there was a three tier system of medical practice in London. In top place were the elitist physicians who examined, diagnosed and prescribed medication but they did not dispense medication or perform surgery. In 1800 there were less than 200 members of the Royal College of Physicians in London. An applicant for membership to the Royal College of Physicians was required to have a medical degree from Oxford or Cambridge[71]. In the case of Oxford where there was no examination in medicine the candidate took his BA and studied medicine elsewhere and was granted the degree as a formality. Surgeons had split from the Barber-Surgeons Company in 1745, forming the Royal College of Surgeons in 1800. The surgeons undertook the bulk of doctoring, setting bones, treating skin disorders and managing gynaecological complaints. However, it was the Apothecaries, who had developed from untrained shop keepers dispensing medicine by way of the 1815 Apothecaries Act[72] who became governed by a professional body, the Society of Apothecaries. The Society of Apothecaries "*licensed*" the prescribing and dispensing of medication and this control meant that even surgeons were obliged to become the Licentiates of the Society of Apothecaries in order to prescribe medication. Until 2003 the Society of Apothecaries continued to award a Licence in Medicine and Surgery, the LMSSA was a registrable qualification under the 1886 Medical Act[73]. The route to General Medical Practice, as we might understand it today, was as Surgeon Apothecary and it was from these ranks that Police Surgeons were recruited.

This regimented structure of medicine as practiced in London stifled the development of Forensic Medicine. The position was different in Scotland where links with Europe led to a greater appreciation of Forensic Medicine north of the border. Andrew Duncan who was Professor of Physiology at Edinburgh in 1789, delivered the first course of lectures on legal medicine[74]. Andrew Duncan's concept encompassed the

[71]http://www.rcplondon.ac.uk/museum-garden/history/college-history
[72]Apothecaries Act 1815
[73]Medical Act 1886
[74]M. McCrae, Andrew Duncan and the Health of Nations, J. R. Coll Physicians Edin (2003),

forensic base familiar to practitioners today but also the concept of medical police or what would now be described as public health. This dealt with health propagation, a public analyst service that would deal with purity of air, water, food and drink. His son, Andrew Duncan was the first occupant of the Regius Chair of Medical Jurisprudence and Medical Police in 1907[75].

John Gordon Smith was appointed England's first Professor of Forensic Medicine in 1828 according to the University of London Council minutes[76], but the position was not guaranteed and the salary was dependent on student fees. Smith began a campaign to have the subject examined and thus compulsory, so encouraging students to attend his lectures. Smith was a veteran of the Battle of Waterloo and a graduate of Edinburgh University but despite his distinguished academic background he could not practice physic in London because of a lack of the liberal education that could only be obtained at Oxbridge, therefore he could not be admitted to the Royal College of Physicians. Smith wrote his Principles of Medical Jurisprudence in 1821. The book was severely criticised for its lack of references and general style of writing and was rapidly superseded by Medical Jurisprudence by Paris and Fonblanque[77]. Smith's application to be a coroner for Southwark and the City of London failed because of his lack of a liberal education. No doubt medical protectionism was operating but Smith's treatise was condemned by a contemporary Scottish medical jurist, William Dunlop[78].

Summers, documenting the history of the Police Surgeon in 1978[79] noted that the first mention of a police doctor was in 1805, when a doctor was appointed by the Bow Street Runners to examine recruits and provide medical services to the patrol, for a salary of £100 *per annum.* It was the Metropolitan Police Act 1829 that created a divisional surgeon, whose primary role was the health and welfare of the police,

pp. 2-11

[75]M H Kaufman, Origin and History of the Regius Chair of Medical Jurisprudence and Medical Police established in the University of Edinburgh in 1807, J Forensic Leg Med (2007), pp. 121-130

[76]Ward, Jennifer (1993). Origins and Development of Forensic Medicine and Forensic science in England, 1823-1946. Ph,D thesis, The Open University, p.30.

[77]J A Paris and J S M Fonblanque, Medical Jurisprudence (1823)

[78]T.R Beck, Elements of Medical Jurisprudence (1825)

[79]R. D. Summers, History of the Police Surgeon., Practitioner (1978), pp. 383-387

but as the first educated man on the scene the Police Surgeon could find himself practicing Forensic Medicine[80]. Following the Metropolitan Police Act of 1829, Dr R. W. Fisher was appointed Superintending Surgeon to the force with a salary of £350 *per annum.*

The Metropolitan Police Surgeon Association was formed in 1888 and existed until 1948. From Summer's analysis of the Metropolitan Police Surgeon's Association it seems that many of the issues have not changed to this day; doctors not being paid when attending court, pressures from interested parties for example, the Union of Licensed Vehicle Workers that doctors should take more care when examining their members because of the potential for loss of livelihood and issues concerning the health and safety of officers. Compare this with modern times when there can be local pressures from the drinks lobby to serve alcohol unfettered.

By 1937 all Metropolitan Police stations had a room set aside for medical examinations. The service offered by the Police Surgeons was proven to be good because when a vote was taken whether officers should remain with the Police Surgeon or transfer to the National Health Service on its inception, 98% of officers voted to stay with the Police Medical Service. Fees paid to doctors ranged from 3s and 6d to 15s for a call.

Date	Value	Service	2011 value
1751	20s	Inquest	£85.16
1751	1d	Mileage	£0.35
1805	£100	Honorarium	£3,217.00
1830	£350	Salary	£17,321.50
1937	3s/6d	Call	£6.47
1937	15s/0d	Call	£27.74

Table 2.1: Comparison of Police Surgeons remuneration

After National Archives conversion table: http://www.nationalarchives.gov.uk/ currency/results.asp

The Metropolitan Police Association developed into the Association of Police Surgeons of Great Britain with the aim of improving the education of Police Surgeons

[80]J. F Clarke, Recollection of the Medical Profession, London (1874), p. 98

and following pressure from the Association the Society of Apothecaries, offered a Diploma of Medical Jurisprudence in 1962.

When Summers[81] was writing, he felt that one of the most important responsibilities of the Police Surgeon was the examination of recruits, examination and advices about disabilities, pensions and advice about the working conditions of the police. Summer's review ends in 1978. The *status quo* persisted until the early part of the 21st Century, when police forces, as ever under financial pressures and with examples set by other public services, found the notion of contracting Forensic Medical Services to providers to be attractive. At the same time the Association of Police Surgeons elected to change it's name to the Association of Forensic Physicians. This may not have been purely an act of self-aggrandisement but a step in the process of forming a faculty of the Royal College of Physicians. Others may write about this process and why the Physicians were chosen, rather than the General Practitioners or Pathologists.

The complacency of the post war years where there was a failure to professionalise the craft beyond that of the Diploma issued by the Society of Apothecaries, allowed the private providers to claim that nurses and paramedics had the clinical skills required to operate a forensic service. Changes in the law removed the requirement that certain procedures be conducted by Registered Medical Practitioners and instead stated that Healthcare Professionals could take various samples[82]. It is likely that with further revisions to statute that this medical requirement will be totally removed.

This will have considerable financial savings. However, exposure of doctors to Clinical Forensic Medicine will be limited, raising doubts about where the next generation of forensic expert and in particular how the expert witness will obtain experience.

In the 1880's Forensic Medicine was split into four areas of practice, these being: Special Pathology, Toxicology, Metropolitan Police Surgeon and General Practi-

[81]R. D. Summers, "History of the police surgeon.", Practitioner 221, 1323 (1978), pp. 383-387.
[82]Police Reform Act 2002

tioner[83]. There was no distinction between civil and criminal cases. Today there is some degree of specialisation. Victims of sexual assault are examined in sexual assault referral centres (SARCS), children are jointly examined by a Forensic Physician and a Paediatrician, victims of general assault are examined in police facilities and detainees and road traffic act offenders are examined in custody suites. Death investigation is currently marginalised although Medical Examiners are envisaged as part of the 2009 Coroners and Justice Act.

2.6 Clinical Forensic Medicine

It is not difficult to imagine how the early members of the Royal College of Physicians, the elite 200 or so doctors with a liberal education, would have reacted to the idea that some surgeon - apothecaries working in the grubby area of Forensic Medicine, would become members of a faculty of their Royal College.

However, in 2007 the Faculty of Forensic and Legal medicine emerged with these aims:

- ▷ *To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine.*
- ▷ *To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity*[84].

The representation of Police Surgeons, one of the aims of the Association of Police Surgeons had been dropped with the emphasis of the new organisation being placed on governance and protection of the public. From the start the faculty was elitist, memberships were offered only to those in possession of a postgraduate diploma

[83]Jennifer Ward, "Origins and Development of Forensic Medicine and Forensic Science in England 1823-1946" (1993). p2.

[84]http://fflm.ac.uk/

and fellowships to those who had distinguished themselves in the field of Forensic Medicine. Some saw affiliateship a cadre, open to those working in Forensic Medicine or a field closely related to Forensic Medicine where the need for a medical qualification is not mandatory, as a token gesture to their experience and many elected not to accept what was perceived as an unattractive offer.

The faculty opened with 122 Fellows, 190 Members and 105 Affiliates, and by 2011 the total membership had reached 760.

Membership details of Fellows, Members and Affiliates classed as Forensic Practitioners, released by the Faculty of Forensic and Legal Medicine, show a more or less constant number of fellows and a steady rise in the number of affiliates[85]. Of some concern is the fall in those holding Membership in 2011. One explanation for this is the decision of many Police Surgeons based in London to withdraw from the Faculty of Forensic and Legal Medicine[86] to form a London specific grouping.

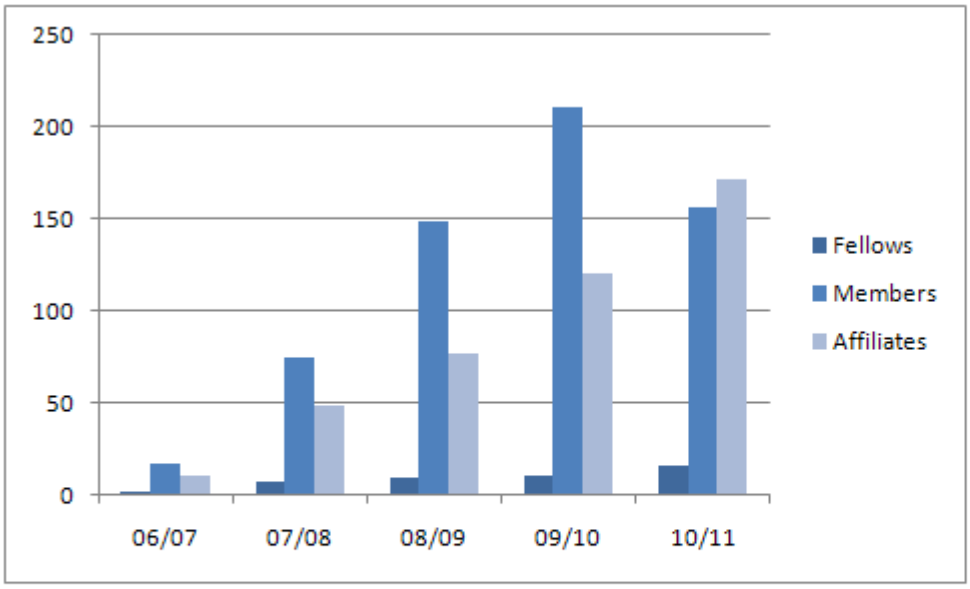

Figure 2.6.1: Clinical Membership FFLM

*Prepared from raw data kindly supplied by Dr George Fernie, President of the Faculty of Forensic and Legal Medicine.

[85]Dr George Fernie, Faculty of Forensic and Legal Medicine
[86]Personal Communication, Prof Ian Wall, President FFLM 2010

However, review of the rate of growth shows a decline in both members and affiliates added to the Faculty.

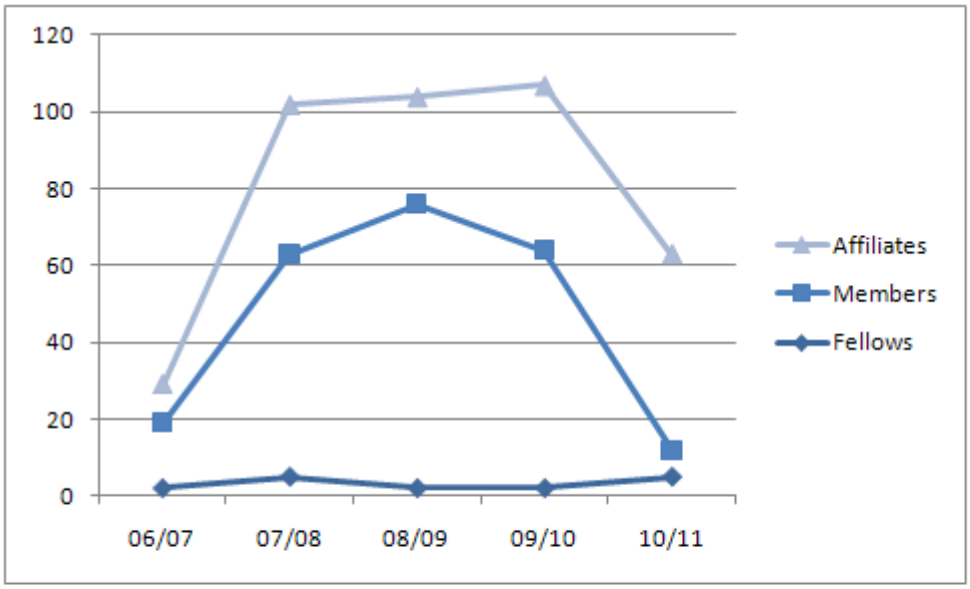

Figure 2.6.2: Rate of Growth of the Clinical Membership FFLM

*Prepared from raw data kindly supplied by Dr George Fernie, President of the Faculty of Forensic and Legal Medicine.

Figures recording the number of lapsed members, that is those who have not paid their annual subscriptions, shows that there has been a rise in the number of affiliates who are flagged as lapsed and a slight rise in the number of members who are lapsed. Suggesting that there is a problem of retention of members.

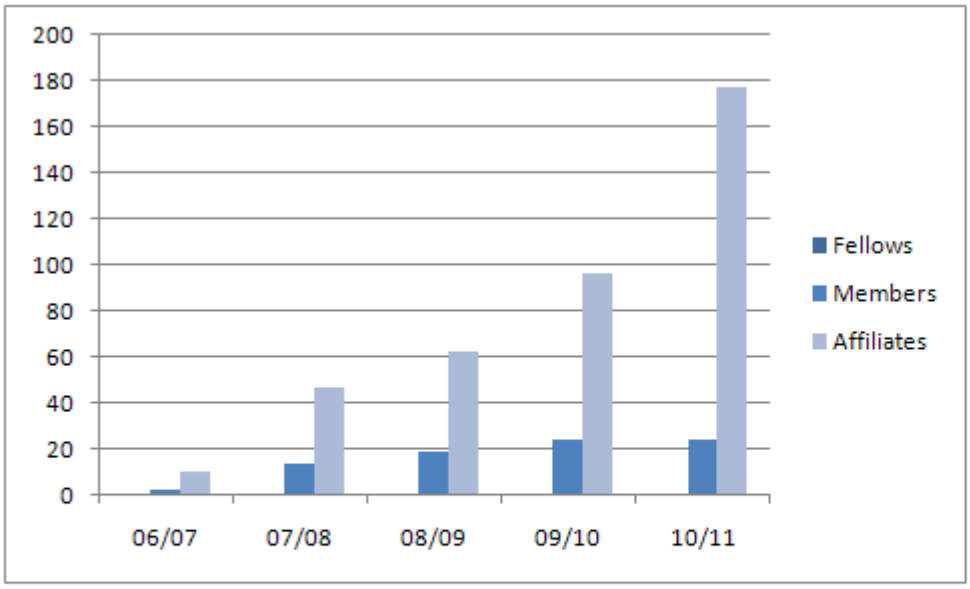

Figure 2.6.3: Lapse of Clinical Membership

*Prepared from raw data kindly supplied by Dr George Fernie, President of the Faculty of Forensic and Legal Medicine.

It is possible to plot the rate of lapses of Members and Affiliates and this shows that there is fluctuation amongst affiliates but that there is a steadier decline in members. This decline is not explained by members being elected fellows and must be a worrying trend for the Faculty.

There is a possibility that a new class of professional will find their home within the Faculty, these are the Medical Examiners to be appointed under the Coroners and Justice Act 2009[87].

[87]Coroners and Justice Act 2009

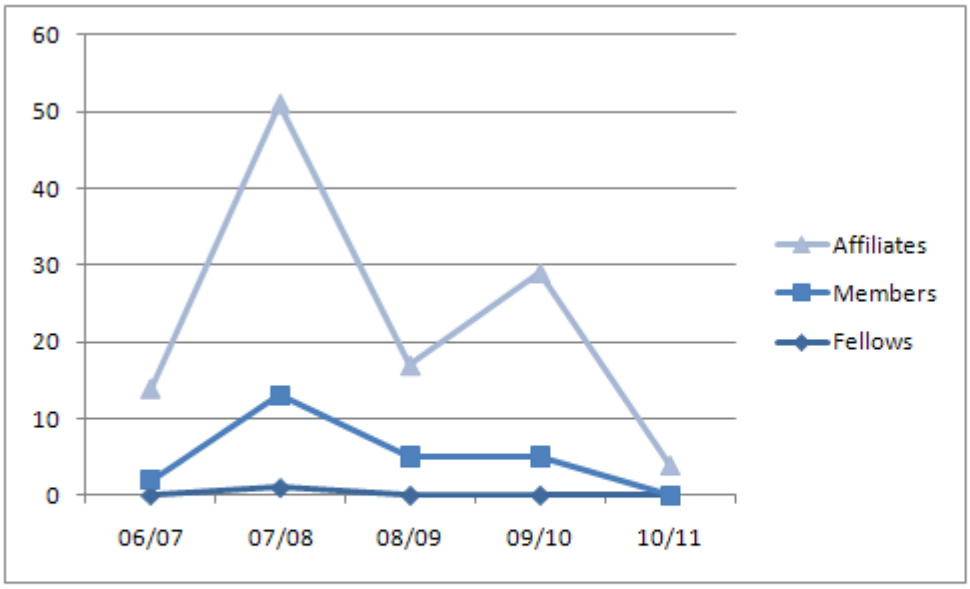

Figure 2.6.4: Rate of lapse of Clinical Membership

*Prepared from raw data kindly supplied by Dr George Fernie, President of the Faculty of Forensic and Legal Medicine.

Whilst the numbers of doctors and healthcare professionals working in Clinical Forensic Medicine are not readily available, it is possible to identify the number and size of some of the custody suites in the UK. In a joint initiative the HM Inspectorate of Prisons and HM Inspectorate of Constabulary undertake inspections of custody suites[88], thus satisfying the conditions of the UN Optional Protocol against Torture[89] that all places of detention be inspected. This process is in it's infancy and not all custody suites in all police forces have been inspected. The emphasis of the inspection is on quality assessment rather than data collection.

The Metropolitan Police Service does not routinely collate details of custody suites or detainees being held in such suites. Table 1.2 compiled from a Freedom of Information Request[90] shows the data for the inner London Boroughs, and from this it appears that in excess of 150,000 persons pass through the custody suites of the

[88]http://www.hmic.gov.uk/inspections/

[89]Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199.

[90]Freedom of Information Request Reference 2011030004968

Inner London Boroughs each year.

Figure 2.6.5: Map of London Boroughs

*www.statistics.gov.uk/geography/downloads/london_boro.pdf

Custody Suites Inner London Boroughs [91]

[91]http://www.justice.gov.uk/inspectorates/hmi-prisons/police-cell-inspections.htm

Borough	Report	No. of suites	Number	FME services comment
Camden		Albany Street (9)	177	
		Kentish town (11)	4,078	
		Holborn (16)	5,594	
Hackney	✓ 2010	Stoke Newington (16)	6,321	Clinical governance & attendance time required improvement
		Shoreditch (9)	3,454	some clinical rooms were in poor condition,
		Hackney (5)	312	medicines management required thorough review
Hammersmith & Fulham		Fulham (9)	3,243	
		Hammersmith (18)	5,369	
		Shepherd's Bush (9)	119	
Haringey		Hornsey (11)	4,638	
		Tottenham (7)	4,239	
Islington	✓ 2008	Islington (24)	9,932	Reasonable service, poor governance
		Holloway (8)	306	
Kensington & Chelsea	✓ 2010	Chelsea (8)	3,228	Absence of robust monitoring, poor storage of medication
		Notting Hill (6)	2,487	
		Kensington* (6)	220	
Lambeth	✓ 2009	Brixton (16)	7,077	Variable record keeping, mixed quality
		Kennington (9)	3,766	
		Streatham (6)	2,665	
		Catford (12)	0	
Lewisham		Lewisham (33)	11,687	
Newham		Forest Gate (15)	7,112	
		Plaistow (12)	5,791	
Southwark	✓ 2008	Peckham (18)	7,343	Adequate, service providers lacked
		Walworth (20)	7,512	understanding of Caldicott principles.
Tower Hamlets	✓ 2009	Bethnal Green (19)	7,336	Poor training, supervision or accountability,
		Limehouse (7)	3,260	poor medication
Wandsworth		Battersea (10)	4,024	
		Tooting (5)	187	
		Wandsworth (11)	4,250	
Westminster		Belgravia (16)	5,198	
		West End Central (28)	1,024	
		Charing Cross (45)	12,916	
		Marylebone (9)	81	
		Paddington Green (14)	5,583	
		Harrow Road (14)	124	

Table 2.2: Custody Suites in Inner London Boroughs

**Denotes over flow custody suite Total 150,503 (check figure)*

In London Police Surgeons are contracted at two levels, a Level 1 Police Surgeon has

no formal qualification in forensic medicine, whereas a Level 2 Police Surgeon has a postgraduate qualification. It is possible to identify the number of police surgeons in each level.

Total	Level 1	Level 2	% Level 1	% Level 2
129	77	52	59.6	40.3

Table 2.3: Level 1 and 2 Police Surgeons in London

* Data provided by the Metropolitan Police Service in response to a Freedom of Information request

Given the size of the detainee population, the drive to provide Forensic Medical Services as cost effectively as possible is understandable. The precedent of privatisation of state funded services encouraged police forces to contract out Forensic Medical Services to various companies and individuals. Such contracts serve to cap the costs faced by police forces of providing medical services and may have improved custody safety by an increased provision of the presence of a full time healthcare professional within a custody suite, although analysis of death in custody would not support such a claim. However, analysis of doctors appearing before the Fitness to Practice Panel of the General Medical Council[92] gives cause for concern and may reflect in part this new practice. Although the reasons for the increase are not clear, about 30% of those doctors trained outside the UK and approximately 40% of those Police Surgeons were employed by the private operators. It may well be that a greater appreciation of the detainee's rights effected by the Police and Criminal Evidence Act[93] has identified shortfalls in performance. The greater focus by the police from a value for money perspective and the sense that the Police Surgeon is not "*employed*" by the police may have reduced the reluctance of the police to complain.

[92]Information obtained and supplied by Ms Elizabeth Hiley, General Medical Council following a search of the GMC database of Fitness to Practice minutes.

[93]Police and Criminal Evidence Act 1984

ID	Hearing	Incident	University	Issue	Outcome	Employer
Apta	2010	1995	Utkai	Forensic performance	Conditions	Staffordshire
Barragry	2010	2004	Sheffield	Misuse of drugs	Restriction lifted	
Gallagher	2010	2007	NU Ireland	Forensic performance	Erasure	Durham
Matthews	2010	2004	Sheffield	Forensic performance	Restriction lifted	Derby
Oelofse	2010	2008	Stellenbosch	Forensic performance	Exonerated	G4S
Oshinyemi	2010	2008	Lekarz	Forensic performance	Conditions	Medacs
Parihar	2010	2003	Kanpur	Deception	Suspension	GMP
Upong Dan	2010	2007	Jos	Forensic performance	Suspension	Medacs
Jhetam	2009	2006	Natal	Forensic performance	Conditions	Devon & Cornwall
Omerod	2009	2004	Sheffield	Forensic performance	No censure	Primecare
Kader	2007	2005	Salahadin	Forensic performance	Erasure	Medacs
Anirudhra	2006	2003	Natal	Forensic performance	Suspension	Medacs
Rai	2005	1999	Mysore	Forensic performance	Suspension	Nottinghamshire
Eaton	2004	2001	Nottingham	Forensic performance	Conditions	Leicester
Hora	2004	1998	Lucknow	Forensic performance	No censure	MPS
Lakhera	2003	1992	Nagpur	Forensic performance	Erasure	Kent

Table 2.4: Cases before the General Medical Council

*Data provided by Ms Elizabeth Hiley after searching the GMC database of Fitness to Practice minutes

It is possible that the appraisal process advocated by the Faculty of Forensic and Legal Medicine would have identified concerns about performance if those individuals had been appraised. The challenge to the Faculty is to roll out the appraisal to all Forensic Practitioners wherever they work. One of the difficulties is accessing those Healthcare Professionals who are undertaking many of the roles of the Police Surgeon.

Summary

This chapter has focused on the roles of those working in this area. That of the coroner being the most constant and that of the Forensic Pathologist developing with advances in forensic science and that of the Police Surgeon developing with the formation of modern policing. The functions of the Police Surgeon and in particular the legal basis that underpins Clinical Forensic Medicine will be discussed next.

Chapter 3

Contemporary dilemmas facing the Police Surgeon

Introduction

The Police Surgeon operates at the interface between the law and medicine. Whilst the law governs the duties and regulates the actions of the police towards suspects, offenders, witnesses, victims, and society generally, a Medical Practitioner registered with the General Medical Council is governed by an ethically based code of practice that is subject to the law. The defining feature of the practice of Clinical Forensic Medicine is an appreciation of the interface between the legal basis of the Criminal Justice System and the ethical basis of medicine. This tension pervades the work of all clinical forensic medicine practitioners especially Police Surgeons working in Custody Medicine.

The aim of this Chapter is to discuss those issues that are pertinent to the work of the Police Surgeon and to highlight the tensions between the Police Surgeon's duty to the detainee and the Police Surgeon's duties to society in particular the Criminal Justice System, concentrating on selected issues applicable to consent, custody, assault, road traffic medicine, and evidence presentation.

3.1 Ethics and the Law

The General Medical Council

The General Medical Council was formed by the 1895 Medical Act. Irvine[1] explains how the medical register differentiated the qualified from the unqualified practitioner, fulfilling the main aim of the council. The role of the General Medical Council was to change first with the introduction of the National Health Service when the balance of influence shifted away from a powerful autonomous profession to regulating a profession where available care was rationed on the basis of clinical need and more recently when the standing of the General Medical Council was scrutinised in 1998 following the Professional Conduct Committee's investigation of the failures of paediatric cardiac surgery in Bristol and other issues in the National Health Service. The General Medical Council was at an all time low after Bristol and sank further when Dame Janet Smith raised more concerns during the Shipman Inquiry[2]. The bargain as Irvine[3] calls it, whereby the profession was granted self-regulation on the understanding that the public would be served by good doctors and protected from bad ones had been broken. Self-regulation has not been replaced, mainly because it would be difficult if not impossible for the government to introduce another system. It is evident that measures have to be taken to maintain the public trust in the profession. Consequently, in the early 1990's the General Medical Council of its own volition says Irvine took the steps to *"develop a new, conceptually advanced model of professional regulation for doctors that integrated professionalism, licensure, medical education and clinical governance in the workplace".* Although others might argue out of a sense of self-preservation.

[1]D Irvine, A short history of the General Medical Council, Medical Education (2006), pp. 202-211

[2]Dame Janet Smith, The Shipman Inquiry, HMSO (2005)

[3]D Irvine, A short history of the General Medical Council, Medical Education (2006), pp. 202-211

The legal perspective

Turning to the legal basis, Hockton[4] reviewed the predominantly English case law that defines the law. This case law has largely developed from claims in respect of medical negligence, that has identified a number of principles. Hockton list those principles as, autonomy, consent, capacity, best interests, emergency treatment and public policy. These principles are mirrored in guidance to doctors issued by the General Medical Council, in Good Medical Practice[5], which underpins the notions of *"working with colleagues in the patient's best interest*", and *"respecting the patient's right to confidentiality"* and *"good clinical care*".

Autonomy

Cardozo's judgment still stands[6] although the Society of New York Hospital, which received its Charter from King George III in 1771 and was at the centre of the case has long since merged with Cornell University Medical College.

> *Every person being of adult years and sound mind has a right to determine what shall be done with his own body*[7]

Consent

Consent is predicated on the fundamental principle of autonomy. In Re T[8] Lord Donaldson itemised the required characteristics, being an adult, of sound mind, that the reasons for making the choice are immaterial and unless it is an emergency absence of consent should default to being treated as a refusal. This last criterion has significance for the Police Surgeon because at times the only freedom that a detainee has is that of refusing to give consent, often using basic vernacular English

[4]Andrew Hockton, The Law of Consent to Medical Treatment (Sweet &Maxwell, 2002). pp. 5-16

[5]General Medical Council, Good Medical Practice (1995) p.1

[6]Schloendorff v. Society of New York Hospital [1914] 105 N. E. 92

[7]http://www.med.cornell.edu/archives/history/nyp.html?name1=New+York+Hospital&type1=2Active

[8]Re T [1992] 3 W.L.R 782

to emphasise the point that a medical assessment is not required. The term 'sound mind' nowadays is generally termed capacity. Re F[9], was a case involving an unconscious patient who was incapable of giving consent; it was determined that the patient must be cared for in their best interest.

Capacity

Capacity is a relative concept so that a person required to make a decision about a complex question requires greater capacity than someone making a relatively simple decision[10]. The Mental Capacity Act 2005[11], proposed that capacity be presumed and tested in terms of understanding and retention of information relevant to the decision and the foreseeable consequences of the making or failing to take the decision.

Informed and true consent

In considering the notion of consent, Lord Goff, in Re F, re-stated the conventional legal basis,

> *It is well established that, as a general rule, the performance of a medical operation upon a person without his or her consent is unlawful, as constituting both the crime of battery and the tort of trespass to the person*[12].

The General Medical Council ethical guidance in respect of consent follows this legal principle:

> *You must be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research*[13].

[9]Re F [1990] 2 A.C. 1
[10]Re T [1992] 3 W.L.R 782 at 792
[11]Mental Capacity Act 2005
[12]Re F [1990] 2 A.C. 1 p72
[13]General Medical Council, Good Medical Practice (1995) para. 36 p.20

There is an additional dimension to consent, that is predicated on the approach to offering information to the patient, when the doctor decides what explanation of the nature of the treatment needs to be offered and withholding any information that might be harmful to the patient. The doctor can exercise therapeutic privilege, providing of course, that the information meets the Bolam standard[14] and following the decision in the Bolitho case[15] that decisions taken are logical when scrutinised by the courts. Perhaps of greater significance to the Police Surgeon, is the link between causation and information that was made in Chester v. Afshar[16], which is the basis of the General Medical Council's emphasis on what the patient would want to know including the risks of any procedure as well as the consequences of the lack of treatment, than presenting all available information to the patient. This results in an ethically approved process called informed consent. However, in custody medicine there is also the notion of true consent, where steps need to be taken to ensure consent is obtained without coercion. The right of detainees to self-determination and autonomy is underpinned by Thorpe J[17], a case where prison staff were authorised to accept the decision of adult prisoners of sound mind to refuse all nutrition. In 1990, Lord Goff qualified this right of the individual by stating

> *Of course, as a general rule, physical interference with another person's body is lawful if he consents to it; though in certain limited circumstances the public interest may require that his consent is not capable of rendering the act lawful. There are also specific cases where physical interference without consent may not be unlawful - chastisement of children, lawful arrest, self-defence, the prevention of crime, and so on*[18].

[14]Bolam v. Friern Hospital Management Committee [1957] 1 WLR 583
[15]Bolitho v. City and Hackney Health Authority [1997] 4 All ER 771
[16]Chester v. Afshar [2004] UKHL 41 [2005] 1 A.C. 134 [2004] 3 W.L.R. 927; ;2004] 4 All E.R 587
[17]Secretary of State for the Home Department v. Robb[1955] Fam 127
[18]Re F [1990] 2 A.C. 1 p73

Coercion

In custody the risk that detainees are coerced into giving consent was highlighted in Freeman[19].

The real risk of coercion of detained individuals was documented in the 13th and final report of the Mental Health Act Commission[20], which discussed some of the problems faced by detainees and doctors working in mental health with special focus on the use of Second Opinion Doctors that were introduced in the 1983 Mental Health Act[21]. In the custody setting, coercion to be examined by the Police Surgeon can operate. For example, if the detainee is told that the police will conduct an intimate search for concealed drugs, authorised by Section 55 of Police and Criminal Evidence Act, even if the detainee refuses. The detainee may accept an examination by the Police Surgeon, preferring a clinical examination by a doctor to an intimate search conducted by a police officer. Under such circumstances the assertion that the individual was coerced into a clinical examination is strong.

The influence of custody on the information given to the detainee is most interesting. A detainee who requests legal advice will be told about the benefit of answering "*no comment*" to questions put to them, warning the detainee of the possible consequences of taking this action. The doctor cautions the detainee, that remarks made may not be treated confidentially, but does not say that it is often in the detainee's best interest not to say anything or provide any forensic samples. This is taken further, so Lord Goff, in providing for the prevention of crime as grounds for overriding consent may have had certain sections of the Police and Criminal Evidence Act[22], in mind. At Section 54A a Police Inspector may authorise the search of a detainee to confirm identity, or at Section 55, an intimate search of the detainee, if there is reason to believe that Class A drugs[23] may be concealed either on the body of the detainee, or if the detainee were in possession of Class A drug with criminal

[19]Freeman v. Home Office (No. 2) [1984] Q.B. 524 [1984] 1 All E.R. 1036
[20]Mental Health Act Commission, "13th and final report: Coercion and Consent." (2007-2009).
[21]Mental Health Act 1983 as amended by the Mental Health Act 2007
[22]Police and Criminal Evidence Act 1984
[23]Classified under the Misuse of Drugs Act 1971

intent prior to arrest, or if it is thought that the detainee may have concealed anything on the body that could be used to injure self or others. Section 61 provides for the taking of fingerprints without consent, and Section 63 outlines the grounds when officers may take non-intimate samples. The Protections of Freedom Bill[24], currently before the Houses of Parliament, has not addressed any of these issues. Consequently it is assumed that Parliament is content with the *status quo.*

Sample	Site	Legal provision	With consent
Search		PACE 54A	
Intimate search	Rectum	PACE 55	
Intimate search	Vagina	PACE 55	
Intimate search	Other orifice except mouth	PACE 55	
Fingerprints	Hands	PACE 61	
Non-intimate samples		PACE 63	
Non-intimate samples	Hair (not pubic)	PACE 63	
Non-intimate samples	Nail	PACE 63	
Non-intimate samples	Swab surface of body	PACE 63	
Non-intimate samples	Swab mouth	PACE 63	
Non-intimate samples	Saliva	PACE 63	
Non-intimate samples	Skin impression	PACE 63	
Breath		RTA	✔

Table 3.1: List of samples that can be taken by Police Officers

*Compiled from the Police and Criminal Evidence Act 1984

Obtaining consent from detainees

Obtaining consent from the detainee at the outset of an examination is fundamental to any assessment conducted by the Police Surgeon. Typically the medical practitioner will seek permission and explain the nature of the assessment[25]. There are two important caveats; firstly, that that the detainee is under no obligation to be examined, so satisfying the elements of true consent. Secondly, that the findings of

[24]Protection of Freedoms Bill, 2010-2011, sponsored by Theresa May, Home Secretary, amends some sections of the Police and Criminal Evidence Act 1984 (PACE) but does not propose any alteration in these section of PACE.

[25]Pro forma - Fitness for detention and interview, Faculty Forensic and Legal Medicine: http://fflm.ac.uk/upload/documents/1194536634.pdf

the examination may be disclosed to the police or courts, in statements or in evidence at a later stage, so satisfying the element of informed consent that is required under the ethical responsibilities set out by the General Medical Council[26]

The best interest of detainees

In conventional medical practice, the best interest of the patient does not override consent. For example, a Jehovah's Witness may refuse a blood transfusion, preferring certain death to the compromise of religious principle. The question is, at what point does the Police Surgeon withdraw from an examination? If true consent has not been given, or if the detainee takes action to obstruct any examination? Some drug dealers may routinely internally conceal Class A drugs and may know how much has been concealed, but may not wish to challenge information provided by the police or the Police Surgeon that the concealed drugs may leak and result in death, without that challenge being interpreted as an admission of guilt.

Many detainees are vulnerable. The scale of the prison population with mental disorders was assessed by the Office for National Statistics in 1998[27] and appears to challenge the assumption that detainees are fully cognizant of their predicament. The ONS survey was of psychiatric morbidity among prisoners and it was a comprehensive attempt to provide robust baseline information about the prevalence of psychiatric problems among male and female, remand and sentenced prisoners, the results produced a significant finding,

> *Only one in ten or fewer showed no evidence of any of the five disorders considered in the survey, (personality disorder, psychosis, neurosis, alcohol misuse and drug dependance) and no more than two out of ten in any sample group had only one disorder*[28]

[26] General Medical Council, Good Medical Practice (1995)

[27] Singleton N, Meltzer H, Gatward R (1998) Psychiatric morbidity among prisoners in England and Wales. London: Stationery Office.

[28] *Psychiatric morbidity among prisoners: Summary report: Nicola Singleton Howard Meltzer Rebecca Gatward with Jeremy Coid Derek Deasy. The Stationery Office (1997) p. 23*

Since the overwhelming majority of those held in prisons entered the Criminal Justice System through police custody, detainees in police cells will have a similar degree of psychiatric morbidity. Most should have been assessed by the Police Surgeon and would have been requested to give consent for examination.

This raises the question as to whether persons detained in custody have sufficient capacity to consent to assessment by the Police Surgeon. Clearly some detainees, notably those arrested under Section 136 of the 1983 Mental Health Act[29], may not have capacity whilst other will have impaired capacity. It might be argued that obtaining consent from a detainee with impaired capacity serves more to protect the Medical Practitioner from allegations of assault and battery, than offer the detainee an opportunity to exercise free will. The counter position is that assessment of the detainee is preferable to no assessment and that assessment is in the detainee's best interest. For that position to be valid, it is necessary for the Police Surgeon to be neutral in regard of collecting evidence that might assist the police.

Confidentiality

The transmission of information obtained during an assessment by a Police Surgeon is of concern to some detainees. The General Medical Council guidance in respect of confidentiality is summarised in the following:

> *Patients have a right to expect that information about them will be held in confidence by their doctors. You must treat information about patients as confidential, including after a patient has died. If you are considering disclosing confidential information without a patient's consent, you must follow the guidance in Confidentiality*[30].

One of the duties of a doctor registered with the General Medical Council is to treat patients as individuals and respect their dignity, treat patients politely and considerately and to respect patient's right to confidentiality[31]. The General Medical

[29]Mental Health Act 1983 as amended by the Mental Health Act 2007
[30]General Medical Council, Good Medical Practice (1995) para 37 p. 20
[31]General Medical Council, Good Medical Practice (1995)

Council guidance accepts that doctors must use their judgment, but cautions that decisions and actions may need to be explained and justified. This guidance recognises that whilst confidentiality is an important duty, it is not absolute and that personal information can be shared if it is required by law, if the patient consents or if release of information can be justified in the public interest. This is subject to a number of caveats that include being satisfied that the patient can object and that disclosures are kept to the minimum.

The justification for a confidential medical service is that patients with communicable diseases are encouraged to seek advice and treatment, thereby benefiting society as a whole[32]. However, society can also be protected from the risks of serious harm from communicable disease or crime if confidential information is released. The General Medical Council then encourages the doctor to weigh up the harms to the patient against the benefits to society and the loss of trust between doctor and patient if information is released without the consent of the patient and under such circumstances only to release the relevant information.

The General Medical Council has specifically considered the release of information to police officers and states that the express consent of the patient would be required to do so, unless the doctor is compelled by law or the public interest operates. For example, where a serious crime is being investigated, detected or prosecuted.

The Police Surgeon and the detainee

The peculiar nature of the relationship between Police Surgeon and detainee, where detainees are both patients and suspects or victims, is addressed in the guidance and advice issued by the Ethics Department of the British Medical Association and the Faculty of Forensic and Legal Medicine.

> *Individuals held in custody have the same rights and expectations to medical care as any other patient, which include the right to privacy, dig-*

[32]Irvine D, A short history of the General Medical Council. Medical Education, 40, pp. 202-211.

nity and confidentiality. Nevertheless, the relationship between a forensic physician and his or her patients is rather different from the usual doctor-patient encounters. The forensic physician has dual obligations in that he or she is contracted to the police to provide forensic and therapeutic services but, as a doctor, retains a duty of care to the person being examined or treated. These two roles can come into conflict [33].

The BMA / FFLM advice takes into account the special issues facing the Police Surgeon. For example, under the Human Rights Act 1998[34] detainees like any other individual should be entitled to privacy, but that right should be balanced against any risk or danger to the Police Surgeon, particularly where detainees have a risk of violence. This means that some assessments are carried out with a police officer within a discreet distance, but out of earshot, through to the police officer being present during the assessment[35]. Under the Criminal Procedure and Investigations Act[36] and the associated Codes of Practice, entries in the notebooks of police officers are disclosable. Consequently, a police officer overhearing a conversation between the Police Surgeon and the detainee can make a notebook entry that can then be disclosed. However, the Criminal Procedure and Investigations Act, made clear that reports prepared by Police Surgeons for criminal proceedings must be given to the police but information obtained for therapeutic purposes could remain confidential or privileged. This settled the argument, where on one side it was claimed that Police Surgeons were part of the prosecution team and should disclose all clinical material, and on the other that Police Surgeons were bound by General Medical Council guidance to respect patient's confidentiality totally, unless there was specific justification to release information.

This does not mean the custody officers have access to the detainee's medical record, but elements of the record may be passed to the officer. For example, it is not necessary for custody officers to know the HIV status of the detainee, but it is

[33]Ethics Committee BMA, Health care of detainees in police stations (2009)

[34]Human Rights Act 1998

[35]I*n the case of very violent detainees, for example those suspected of multiple murders, the detainee may be handcuffed to a Police Officer during the medical assessment.*

[36]Criminal Procedure and Investigations Act 1996

necessary for custody officers to know that the detainee is epileptic or diabetic so that measures can be taken to protect their welfare. However, information about the cause of any injury, ailment or condition is not required to be entered on the custody record, even if it appears capable of providing evidence of an offence.

Additionally, the Police Surgeon manages the conflict between providing clinical care for the detainee, against the Police Surgeon's wider duty to society. From an ethical perspective the position is clear, duty to the detainee must take priority. Clever or competent offenders are more successful when it come to avoiding detention in custody. Consequently, it might be argued that many detainees are vulnerable and the Police Surgeon should protect the detainee, but unlike the legal advisor, the Police Surgeon has a duty to society that relates to the collection of evidence for the Criminal Justice System.

The Police Surgeon's role does not extend to offering advice. For instance, a man brought to custody on suspicion of committing a serious sexual assault will be read his rights but may decline the opportunity to have legal advice. The detainee may believe that taking legal advice will be interpreted as evidence of guilt, it is not the role of the Police Surgeon to intervene and advise the detainee to discuss his predicament with a lawyer. The evidence obtained in this scenario can be adduced in the best interest of justice or society.

This notion of best interest is usually applied to the individual, for example, the trustees of a discretionary trust are under a duty to act in the best interest[37] of the beneficiary. Similarly, in family law a guardian has a duty to act in the best interest of the of the child or other person in his care. The Mental Capacity Act 2005[38] demands that those who are faced with the responsibility of acting in a person's best interest do so after carefully assessing any conflicting evidence and then declaring clear and objective reasoning guided by a checklist. In clinical forensic medicine best interest is balanced against public interest. The Information Commissioner's Office has produced guidance in respect of releasing information under the Freedom

[37]http://www.brightllp.co.uk/2011/03/discretionary-will-trusts/
[38]Mental Capacity Act 2005

of Information Act 2000[39], that guidance refers to a test as to whether:

> *something "in the public interest" is simply something which serves the interests of the public. When applying the test, the public authority is simply deciding whether in any particular case it serves the interests of the public better to withhold or to disclose information*[40].

When the Police Surgeon asks an intoxicated young man if he understands the reasons for his detention and the detainee replies *"I think it is something to do with break-ins,"* there are concerns about the detainee's fitness for interview, but the Police Surgeon is also presented with an extra responsibility of balancing the interests of the detainee against the public interest.

3.2 Felony and Misdemeanour

Historically, offences were classified as a felony or a misdemeanour. This distinction was removed when the property of a convicted felon could no longer be confiscated, but the judicial process based on the felony or misdemeanour distinction still operates and explains why some individuals appear in the Magistrates Court and others are indicted to appear at the Quarter Sessions or Assizes.

[39]Freedom of Information Act 2000

[40]Information Commissioner's Office.Freedom of Information Act Awareness Guidance No 3. http://www.ico.gov.uk/freedom_of_information/awareness_guidance_3_ public_interest_test.pdf. p2

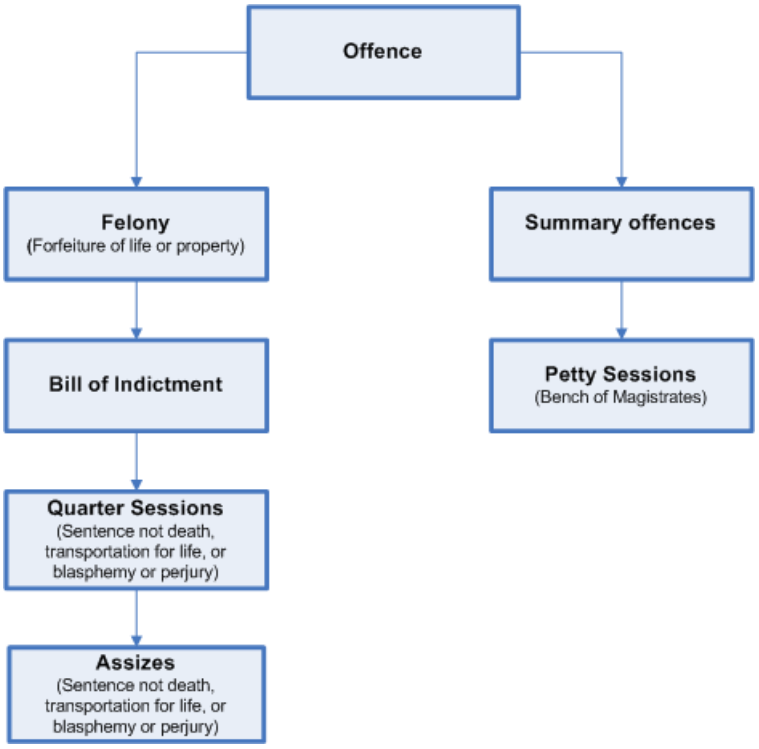

Figure 3.2.1: Indictable offences

Whatever route is taken, it must be established that the individual is criminally liable. Criminal liability requires two notions to be present, those of intention and action. This is encapsulated in the maxim, *actus non facit reum, nisi sit mens rea,* the act itself does not constitute guilt, unless done with a guilty intent. The general principle, *"The intent and the act must both concur to constitute the crime"* are well established in case law. R v. Prince[41] and R v. Tolson[42] being the authorities most commonly cited.

The *actus reum,* the action is usually an act of commission but could also be a failure of commission. For example, a failure to provide specimen under the Road Traffic Law or it could be a condition such as being found drunk in a public place contrary to the Licensing Act of 1872[43], perhaps better considered as a failure to remain sober.

The *mens rea* is the state of mind of the individual and involves the concept of intention so that the individual must have understood the consequences of the action

[41]R v. Prince L.J M.C 122
[42]R v.Tolson 58 L.J M.C 97
[43]Licensing Act 1872

undertaken. The action does not have to be successful. For example, if the accused has discharged a firearm in an attempt to kill another person, it is not necessary for that person to be injured.

One of the main purposes of the police interview is to establish what happened, the *actus reum,* and to determine the intentions of the accused and person, the *mens rea* either by the statements made by the accused or by the conduct of the accused.

The 1967 Criminal Justice Act[44] placed the responsibility of deciding whether the accused either intended or foresaw the probable outcome of his actions on the jury. A person who acts recklessly is deemed to have *mens rea* and consequently criminal liability. There are some offences which carry strict criminal liability. For example, sexual intercourse with a girl under the age of 13 which is Rape under Section 5 of the 2003 Sexual Offences Act[45] or driving a motor vehicle on a public road with a level of alcohol in excess of the prescribed limit when *mens rea* need not be determined by a jury[46].

With the exception of a child under the age of 10, *mens rea* is presumed. Every man is presumed to be sane and to be relieved of the *mens rea,* needs to prove that he is not. This was summarised by Lord Chief Justice Tindal in the M'naghten's Case[47] which led to the formulation of the M'naghten rules that could be used by juries to test a defendant's plea of insanity. There was some scepticism about the formulation of rules with LJ Maule pointing out that the production of rules were an answer to a hypothetical rather than an opinion about the current case. However, of interest to the expert witness was the recognition by Maule of the role of what would become the expert witness. The most pertinent rule that may affect the Police Surgeon is the following:

> *. . . to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused*

[44]Criminal Justice Act 1967

[45]Sexual Offences Act 2003

[46]A failure on the part of magistrates to recognise that strict liability was operating led to a successful appeal by the Director of Public Prosecutions in DPP v. H.

[47]Daniel M'naghten's Case 8 E.R. 718 1843 HL

was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong[48].

The Police Surgeon is most likely to be the first medical practitioner to assess an individual after the crime was committed. Observations about a person's state of mind often shortly after the *actus reus* could be highly significant but adds a dimension to the arguments about the protection of vulnerable persons in custody.

The Police Surgeon's examination may give rise to evidence that affects claims of loss of *mens rea,* the examination may reveal a case for automatism[49]. Although in R. v Katie Gutierrez-Perez[50], a death by dangerous driving case, the defence was unsuccessful because intoxication is considered to be voluntary. Similarly impairment of the accused's ability to differentiate between right and wrong because of the influence of drink or drugs is not excused. There are two exceptions, firstly when the individual takes medication in accordance with medical advice and when the individual is not aware of becoming violent.

Coercion raises similar arguments when Police Surgeons are called to assess persons who internally conceal drugs, and then claim a defence of coercion to traffic drugs. However, in order to succeed the defendant must satisfy the reasonable person test. That is whether an ordinary, sober person, of reasonable firmness sharing the accused characteristics would have responded to threats to the physical well-being of another person or persons to them as the accused did. Mere threats to psychological health or consisting of damage to property is not sufficient. The ordinary person test does not take account of the pliable, vulnerable or suggestive characteristics present in many drug carriers. However married women acting up under the coercion of her husband fare better and can use this defence against all charges save treason and murder.

[48]Archbold Criminal Pleading Evidence and Practice Ed J Richardson Sweet & Maxwell (2012) para.17-30

[49]*A condition that is frequently claimed by epileptics in a post-fit state or diabetics with treatment induced low blood sugar and persons under the influence of drink or drugs.*

[50]R v. Katie Gutierrez-Perez, [2010] 2 Cr. App. R. (S.) 36

It is however, the Police and Criminal Evidence Act 1984 that governs the operation of arrest detention and bail. Persons arrested by a police officer are presented to the custody sergeant who adjudicates on the validity of the arrest and detention. The Custody Sergeant will also arrange bail, if indicated, after questioning has been completed. The Custody Sergeant should be and usually is an experienced police officer whose main responsibilities are the welfare of the detainee and ensuring that there is full compliance with the legal process surrounding arrest and detention. The Custody Sergeant's responsibility for the detainee's welfare during custody does not terminate with release of the detainee from custody. Consequently in cases of death within 48 hours of release from custody, the police force concerned will refer the incident to the Independent Police Complaints Commission for investigation as a death following contact with police.

The authority of the Custody Officer is sovereign so that the Custody Sergeant can elect to follow or reject the advice offered by the Police Surgeon or any other doctor. However, if the Custody Sergeant rejected the advice of the Police Surgeon and an untoward incident occurred, the Custody Sergeant would be exposed to adverse criticism and disciplinary procedures. Consequently, it would be a very brave or very foolish Custody Sergeant who did not accept the advice of the Police Surgeon. In practice the Police Surgeon and the Custody Sergeant "share" responsibility for the welfare of the detainee.

3.3 Custody Medicine

Police Surgeons working in custody units practice custody medicine. They provide assessments of fitness for detention, fitness for interview and record injuries and collect evidence from suspects. Police Surgeons or Forensic Medical Examiners may work in Sexual Assault Referral Centres collecting evidence from complainants of sexual assault and the Police Surgeon can be called to the scene of death.

Police surgeons are required to provide statements for the police and courts and to

provide advice to officers conducting inquiries and officer training generally.

The Faculty of Forensic and Legal Medicine has lobbied for Forensic Medicine to be recognised as a clinical specialty, so far unsuccessfully. This claim that the work of the Police Surgeon should be regarded as a specialty is somewhat undermined when Healthcare Professionals can undertake many of the roles of Police Surgeons.

Most of the work of the Police Surgeon consists of performing assessments.

Assessment	Legal basis	Finding / opinion	Individual
FTD: General	PACE 1984, Code C	Finding	Healthcare professional
FTD: Asthma	PACE 1984, Code C		Healthcare professional
FTD: Diabetes	PACE 1984, Code C		Healthcare professional
FTD: Epilepsy	PACE 1984, Code C		Healthcare professional
FTD: Alcohol	PACE 1984, Code C		Healthcare professional
FTI		Opinion	Registered Medical Practitioner
Medication		Procedure	Healthcare professional
Pre-release		Opinion	Registered Medical Practitioner
Injury	Offences against Person Act 1861	Opinion	Registered Medical Practitioner
Actual bodily harm	Offences against Person Act 1861	Opinion	Registered Medical Practitioner
Grevious bodily harm	Offences against Person Act 1861	Opinion	Registered Medical Practitioner
Sexual Assault	Sexual Offences Act 2003	Procedure	Healthcare professional
Impairment: alcohol	Road Traffic Act 1956	Opinion	Registered Medical Practitioner
Impairment: drugs	Road Traffic Act 1956	Opinion	Registered Medical Practitioner
Blood option	Road Traffic Act 1956	Procedure	Healthcare professional
Hospital Procedure	Road Traffic Act 1956	Procedure	Healthcare professional
Pronouncing death		Procedure	Healthcare professional
Examination of Locus		Opinion	Registered Medical Practitioner
Training staff		Procedure	Healthcare professional
Input to investigation		Procedure	Healthcare professional
Professional statement		Evidence of fact	Healthcare professional
Expert statement		Opinion	Registered Medical Practitioner

Table 3.2: Assessments undertaken by Police Surgeons

Fitness for detention

The notion of fitness for detention is central to managing the risk of death in custody. The criteria for death in or following police custody includes deaths of people who

have been arrested or otherwise detained by the police. It includes deaths which occur whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle. This would include death where injuries were sustained in custody, medical problems identified in custody and deaths in persons detained under Section 136 of the Mental Health Act[51].

Code C, of the Codes of Practice attached to the Police and Criminal Evidence Act 1984 identifies Asthma, Diabetes, Epilepsy and Intoxication by Alcohol as specific medical conditions that merit assessment by the healthcare professional. Statistics produced by the Independent Police Commission from reports submitted by police forces, whilst showing a decline in deaths, do not support the emphasis that is placed on those specific conditions in Code C[52]. The reasons for this dramatic decline in such deaths are not clear.

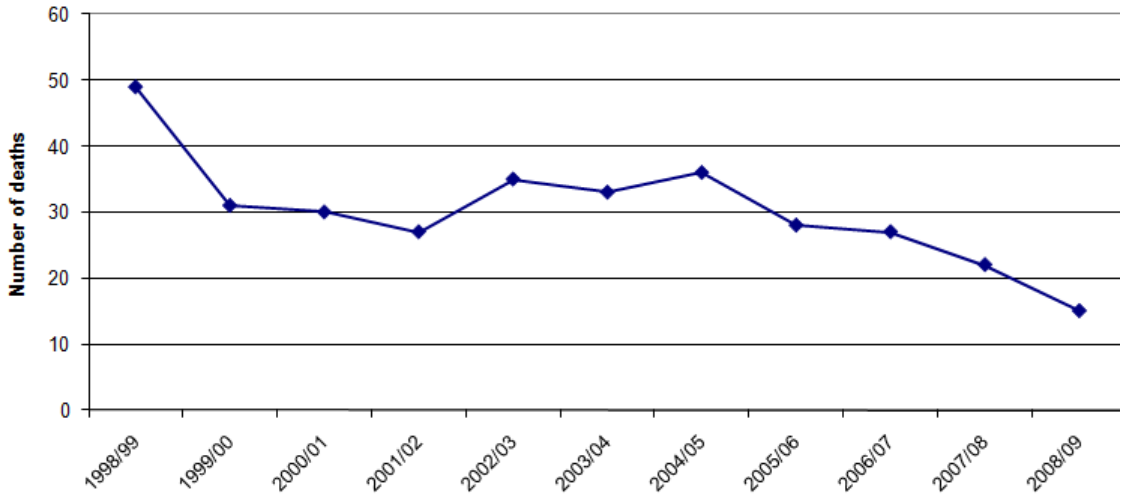

Figure 3.3.1: Decline in deaths in custody

*Deaths in or following police custody: An examination of the cases 1998-2008/09. Independent Police Complaints Commission 2010

The police might say that it is a result of improved training and recognition of the problems associated with restraint, the presence of CCTV or that the presence of healthcare professionals in custody suites are significant factors. Leigh[53] notes

[51]Mental Health Act 1983 as amended by the Mental Health Act 2007

[52]IPCC, Deaths during or following police contact:, Independent Police Complaints Commission (2010)

[53]Adrian Leigh, Deaths in Police Custody - Learning the Lessons, rds.homeoffice.gov.uk/rds/prgpdfs/fprs26.pdf (1998) pp. 64-74

a recurring theme when death in custody was analysed. The interpretation by Police Surgeons as well as other healthcare professionals that head injury was just drunkenness, even when the detainee was so insensible that carriage to the cell was necessary. This has given rise to the walk and talk test, simply a detainee who cannot talk coherently and cannot walk to the cell should not be detained.

	2004/05		2005/06		2006/07		2007/08		2008/09		2009/10	
	N	%	N	%	N	%	N	%	N	%	N	%
Apparent suicide attempt in cell / transit to police station	2	6	1	4	2	7	0	-	2	13	0	-
Died in police station / van /on arrest (non suicide)	7	19	5	18	2	7	2	9	1	7	2	12
Concern raised or taken ill in police station / van / on arrest, dies in hospital	26	72	22	79	22	81	20	91	12	80	14	82
Death following release non suicide	1	3	0	-	1	4	0	-	0	-	1	6
Total fatalities	36	100	28	100	27	100	22	100	15	100	17	100

Table 3.3: Deaths in or following police custody 2004/05 to 2009/10

*Deaths in or following police custody: An examination of the cases 1998-2008/09. Independent Police Complaints Commission 2010

When the decline in death is tabulated there is a suggestion that the fall has levelled out. Analysis of deaths during or following police contact shows encouragingly, for those working in custody, that the greatest and most consistent fall appears to be in the category of death in custody.

	Fatalities					
Category	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Road Traffic fatalities	44	48	36	24	40	29
Fatal shootings	3	5	1	5	3	2
Death in or following custody	36	28	27	22	15	17
Other deaths following police contact	24	40	22	30	35	38
Total fatalities	107	121	86	81	93	86

Table 3.4: Deaths during or following contact with police 2004/05 to 2009/10

*Deaths in or following police custody: An examination of the cases 1998-2008/09. Independent Police Complaints Commission 2010

Of the seventeen people who died in or following police custody in 2009/2010, sixteen

were male and one was female. Sixteen were white and one person was identified as being of mixed ethnicity. The average age of those who died was 47 years, with the youngest person reported to be 19 years old and the oldest to be 73 years old.

When the place of death was analysed, two people fell ill while at a police station and this is where they were also pronounced dead. One died of injuries they sustained in a Road Traffic Collision they had been in shortly before their arrest and the other died of alcohol and drug toxicity. Fourteen people were declared dead at a hospital, five of them within an hour of their arrival. Twelve of the fourteen people who died at hospital fell ill or were identified as being unwell while at the police station or in a police vehicle. The other two individuals fell ill during arrest; one occurred in a public place and the other in a mental health hospital. One person died at their home after being released from custody (this individual was suspected of swallowing drug packages during their arrest, one of which later split and caused a drugs overdose).

Given the decline of deaths in custody and analysis of the cause of death for the most recent data, it is possible to reach a conclusion that death in custody may not be entirely preventable.

Cause of death	Deaths in or following police custody
Injuries	4
Natural causes and alcohol and/or drug related	4
Natural causes	3
Overdose accidental - drugs	2
Alcohol and/or drugs	1
Head injury and natural causes	1
Alcohol and/or drugs while restrained*	1
Awaited	1
Total fatalities	17

* Not possible to determine whether the restraint was a direct causal link to the death

Table 3.5: Deaths in or following police custody by cause of death 2009/10

*Deaths in or following police custody: An examination of the cases 1998-2008/09. Independent Police Complaints Commission 2010

The reasons for those persons coming into custody were varied, the most common

being arrest for driving offences such as drink driving (five people). This was followed by offences linked to violence such as public order offences (four people). Four people were identified as having mental health issues. Of these, two had been detained under Section 136 of the Mental Health Act 1983[54]. All of the deceased had a link to alcohol or drugs in that they had recently consumed, were intoxicated from or were in possession of drugs or alcohol at the time of their arrest. In eight of these cases alcohol or drugs were related to the cause of death. Of these, two people died from a drug overdose due to the rupture of wrapped drug packages in their bowel, three deaths were linked to long-term alcohol abuse and subsequent natural causes, such as chronic cirrhosis, fatty liver and heart attack; one death was a combination of chronic alcoholism, mixed drug intoxication and inhalation of vomit while struggling against restraint.

The Police Surgeon should use a fitness to detain assessment to divert persons from custody to hospital. The police generally might find such an action inconvenient and expensive in terms of resources required to guard the detainee when in hospital. However, the effect on Custody Officers[55] who have to undergo debriefing following a death in custody and the cost to the police of the IPCC investigation would more than compensate for a cautious approach taken by the Police Surgeon.

Mental Health Assessments

Many of the persons passing through custody suites suffer from mental health problems. Some will display a florid presentation of acute mental illness, others will demonstrate the lesser symptoms resulting from personality disorder or learning difficulties. Whether it is their illness or social and educational disadvantage, members of this sub-population have lifestyles that result in contact with the Criminal Justice System. Some will be unwell and in need of urgent psychiatric assessment and others will be temporarily unable to function in society by reason of the influence of drink or drugs. All are vulnerable persons.

[54]Mental Health Act 1983 as amended by the Mental Health Act 2007

[55]http://ftvdb.bfi.org.uk/sift/title/797528 *A training video for police officers on preventing deaths in custody. Features five scenarios highlighting various learning points, including advice from medical experts who identify key warning signs. Includes sections on restraint deaths.*

In 1992, Robertson[56] found that 30.5% of calls to examine persons in custody were concerned with drunkenness, drugs, mental illness or handicap. Davison's study[57] focused more on workload than reason for call-out, making comparison difficult. Even across the 5 year time scale of his practice and his study, it still produced figures of 26% for 1993 and 39% for 1988 of persons who might be under the influence of drink or drugs or have mental health problems.

Fitness for interview

Suspects are detained to obtain evidence by questioning. In the past such questioning produced a number of miscarriages of justice made usually by vulnerable persons. Gudjonsson[58] documents some of the more notorious cases but it might be presumed that there are convictions for lesser charges that are also based on confession, but because the crime is less serious and sentences lighter there is less public support to redress such miscarriages.

Name	Date	Served	Crime
Andrew Evans	1972	25	Murder
Stephen Downing	1973	27	Murder
Stefan Kiszko	1976	16	Rape & Murder
John Joseph Boyle	1977	12	Possession firearms, membership IRA
Paul Blackburn	1978	25	Attempted murder
Peter Fell	1984	19	Murder
Sean Hodgson	1982	27	Murder

Table 3.6: Examples of unreliable confessions

Gudjonsson has focused on exploring the psychological processes associated with confession. This material is presented to Police Surgeons undergoing training and has been used by Norfolk[59] [60] [61] [62] to examine vulnerable detainees in custody.

[56]G Robertson, The Role of Police Surgeons, Study 6, Royal Commission on Criminal Justice (1992)

[57]CP Davison, A workload survey of police surgeons in Darlington, UK, Journal of Clinical Forensic Medicine (2000), pp. 10-18

[58]Gisli Gudjonsson, Unreliable confessions and miscarriages of justice in Britain, International Journal of Police Science and Management (2002), pp. 332-343

[59]G. A. Norfolk, "Physiological illnesses and their potential for influencing testimony.", Med Sci Law 39, 2 (1999), pp. 105-112.

[60]G. A. Norfolk, "Defining fitness for interview.", J Clin Forensic Med 7, 2 (2000), p. 109.

[61]G. A. Norfolk, "Physiological illnesses and their potential for influencing testimony.", Med Sci Law 39, 2 (1999), pp. 105-112.

[62]G. Norfolk, "Fit to be interviewed by the police–an aid to assessment.", Med Sci Law 41, 1 (2001), pp. 5-12.

Confession	Description
Voluntary	*Individuals go to the police and confess to a crime that they have read about, unable to distinguish between fact or fiction, notoriety ,guilt, personality disorder*
Accommodating compliant	*Suspects confess because they want to please the officers Unable to contradict any assertion made by the police*
Coerced compliant	Suspects know they didn't commit the act, but give way under questioning, Think that by confessing they will be allowed home
Coerced internalised	Suspects gradually come to the conclusion that they must have committed the act. No memory e.g. intoxicated. Memory is changed by subtle interrogation techniques

Table 3.7: Types of confession

*After Gudjonsson

There is another facet to fitness for interview that appears to have received less attention during Police Surgeon training and this involves the interview itself. The introduction of the Police and Criminal Evidence Act 1984, was driven in part to address the issue of the type and quality of interview. The importance to the Criminal Justice System of interview cannot be over emphasised. According to Wolchover and Heaton Armstrong, the interview is :

> *the bedrock of adversarial process is the evidence of witnesses for the prosecution not the confession of the accused*[63].

The accused is detained for the purpose of obtaining evidence by questioning. Witnesses are also interviewed to obtain evidence by questioning and although they

[63]D Wolchever and A Heaton-Armstrong, Tape recording witness statements, New Law Journal (1997), pp. 855-857

attend the police station on a voluntary basis there are circumstance when their fitness for interview should be formally assessed. PACE introduced some protection for the accused person detained for the purpose of obtaining evidence by questioning, in the form of an Appropriate Adult[64]. The police interview should be based on sound psychological principles. The PEACE,[65] interview was developed from Association of Chief Police Officers sponsored training courses in the 1990's into investigative interviewing. Investigative interviewing replaced interrogation where the focus of the interview was to obtain a confession with a process that was designed to obtain a version of the truth and was adopted as the National Investigative Interviewing Strategy in 2009[66]. The PEACE method[67] is a process of interviewing that if used effectively could provide an explanation of events rather than just identification or the confession of an individual.

Despite such laudable aims many witnesses are not interviewed in the full spirit of PEACE, police officers ask questions from which a statement is produced. This rearrangement of what the interviewee said becomes the interviewer's representation of events which is not necessarily the interviewee's perception[68]. It takes a degree of confidence with good language skills and a degree of intellect to challenge a statement that has been produced in this way, both on the part of the detainee and also on the part of any other person such as an Appropriate Adult. The persistence of the use of a closed question style of interview by police officers may reflect time constraints and the inability of the interviewee to cooperate with the open ended nature of questions posed during application of the PEACE process. Although, suspects and witnesses involved in more serious crimes are more likely to be processed using a properly implemented PEACE approach[69]. The continued use of statements produced from questions and answers remains a serious threat to justice.

[64] *Defined under the Police and Criminal Evidence Act 1984, someone who is completely independent of the police and who is present with a vulnerable person during a police interview*

[65] *Planning & Preparation, Engage and Explain, Account, Closure and Evaluate*

[66] National Investigative Interviewing Strategy, National Policing Improvement Agency 2009

[67] A practical guide to investigative interviewing, National Crime Faculty and National Police Training Payne, DG (1987).

[68] R Milne & R Bull, Investigative interviewing: Psychology and practice., Chichester: John Wiley & Sons (1995)

[69] Kebbell M, Milne R, Wagstaff C, The cognitive interview: A survey of its effectiveness., Psychology, Crime and Law (1999), pp. 127-138

Many Police Surgeons are recruited from General Medical Practice. General Medical Practitioners conduct a large number of *"interviews"* in medical practice. It is this experience that can make a General Practitioner adept at identifying individuals who would be particularly susceptible to the interview process. The Police and Criminal Evidence Act provides legal advice for those who are under the age of 17 or mentally vulnerable, an Appropriate Adult must be present during searching and questioning to make sure they understand what they are being told[70]. Once the statement has been constructed by the interviewer and signed by the suspect or witness, the next opportunity to challenge this piece of evidence is in court at a time when the signed statement has developed a status that is difficult to impune.

Appropriate Adults are widely used and are often deemed necessary for all interactions between detainee and the police and sometimes between the detainee and the Police Surgeon. This is not so in Francis v. DPP[71], an appeal where, it was claimed that a sample of breath should not be provided unless an Appropriate Adult was present, was dismissed. Francis had been detained under Section 136 of the Mental Health 1983 Act[72] . It was ruled that providing a sample of breath is a procedure and not an interview and so an Appropriate Adult under Code C, Annex E Section 66 Police and Criminal Evidence Act, was not required.

[70]http://www.homeoffice.gov.uk/police/powers/custody/
[71]Francis v. DPP [1997] RTR 113, 29 April 1996, QBD (DC)
[72]Mental Health Act 1983 as amended by the Mental Health Act 2007

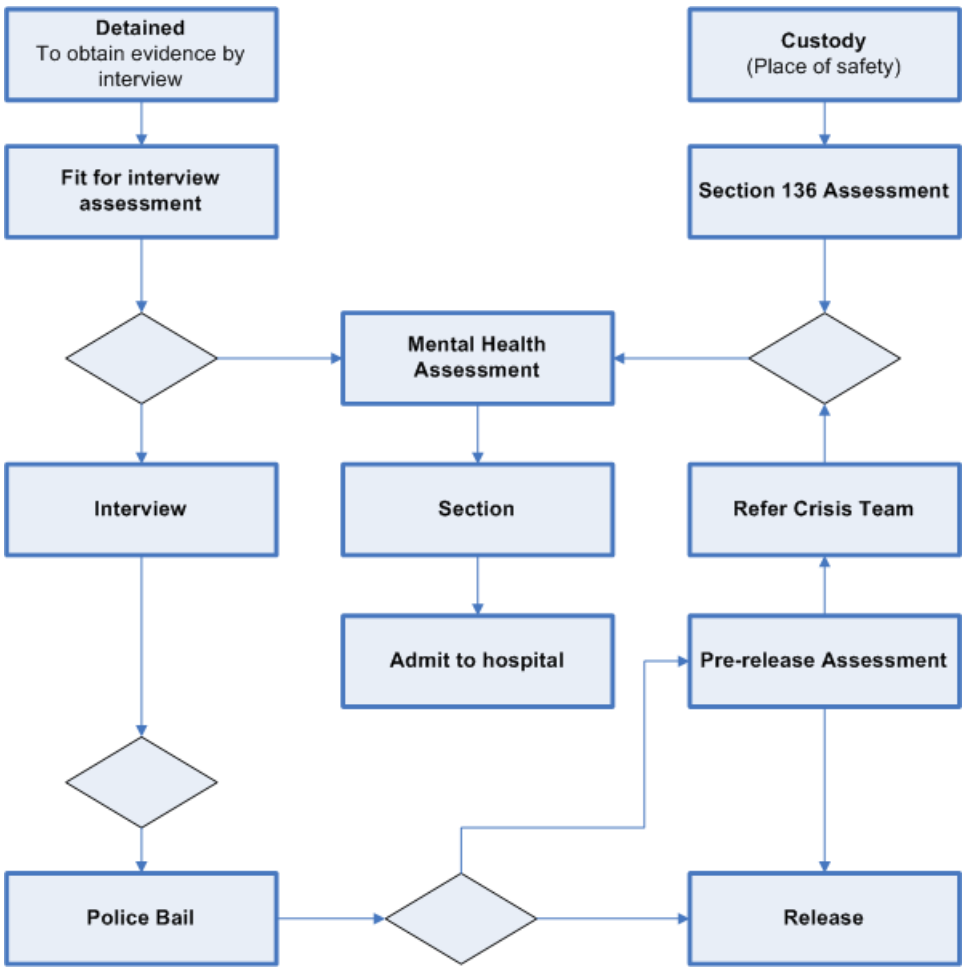

Figure 3.3.2: Mental Health Assessment flow chart

Police Surgeons are asked to opine about a detainees fitness for interview and on occasion about the fitness for interview of a police witness. Norfolk[73] has drawn attention to two issues. Firstly those persons whose condition may be worsened by police interview and those persons who are vulnerable to coercion to falsely confess. Gudjonsson[74] argues that the impact of psychological research and expert testimony on law and procedure, police practice and legal judgments in England is unparalleled anywhere else in the world. The Norfolk - Gudjonsson view represents only one aspect of fitness for interview which might be better considered as a form of Mental Health Assessment.

[73]G. A. Norfolk, "'Fitness to be interviewed'- a proposed definition and scheme of examination.", Med Sci Law 37, 3 (1997), pp. 228-234.

[74]Gisli Gudjonsson, Unreliable confessions and miscarriages of justice in Britain, International Journal of Police Science and Management (2002), pp. 332-343

Pre-release assessment

Fitness to release or post interview assessments are being used more frequently because persons questioned about certain matters, usually child sexual offences are at greater risk of self harm after release from custody than persons questioned about other offences. This issue is not restricted to sexual offences. Following the inquest of a police officer found hanging after release from questioning and interview about professional misconduct, the coroner wrote

> *Where it is brought to the attention of the custody officer by any person that a detained person is or may be at high risk of suicide or self harm the custody officer must call the relevant emergency mental health team for a full mental health assessment to be undertaken, even if a forensic medical examiner has purported to carry out such an examination*[75].

Clearly, the coroner had reservations about the effectiveness of the Police Surgeon in this case.

If, at a fitness for interview assessment the detainee declares an intention to self harm, and if the crisis intervention team is called, the detainee is transferred to psychiatric care either voluntarily or compulsorily under the relevant Section of the 1983 Mental Health Act[76], the inevitable postponement of the interview may not be helpful. Whilst in psychiatric care, the individual would not know the extent of the case against him and that alone might inhibit his response to treatment. Better for the detainee to have legal advice and if necessary support at interview with an Appropriate Adult within the meaning of the Police and Criminal Evidence Act 1984[77].

[75] *Unpublished data, from M Barrett's records. Andrew Walker, HM Coroner for Northern District of Greater London applied rule 43 of The Coroners Rules 1984, and reported to Commander Stuart Osborne of the Directorate of Professional Standards concerns about a Police Surgeon. The coroner issued this letter because during the inquest it was found that the deceased had disclosed to the police doctor his feelings of self harm and an attempt to hang himself the day before he answered bail to re-attend the police station for further interview. The verdict of the jury and perhaps the reason for the rule 43 letter was the issue of the quality of the assessments performed by the Police Surgeons involved in the case. However, the coroner did not appear to consider the problem facing the doctor.*

[76] Mental Health Act 1983 as amended by the Mental Health Act 2007

[77] Police and Criminal Evidence Act 1984

The difficulty with an approach of allowing interview with safeguard is, if at the end of the process the police are unable or unwilling to charge the detainee, they must be released according to the terms of the Bail Act[78]. The duties of the custody sergeant after charge are clearly outlined at Section 38 of the Police & Criminal Evidence Act and Section 25 of the Criminal Justice and Public Order Act 1994, both of which link to the 1976 Bail Act. Those duties are that the detainee is released either on bail or without bail unless:

> *the custody officer has reasonable grounds for believing that the detention of the person arrested is necessary for his own protection*[79].

The basic right of the individual not to be detained without charge is protected by the Bail Act. It does not protect a vulnerable person from self harming when released from custody. It can be used to protect the detainee from other persons but it does not seem to be used to protect the person from self harm.

Section 136 Assessments and place of safety

Place of Safety assessments take place when persons are brought to custody by a police officer for a mental health assessment under Section 136 of the Mental Health Act[80]. The criteria for removal by a police officer is that the person must appear to be suffering from a mental disorder, be in a public place and that their removal is either in the interests of the person or for the protection of others. The period of detention cannot exceed 72 hours, allowing time for the detainee to be examined by a Registered Medical Practitioner and an approved social worker for the purpose of arranging treatment or care. The process is not dependent on the person committing an offence and is usually implemented when the person's abnormal behaviour is causing a nuisance or offence. The Mental Health Act Commission[81] cautions that Section 136 is not an admission order that should be used to supplant other sections of the MHA. The Code of Practice to the Mental Health Act 1983states that:

[78]Bail Act 1976

[79]Police and Criminal Evidence Act 1984, s38(1)(a)(vi)

[80]Mental Health Act 1983 as amended by the Mental Health Act 2007

[81]Mental Health Act Commission, Second Biennial Report, Mental Health Act Commission (1987)

> *Health Authorities, Trusts and local Social Services should co-operate in ensuring regular meetings take place between professional involved in mental health assessments..... Professionals should also keep in mind the interface with the criminal justice agencies, including probation service and the police*[82] .

Police Surgeons are recognised as a special group by organisations such as the Royal College of Psychiatrists[83] so that training for doctors approved under Section 12[84] is available.

Once at the police station the detainee is subject to the Police and Criminal Evidence Act, in particular Section 56, - the right to have another person told of the detention, Section 58, - the right to consult privately with a solicitor and Code C of the Codes of Practice that requires the police to arrange for an Appropriate Adult to attend. The role of the Appropriate Adult is usually to protect the interests of the detained person. That may not be absolutely necessary if detention is purely for the purposes of assessment, but would be required if the detained person is also going to be involved in a procedure under the criminal law[85]. Many custody units have resident Healthcare Professionals who might initially triage Section 136 cases. If the outcome of triage is that the person is then placed before a Registered Medical Practitioner for a formal assessment, all is well, but if the outcome of the triage is that the person can be released without further assessment then in effect the Healthcare Professional has conducted a Section 136 assessment without being qualified to do so. Leading to some tension with the recommended practice expressed in the Codes of Practice to the Mental Health Act:

> *It is imperative a mentally disordered or otherwise mentally vulnerable person detained under the Mental Health Act 1983, s136, be assessed as soon as possible*[86].

[82]Codes of Practice: Mental Health Act 1983 (Revised 2008) Department if Health (2008) p.80
[83]www.rcpsych.ac.uk/pdf/CETC_Sec12%20Induction%20Notts.pdf
[84]Mental Health Act 1983, s12
[85]Richard Jones, Mental Health Act Manual, Thomson (2004) 1-1228 p. 482
[86]Codes of Practice: Mental Health Act 1983 (Revised 2008) Department if Health (2008) para 3.16

The reason for this tension is that the mental state of the detainee may be influenced by drink or drugs. Consequently, there is a good case for the Police Surgeon to make an initial assessment with a view to calling in a second doctor and approved social worker, either immediately or after a period of time when the detainee can regain sobriety and when further assessment by the Police Surgeon may determine that formal assessment is unnecessary.

Surprisingly, viewed from a practical perspective there is no power to transfer a person from one place of safety to another. It is strange to think of a police station as a place of safety to assess mentally disordered persons. Of course, some mentally disordered person's behaviour may be so dis-inhibited that assessment can only be made at a place of detention where the person can be managed securely. Perhaps this is what the commission had in mind when writing:

> *legality of the common practice of taking prospective patients to a police station en route to hospital needs clarification, but it may be unavoidable....*[87]

There is no requirement that Police Surgeons are Section 12 approved although given the frequency and limited knowledge of the individual such recognition is desirable because Section 12 comments on the qualities of the Medical Practitioners making recommendations:

> *Of the medical recommendations given for the purpose of any such application, one shall be given by a practitioner approved by the Secretary of State as having special experience in the diagnosis of treatment of mental disorder; and unless that practitioner has previous acquaintance with the patient, the other such recommendation shall if practically possible, be given by a registered medical practitioner who has such previous acquaintance*[88].

[87]Mental Health Act Commission, Fifth Biennial Report, 1991-1993. Para10(7)(c)
[88]Mental Health Act 1983, s12(2)} As amended by the Mental Health Act 2007

Police Surgeons frequently play a role in compulsory admission of individuals to hospital. Sir Thomas Bingham in Re S-C opined that:

> *No adult citizen of the United Kingdom is liable to be confined against his will, save by the authority of the confinement of an individual in any institution against his will*[89].

and traced this principle back to Magna Carta.

The outcome of a Section 136 assessment is usually that a doctor and a social worker approved under the Mental Health Act are called to the police station so that an assessment can be undertaken with a view to applying Section 2 of the Mental Health Act, which is an assessment order that lasts for 28 days. The person can remain in hospital for a period of no longer than 28 days either as a voluntary patient or under Section 3 of the Mental Health Act because a Section 2 order cannot be renewed. Tucker J in Wilson[90] decided that the purpose of Section 2 was to ascertain if application of Section 3 would be appropriate. Section 3 is a treatment order and should be used for those well known to Mental Health Services. It is sometimes used in preference to Section 2 because practitioners are under the impression that treatment cannot be given under Section 2. The legal preference is that the mentally ill should be admitted to hospital voluntarily. Whilst this notion appears noble some mentally ill patients will accept the offer of voluntary admission when assessed, only to self discharge when confronted with treatment programs on admission to hospital. Section 3 must be used if the period of treatment is likely to take longer than 28 days. Dixon[91] found that the level of agreement between doctors conducting mental health assessments varied. 67% thought that persons were detained for both protection of others and in the interests of their own health or safety, 32% that they were detained for their own protection 1% solely for the protection of others.

[89]Re S-C (Mental patient: Habeas Corpus) [1966] All ER 532

[90]R v. Wilson Ex Parte Williamson [1996] C.O.D 42

[91]M. Dixon and F. Oyebode and C. Brannigan, Formal justifications for compulsory psychiatric detention., Med Sci Law (2000), pp. 319-326

3.4 Assault

This area of practice is governed by the 1861 Offences Against the Person Act[92]. Despite the 1861 Act having stood the test of time for 150 years, there is pressure to bring this piece of legislation into the 21st Century. The reasons appear to be the antique and obscure language used in the act, in particular the meaning of words such as malicious. Lord Ackner described the act as *"piece-meal legislation"* [93]. The Law Commission produced a consultation paper, LCCP122[94]. In 1993 the Law Commission looking at a Draft Code and related draft Bill[95] produced a report that set out to produce a series of Bills that would reform the criminal law.

In support of reform, the Law Commission has invoked the "*rule of law*" principle to re-organise the Act. John Gardner[96] cites the "*antiquated and illogical structure*" and the labels it *"a disgrace"*. The Law Commission's reform package (LCCP 122) led Gardner to conclude that it is Sections 18, 20 and 47 of the Offences Against the Person Act that cause most of the problems. The lack of a hierarchy of offences in terms of seriousness of the nature of the injury and problems assessing the degree of intent being the main drivers for a reform of the law. Classificationists constructing hierarchies by a single dimension or axis can easily represent their findings in a table but when there are multiple dimensions or axes, as in this case, the nature of the injury and the quality of intent, tabular representation is much harder if not impossible to achieve. The existing criteria of seriousness of injury presents less difficulty than defining the notion of intent. The reformers propose that the basic definition of intention be purpose, a meaning that has long been used in practice. Along with intention, the concept of reckless has been defined with two elements; one being a circumstance, when a person is aware of the a risk and a result when the person is aware of a risk than can occur.

[92]Offences Against the Person Act 1861

[93]R v Savage (Susan) [1992] 1 AC. 699 at p 752C

[94]Legislating the Criminal Code: Offences against the Person and General Principles (1992) , LCCP122

[95]A Criminal Code for England and Wales (Law Comm No 177, 1989)

[96]J Gardner, Rationality and the Rule of Law in Offences Against the Person, The Cambridge Law Journal 502-523 (1994), pp. 502-523

In defence the 1861 Act never set out to organise offences by severity but stated punishments for various common law offences[97]. Section 47 assault occasioning bodily harm, can result in imprisonment for 10 years and on indictment for common assault up to 2 years imprisonment. Whereas, Section 20, inflicting bodily injury, with or without a weapon, conviction on indictment is punishable by a prison term not exceeding 7 years. Section 18, shooting or attempting to shoot, or wounding with intent to do grievous bodily harm, the more serious offence is a felony with liability of penal servitude for life.

The gathering of evidence by interview was the main method used to assess the quality of intention, but since the wider use of public CCTV there is a second source of information that under good conditions can provide objective evidence. The material that the prosecutor requires to charge and which the court will adjudicate relates to the nature of the intent and the nature of the injury.

[97]Brown [1993] 2 WLR 556 at p576C

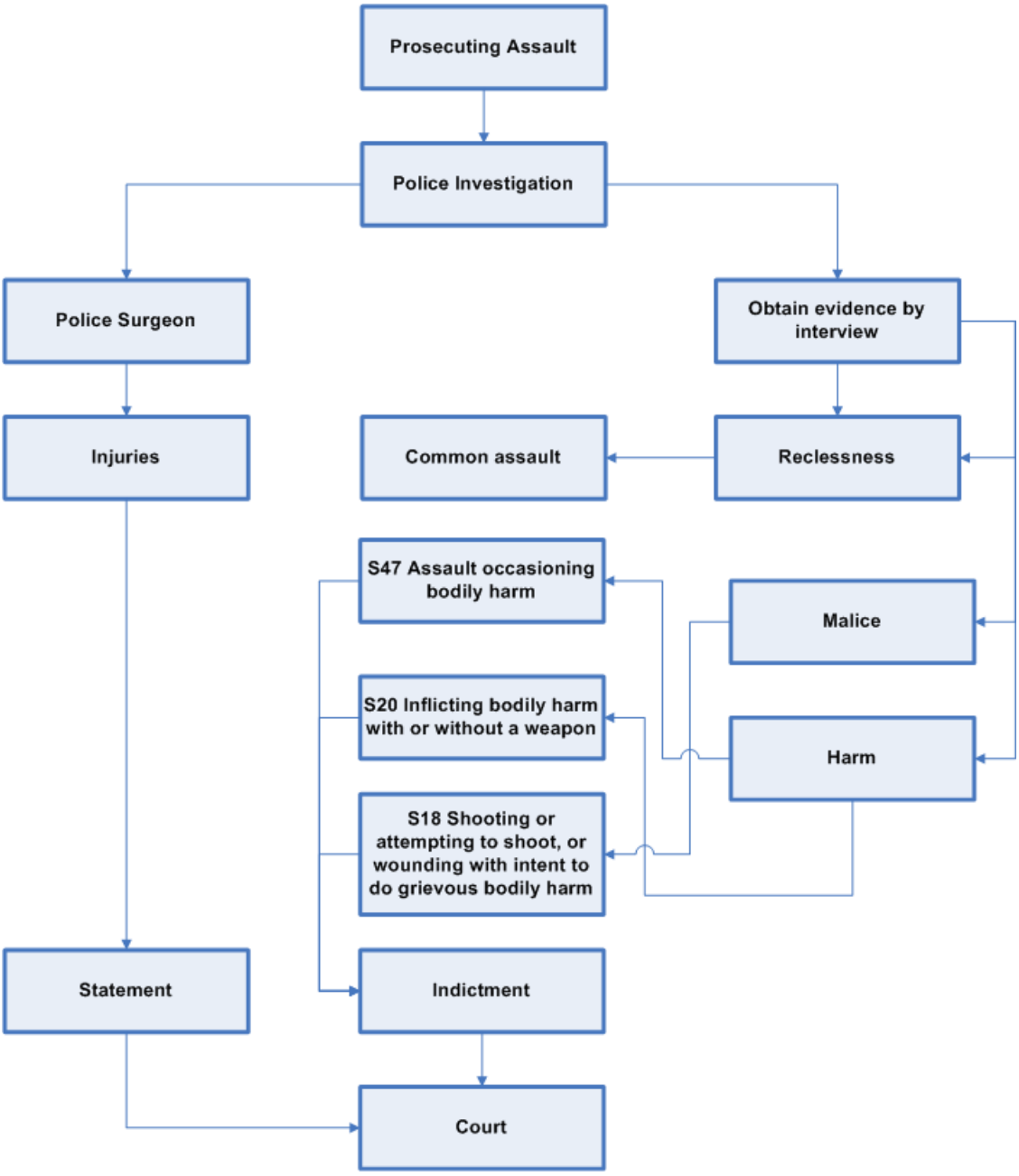

Figure 3.4.1: Offences against the person

The courts rightly differentiate between recklessness and malice. Whether the individual should have foreseen that the action taken would result in an assault and therefore was acting recklessly or whether the individual was acting out of malice.

As might be expected, a Section 47 assault occasioning bodily harm, the lesser of the three charges being considered, requires less evidence. This is shown in R v. Savage[98], a case that is the subject of comment[99]. The outcome was that for a

[98]R v. Savage (Susan) [1992] 1 A.C. 699

[99]CLR, Offences Against the Person Act 1861 - s20 and s47 - intent-review of the authorities, Crim. L.R (1992), pp. 288-92

Section 47 offence, only the assault or battery needs to be proved. That of course usually requires some form of medical evidence to be adduced. Section 20 and Section 18 offences require the accused to have acted with malice. The concept of malice, in R. v. Cunningham[100], was established as meaning a foresight of the consequences and consequently the prosecution needs to prove an intention on the part of the defendant to perpetrate the harm, or if the defendant did foresee the possibility a reckless response as to whether such harm should occur or not. This is an established principle of law propounded by C.S.Kenney in the first edition of '*Outlines of Criminal Law*' and repeated in the 16th Edition:

> *In any statutory definition of a crime, malice must be taken not in the old vague sense of wickedness in general but as requiring either (1) an actual intention to do the particular kind of harm that in fact was done; or (2) recklessness as to whether such harm should occur or not (i.e., the accused has foreseen that the particular kind of harm might be done and yet has gone on to take the risk of it). It is neither limited to nor does it indeed require any ill will towards the person injured*[101].

However, in R. v. Caldwell, the notion of recklessness includes failure to give thought to any potential risk when if any thought were given it would be obvious that risk was present.

The lesser offence of common assault is committed when a person either assaults another person or commits a battery. According to Archbold an assault is committed when a person intentionally or recklessly causes another to apprehend the immediate infliction of unlawful force. A battery is committed when a person intentionally and recklessly applies unlawful force to another resulting in harmful contact[102].

As in any criminal act both *actus reus* and *mens rea* must be present. In Fagan v. Commissioner of Police of the Metropolis[103], a motorist accidentally parked the

[100]R v. Cunningham [1957] 2 Q.B.396
[101]'Outlines of Criminal Law', C.S Kenney, University Press, 1952
[102]Barbara Barnes, Archbold Magistrate's Court Criminal Practice 2010, Sweet & Maxwell (2010) p. 621
[103]Fagan v. Commissioner of Police of the Metropolis [1969]1 Q.B.439

front wheel of his car on a policeman's foot and then turned the engine off. When the officer asked Fagan to move the car Fagan replied using abusive language. If it is assumed that the placing of the wheel on the policeman's foot was an accident then there was no *actus reus* however, once Fagan understood that the wheel was on the policeman's foot, turning the engine off established *mens rea* and the innocent act became converted to a guilty one. The question of *mens rea* was central in DPP v. Morgan[104] initially found guilty, the House of Lords directed that there should be no qualification to the *mens rea.* In this case, four men were invited to have sexual intercourse by the woman's husband who reassured the men that her protestations were just a pretence. The lower courts found that a defence based on the belief held by the four men that it was just a kinky form of sex was unreasonable, but the House of Lord's decision referred to The Queen v. Tolson[105], where Tolson had been found guilty of a bigamous marriage believing that her first husband had perished in a shipwreck. The legal maxim "*ignorantia facti excusat*" ignorance of the fact excuses, was applied but significantly in this case bigamy is a felony and a felony requires a *mens rea* without which a felony cannot be committed.

Assault occasioning actual bodily harm, bodily harm was defined by Swift J, in R v Donovan :

> *For this purpose, we think that "bodily harm" has its ordinary meaning and includes any hurt or injury calculated to interfere with the health or comfort of the prosecutor. Such hurt or injury need not be permanent, but must, no doubt, be more than merely transient and trifling*[106] .

A ruling that has been confirmed over the years, in R v. Miller[107] in 1954 and R v. Brown[108] in 1994. In R v Chan-Fook, Hobhouse LJ. said that "actual bodily harm" should be given its ordinary meaning:

[104]DPP v. Morgan [1976] A.C. 182
[105]The Queen v. Tolson [1889] L.R 23 Q.B.D 168
[106]Rex v. Donovan [1934] KB 498
[107]R v. Miller [1954] 2 All ER 529, [1954] 2 QB 282
[108]R v. Brown (Anthony) [1994] 1 A.C. 212

These are three words of the English language that receive no elaboration and in the ordinary course should not receive any. The word "harm" is a synonym for injury. The word "actual" indicates that the injury (although there is no need for it to be permanent) should not be so trivial as to be wholly insignificant[109].

Pott LJ expanded bodily harm slightly in R v. Morris to include psychiatric injury:

Bodily harm has its ordinary meaning and includes any hurt or injury calculated to interfere with the health or comfort of the victim: such hurt or injury need not be permanent, but must be more than merely transient or trifling ...

Actual bodily harm is capable of including psychiatric injury but it does not include mere emotion, such as fear, distress or panic ... [110]"

Harm can also encompass an attribute of the body even though the substance might be dead tissue, this was the finding in DPP v. Smith The defendant held down his former girlfriend and cut off her ponytail with kitchen scissors a few weeks before her 21st birthday. The Divisional Court allowed an appeal by the DPP, rejecting the argument for the defendant that the hair was dead tissue above the scalp and so no harm was done:

"In my judgment, whether it is alive beneath the surface of the skin or dead tissue above the surface of the skin, the hair is an attribute and part of the human body. It is intrinsic to each individual and to the identity of each individual. Although it is not essential to my decision, I note that an individual's hair is relevant to his or her autonomy. Some regard it as their crowning glory. Admirers may so regard it in the object of their affections. Even if, medically and scientifically speaking, the hair above the surface of the scalp is no more than dead tissue, it remains part of

[109]R v. Chan-Fook [1994] 2 All ER at 557D
[110]R v. Morris (Clarence Barrington) [1998] Cr. App. R. 386 at 393

the body and is attached to it. While it is so attached, in my judgment it falls within the meaning of "bodily" in the phrase "actual bodily harm". It is concerned with the body of the individual victim[111]"

Actual bodily harm can then include any hurt or injury that interferes with the health or comfort of the victim and which is more than transient or trifling. To damage an important physical aspect of a person's bodily integrity must amount to actual bodily harm, even if the element damaged is dead skin or tissue.

As Creswell J. commented in his short concurring judgment:

To a woman her hair is a vitally important part of her body. Where a significant portion of a woman's hair is cut off without her consent, this is a serious matter amounting to actual (not trivial or insignificant) bodily harm[112].

Non-physical or psychiatric injury can be considered actual bodily harm, although there must be medical evidence of the injury. The original legislative intent was probably restricted to physical injury because Parliament required "*bodily*" rather than "*mental*" or "*emotional*" harm. In R v. Clarence[113] the court was reluctant to accept that communicating a venereal disease to ones wife was an injury within the act. In modern times, R v. Chan Fook[114] did not accept hysteria or other very strong emotions as an injury when the defendant locked up a suspected thief who became very upset and tried to escape. Before the Harassment Act 1997[115] came into force, there were two cases that centered around the psychiatric harm that can be caused by harassment, in these cases telephone calls. In R v. Constanza[116] and R v. Burstow[117], the victims were caused to suffer psychiatric illness. The best medical practice today accepts a link between the body and psychiatric injury. So

[111]DPP v. Smith (Michael Ross) [2006] EWHC 94 (Admin)
[112]DPP v. Smith (Michael Ross) [2006] EWHC 94 (Admin)
[113]R v. Clarence [1888] 22 QBD 23
[114]R v. Chan Fook [1994] 1 W.L.R 689
[115]Harassment Act 1997
[116]R v. Constanza [1997] 2 Cr. App. R. 492
[117]R v. Burstow, R v. Ireland [1997] A.C. 147

the words "*bodily harm*" in Section 20 and 47 are capable of covering recognised psychiatric illnesses, such as an anxiety or a depressive disorder, which affect the central nervous system of the body. However to qualify, those neuroses must be more than simple states of fear or problems in coping with everyday life, which do not amount to psychiatric illnesses.

Injury	Common assault	Actual Bodily Harm	Grievous bodily Harm	Wounding
Grazes	✔			
Minor bruising	✔			
Swelling	✔			
Superficial cuts	✔			
Black eye	✔			
Significant psychiatric illness		✔	✔	
Loss or breaking of tooth		✔		
Temporary loss of sensory function		✔		
A displaced broken nose		✔		
Minor fractures of bones		✔		
Minor (but not superficial) cuts requiring medical treatment		✔		
A recognised psychiatric disorder		✔		

Table 3.8: Injuries and assault

*CPS guidelines

99 Consecutive cases of assault

Police Surgeons are called to examine those accused of assault and those complaining of being assaulted to document the presence and nature of injuries.

Data was collected from a personal series of 99 consecutive assault assessments of victims between 01/06/2010 and 31/07/2011[118]. Statistical analysis has not been undertaken. However, it does appear that males only slightly outnumber females. The data includes assaults that occurred at home which accounts for a large number of female victims.

[118] *Unpublished data obtained from M. Barrett's records*

	Age			Location			Alcohol		Drugs	
Victims	Total	>21	<21	Home	Licensed premises	Public place	Yes	No	Yes	No
Male	57	46	11	7	11	39	42	15	5	52
Female	42	33	9	23	1	18	18	24	2	40

Table 3.9: Victims of assault data table

* Data collated from the forensic medical records held by the author

As might be expected the age-sex histogram show that the majority of victims are aged between 15 and 29. With a surprising number of young females reporting as victims.

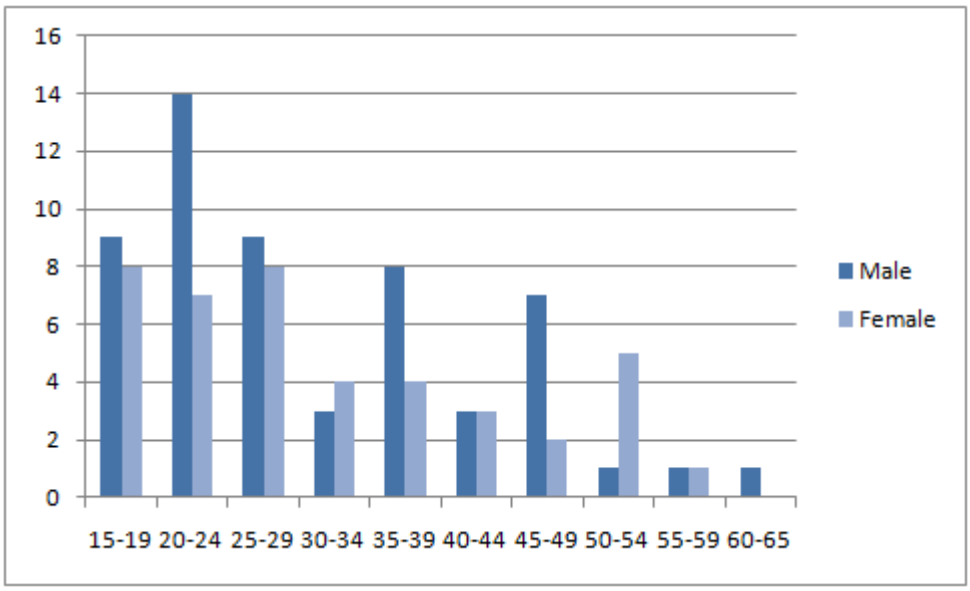

Figure 3.4.2: Age-sex distribution of victims

* Data collated from the forensic medical records held by the author

The place of assault classified as home, licensed premises or a place to which the public has access show that most assaults occur in a public place with home in second place.

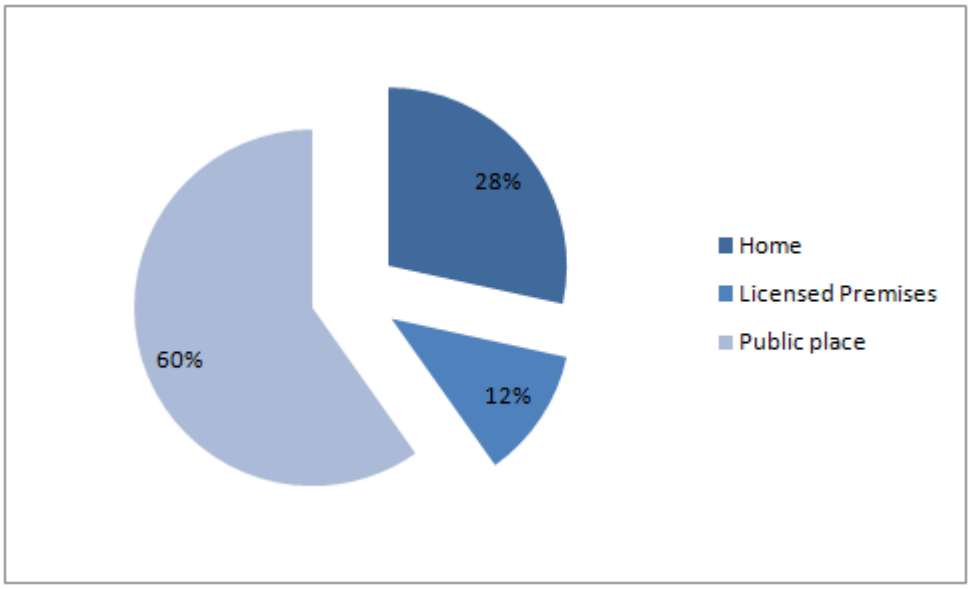

Figure 3.4.3: Place of Assault

* Data collated from the forensic medical records held by the author

In this sample about 64% had consumed alcohol or taken drugs.

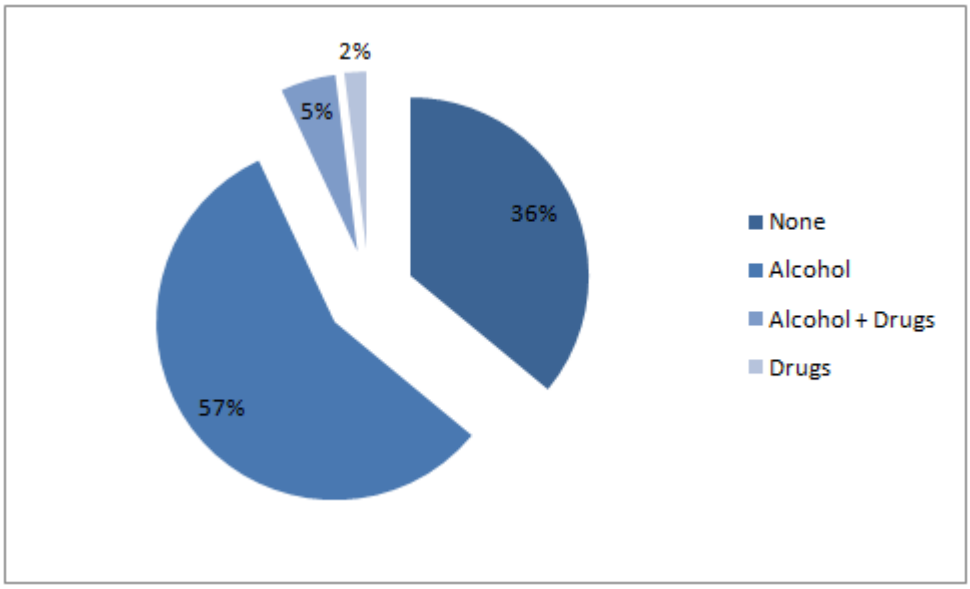

Figure 3.4.4: Drink and drugs

* Data collated from the forensic medical records held by the author

Only 15 out of the 99 cases occurred inside office hours of 09:00 - 19:00.

The distinction between accused and defendant is frequently blurred. On some occasions it appears that the definition of a victim is the party that is first to report the incident to the police station or even the first to reach a telephone, and in gang-related affray that the gang that lost were the victims and the gang that won are

treated as assailants. Whilst this might be a convenient way of handling these type of offences, particularly in a legal system that is predicated on an adversarial basis, a person treated as an assailant may not always be guilty and a victim may not necessarily be innocent.

3.5 Road Traffic Medicine

The Licensing Act 1872[119] introduced the concept of being responsible to others whilst in charge of carriages, horses and steam engines and being drunk in charge of such modes of transport. It was some fifty-three years later that the Criminal Justice Act 1925[120] extended the offence to penalise a person drunk in charge on any highway or any public place of any mechanically propelled vehicles. The 1930 Road Traffic Act[121] qualified the degree of intoxication, stating that it was necessary to be properly *"drunk"* or incapable at Section15:

> *..is under the influence of drink or drugs to such an extent as to be incapable of having proper control of a vehicle.*

Over the next 58 years there was a series of amendments. The 1956 Road Traffic Act[122] coined the term *"unfit to drive"* and the 1962 Road Traffic Act[123] added the concept of being under the influence of drink or drugs. Then in a remarkably rapid response to a report from the British Medical Association in 1960[124], the notion of a finite proportion of alcohol or drugs in body fluids such as blood or urine was introduced. This resulted in the introduction of the Breathalyser, a tube of crystals that changed colour if the breath blown through them contained alcohol. A statutory limit was set to 80 mg of Alcohol in 100 ml of blood or 107 mg of alcohol in 100 ml of urine of evidential specimens being proscribed in the 1967 Road Safety Act[125].

In response to advances in technology the Road Traffic Act 1972[126] embodied evidential breath testing, a procedure that was introduced by schedule in the Transport Act 1981[127], which became fully incorporated in the 1988 Road Traffic Act[128].

[119]Licensing Act 1872
[120]Criminal Justice Act 1925
[121]Road Traffic Act 1930
[122]Road Traffic Act 1956
[123]Road Traffic Act 1962
[124]B. R. Hopkinson and G. M. Widdowson, Relation of Alcohol to Road Accidents, Br Med J (1964), pp. 1569-1570
[125]Road Safety Act 1967
[126]Road Traffic Act 1972
[127]Transport Act 1981
[128]Road Traffic Act 1988

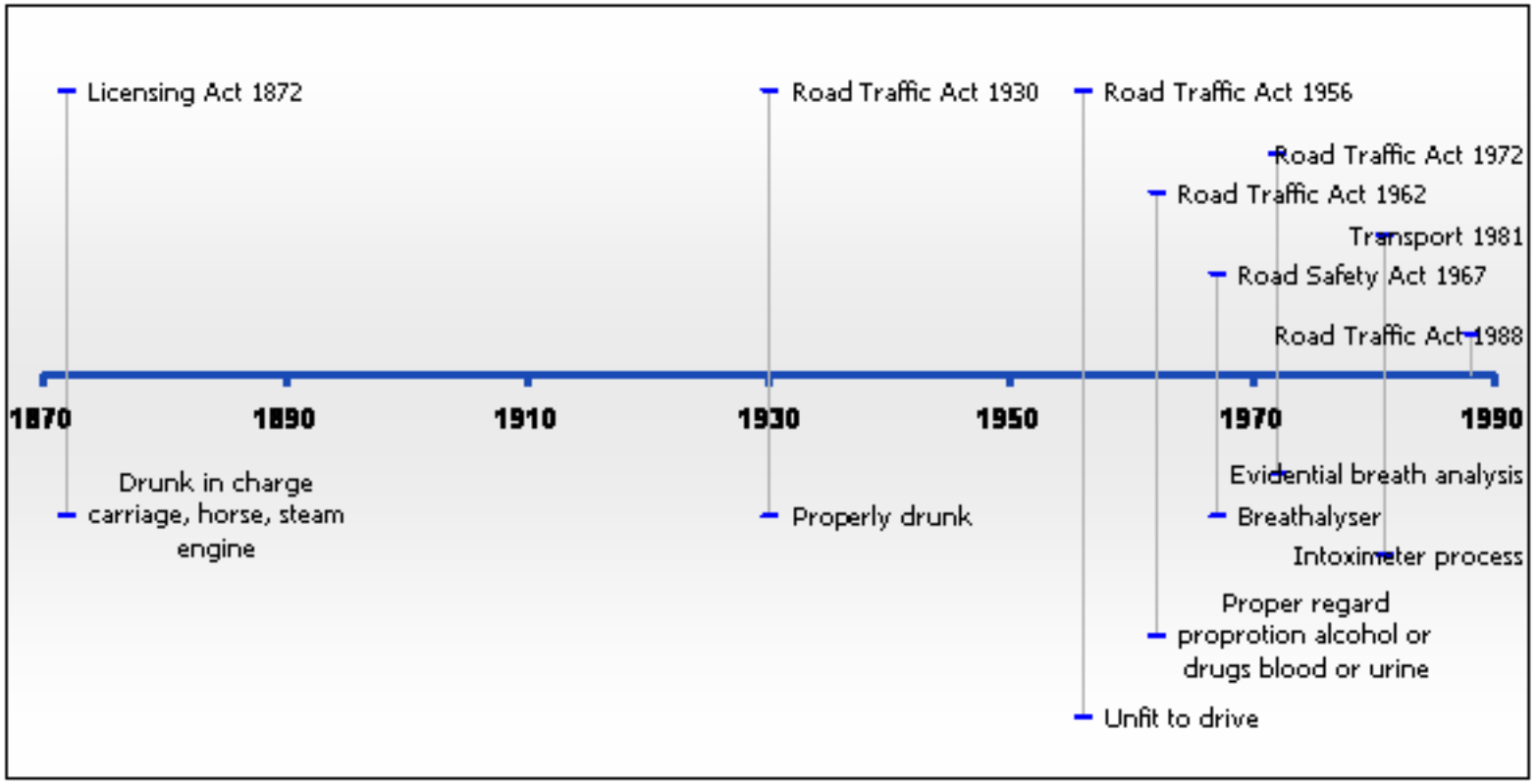

Figure 3.5.1: Road Traffic Statutes

*Timeline using template located at www.vertex42.com/Excel/articles/create-a-timeline.html

The simple concept that motorists should not drive whilst breath, blood or urine alcohol is greater than a proscribed limit has resulted in a large number of cases that have established case law. It is a testament to the ingenuity of lawyers that so many loopholes in the legislation have been exploited. Most of the cases exploit deficiencies in procedure rather than disputes about the underlying forensic science or actions of the Police Surgeon. Such loopholes are closed by changes to police procedures.

The introduction of the breathalyser in the 1967 Road Safety Act resulted in a process since called the "*old code*" by Lord Bridge of Harwich in Warren[129], when a motorist failing a road side breath test would be taken to a police station and given the choice of providing a specimen of blood or a specimen of urine, the driver's option. The process changed with the 1981 Transport Act which sanctioned the use of intoximeters and installed these machines in police stations. This resulted in a process called "*new code*" where motorists taken to the police station are required to provide samples of breath. Horrocks v. Binns[130] established the principle that it is unlawful to require a specimen of blood or urine where there are no medical reasons why breath cannot be provided or should not be required, providing of course that a reliable breath analysis device is available and it is practical to use it. In this particular case the motorist had a cut on the head and the Police Officer requested blood although there was no medical reason that prevented provision of a sample of breath.

A successful prosecution requires two elements to be proved. The first is that the individual was driving or attempting to drive on a public road or otherwise in charge of a vehicle and secondly, that the proscribed limits for alcohol were exceeded. The individual is arrested under Sections 4, 5, or 6 of the 1988 Road Traffic Act and if the roadside breath test is positive or if there are grounds to suspect drug driving, the individual is taken to the Police Station for collection of evidential samples of breath, blood or urine or for examination by a Registered Medical Practitioner.

[129]DPP v. Warren [1993] A.C. 319, [1992] 3 WLR 814, [1992] 4 All ER 865, [1993] RTR 58 5 November 1992 HL

[130]Horrocks v. Binns [1986] RTR 20226 July 1984 QBD

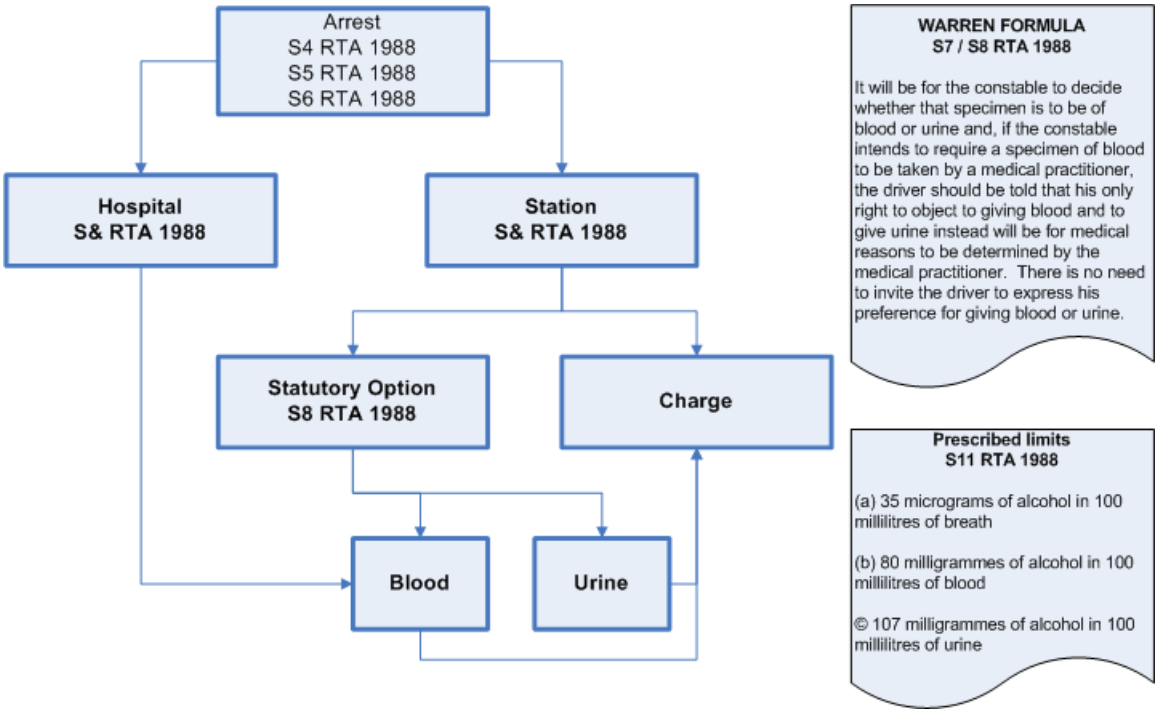

Figure 3.5.2: Drink Drive flow Chart

At the station an intoximeter is used to obtain an evidential sample of breath to produce a breath alcohol reading. It is for the police officer conducting the procedure to adjudicate on any issues concerning the provision of breath specimens. The officer has sole responsibility for allowing the motorist to proceed to provide a specimen of blood or to treat the motorist's refusal to blow on the intoximeter as a failure to provide a sample of breath as defined in Section 4 of the Road Traffic Act.

It is incomprehensible that such a simple process can give rise to so much argument in court, however perusal of CCTV of persons being booked into custody and the behaviour of the motorist in the intoximeter room may go some way to explaining some of the difficulties. The effect that alcohol has on an individual may not be apparent in the court room or envisaged by the law draftsmen.

The invidious position of the police officer being faced with claims by the motorist that provision of a sample of breath is not possible for medical reasons, when as a layman the officer cannot evaluate those medical reasons has been resolved by the courts. It has been established that the officer only needs reasonable cause to believe that a medical condition exists before abandoning any request to provide breath.

Reasonable cause can be problematic. An officer who adjudicated that a motorist who was driving a motor vehicle, a complex machine, did not as claimed have a phobia of machines to such an extent that the motorist could not use the intoximeter. He was found in Dempsey[131] to have dismissed Dempsey's claim to be mechanophobic unjustly.

An officer's decision to insist on breath despite being told that the motorist has asthma and is suffering from a cold is unreasonable as found in Davies[132], however, Davies objection to providing blood and objection to providing urine gives an idea of the attitude of this motorist. This case established the principle that it is the officer's duty to obtain reliable and admissible evidence. This is the basis for the adage passed on to Police Surgeons *get a sample any sample* because the courts would prefer to see evidence in terms of a level of breath, blood or urine alcohol rather than evidence of a failed process.

The charge of failing to provide is easier to challenge than laboratory findings and a conviction for failure to provide is perceived by society as a lesser offence than driving whilst unfit. Medically, the individual does not have to consider the possibility of problem drinking.

The reasons accepted by the courts as "*reasonable cause not to provide a sample of breath*" are varied. In Steadman[133] it was the use of sleeping tablets. In Young[134] it was intoxication by alcohol, because intoxication is a medical reason recognised by doctors. However, the use of LSD and other hallucinatory drugs dis-entitle the motorist from a defence of intoxication because it is voluntary as in DPP v. Majewski[135].

[131]Dempsey v. Catton [1986] RTR 194, 21November 1985 QBD (DC)
[132]Davies (Gordon Edward) v. DPP ([1989] RTR 391, [1990] Crim LR 60, 29 June 1989 QBD (DC)
[133]Steadman v. DPP [2002] EWHC 810 (Admin), unreported 15 April 2002 QBD (DC)
[134]Young (Paula) v. DPP [1992] RTR 328, [1992] Crim LR 893, 24 March 1992
[135]DPP v. Majewski [1977] A.C. 443

Medically, Honeybourne[136] and co-workers found that sufferers of asthma and COPD[137] are unable to provide evidential breath samples using the Lion Intoxilyzer 6000, the UK breath alcohol testing device. However, a different conclusion was reached by workers from Australia[138]. On breath-testing patients with a respiratory disability they found that a subject capable of driving should also be capable of providing an evidential sample. In two papers Gomm and co-workers[139] [140] found that persons of small stature were able to provide a sample of breath but those with some lung disorders were unable to provide a specimen of breath.

Mental health problems are no reason to avoid providing a sample of breath. Francis[141] decided that despite being held under Section 136 Mental Health Act 1983[142], an Appropriate Adult is not required to be present because provision of a sample of breath is a procedure and not an interview.

Case law has established that it is the reasonable belief of the Constable that the motorist has a medical reason not to provide breath rather than the opinion of the doctor. This determines the decision of whether a request to provide a sample of breath and whether refusal results in a charge of failure to provide or a subsequent request to provide a sample of blood.

[136]Honeybourne D, Moore AJ, Butterfield AK, Azzan L., A study to investigate the ability of subjects with chronic lung diseases to provide evidential breath samples using the Lion Intoxilyzer 6000 UK breath alcohol testing device., Respir Med. (2000), pp. 684-8

[137]*Chronic Obstructive Pulmonary Disorder*

[138]MS Odell, Breath testing in patients with respiratory disability, Journal of Clinical Forensic Medicine (1998), pp. 45-48

[139]PJ Gomm, Study into the ability of patients with impaired lung function to use breath alcohol testing devices, Med Sci Law (1991), pp. 221-5

[140]P. J. Gomm and C. G. Broster and N. M. Johnson and K. Hammond, Study into the ability of healthy people of small stature to satisfy the sampling requirements of breath alcohol testing instruments., Med Sci Law (1993), pp. 311-314

[141]Francis v. DPP [1997] RTR 113, 29 April 1996, QBD (DC

[142]Mental Health Act 1983 as amended by the Mental Health Act 2007

Reason	Accepted	Reference
Phobia	✔	Dempsey v. Catton
Mechanophobia	✔	Dempsey v. Catton
Small stature	✖	Gomm et al
Asthma	✔	Honeybourne D, Respir Med. (2000), pp. 684-8
Chronic obstructive pulmonary disease	✔	Gomm et al
Mental Health Problems	✖	Francis v. DPP
Intoxication by alcohol	✔	Young (Paula) v. DPP
Intoxication by LSD	✖	DPP v. Majewski
Sleeping tablets	✖	Steadman v. DPP

Table 3.10: List of reasons why breath cannot or should not be taken

It is acknowledged in statute that there can be a degree of error with the evidential breath testing machine. Section 8 of the 1988 Road Traffic Act directs that it is the lower reading of the two specimens of breath that should be accepted and if that lower reading is below 50mcgs of alcohol per 100mls of breath, the motorist can claim that the breath specimen be replaced by a specimen of blood or urine. It is intriguing that such a simple concept should have given rise to so much case law and disparate rulings. Nolan J, in Anderton may have had the "*old code*" in mind when opining

> *The position, as it seems to me, is that the legislation, by [section 8(6)] contemplates two possible ways in which guilt or innocence are to be established. One is by the breath sample. The other if the suspect so chooses is by the sample of blood or urine. The alternatives must both be made available to the subject if the plain purpose of the section is to be achieved*[143].

This was the process when the breathalyser was introduced. It appears that Nolan J still believed that the motorist has the option to choose blood or urine. This belief is shared by many motorists who challenge the police officer during the statutory

[143]Anderton v. Lythgoe [1985] R.T.R. 395 at 400

option process. Not an easy task when the motorist's cognitive ability[144] is impaired by one sample of breath that contains at least 35 mcgs of alcohol in 100 mls breath.

The confusion that developed from cases reliant on Nolan's judgment was addressed in Warren by Lord Bridge of Harwich who expressed concerns about a position:

> "*which afforded too many drunken a variety of wholly unmeritorious avenues of escape from conviction*[145]"

When the police officer makes the decision to request a sample of blood or urine either because the intoximeter is unserviceable Section 7(3)(b) or one of the lower of the two breath specimen readings provided is below 50mcg per 100mls of breath, Section 8(2), states that the officer must offer the motorist the opportunity to consider which sample the motorist would prefer to provide if given free choice and to express any reasons for the motorist's preference. This is Lord Bridge's ruling who summarised his findings in a "formula" expressed in the following terms:

> *In a case where the driver's option is to be explained to him under section 8(2), the driver should be told that if he exercises the right to have a replacement specimen taken under section 7(4), it will be for the constable to decide whether that specimen is to be of blood or urine and, if the constable intends to require a specimen of blood to be taken by a medical practitioner, the driver should be told that his only right to object to giving blood and to give urine instead will be for medical reasons to be determined by the medical practitioner. In neither case is there any need to invite the driver to express his preference for giving blood or urine*[146]"

The doctor is in a slightly different position to the police officer when requesting a sample of breath, who only has to determine if the motorist had reasonable cause

[144] *Thinking ability*

[145] DPP v. Warren [1993] AC 319, [1992] 3 WLR 814, [1992] 4 All ER 865, [1993] RTR 58 5 November 1992 HL

[146] DPP v. Warren [1993] AC 319, [1992] 3 WLR 814, [1992] 4 All ER 865, [1993] RTR 58 5 November 1992 HL at 332

to decline providing a sample. According to Lord Bridge the doctor can adjudicate on the nature of the medical reason not to provide blood in preference to supplying urine. However, the officer still has to accept reasonable cause. The appeals of Jackson and Stanley[147] were two cases heard together in the House of Lords. Jackson, concerned a discharge by the Divisional Court because the sergeant had failed to comply with the Lord Bridge's formula in Warren, by not asking the defendant if there were other reasons than the defendant's assertion *"I don't like needles but I'm not giving anything anyway*[148]"

In the lead judgment, Lord Hutton reluctantly allowed the appeal:

> *"If what is required, to cite Lord Bridge's ruling, is that the Warren formula must be used and must not be added to or subtracted from, then we are reluctantly forced to conclude that a rider to that formula that can plausibly be read as indicating that the only reasons that the driver is being invited to state are medical ones does indeed provide less than Warren's case requires. We therefore feel forced to follow the authority of the House of Lords in Warren's case rather than that of this court in Director of Public Prosecutions v. Donnelly and allow this appeal*[149].

In the other case Stanley revolved around a similar issue when the officer regarded the defendant's reply that he did not want a needle, as constituting a refusal to provide. Stanley stated *"I don't want no needle*" in response to the request for a sample of blood or urine. The sergeant had not asked why the defendant had refused and through forgetfulness and a belief that the defendant had refused did not proceed to ask the medical reasons question, "*Are there any medical reasons why a sample of blood cannot or should not be taken by a doctor*?"

The Crown Court rhetorically asked "*whether the law required a police officer in the face of a refusal to continue and ask a raft of irrelevant questions*" and reached

[147]DPP v. Jackson [1999] 1 A.C. 406
[148]DPP v Stanley [1999] 1 A.C. 406 at 412
[149]DPP v Stanley [1999] 1 A.C. 406 at 414

the conclusion that the law did impose such conditions resulting in a process used by the police where similar questions are asked which can appear confusing to all concerned in the process. The Divisional Court had found that because the sample had been obtained without following the correct procedure, the prosecutor could not rely on the results of the analysis of the sample of blood. Lord Hutton in his judgment restated the Warren formula assigning to the doctor the responsibility to accept or reject the medical grounds proffered by the defendant.

Of greater interest to prosecutors in such cases is whether a failure to observe Lord Bridge's formula in Warren should result in an automatic acquittal or whether a breach of those requirements are not necessarily a bar to a conviction. Lord Hutton takes the view that the formula in Warren is a guidance for the lower courts and not a statute. Helpfully, Lord Hutton sets out the roles of the officer and the doctor:

> *it is for the police officer to decide whether the specimen will be blood or urine. But section 11(4) provides that the specimen of blood is to be taken by a doctor. In addition the right of the police officer to choose whether the specimen will be of blood or urine is subject to the qualification that if a medical reason is raised why a specimen of blood cannot or should not be taken, the issue is to be decided by a doctor and not by the police officer*[150]

Lord Hutton stated that:

> *"The taking of a sample is a much more serious infringement of the subject's ordinary liberties than causing him to blow into a machine, and medical questions of real significance and difficulty may arise. .... The implication is to my mind clear that in deciding the medical issue, the constable has no role to play. This does not however lead to an interpretation at the opposite extreme, which would require the officer to act as no more than a messenger, obliged to turn out the medical practitioner*

[150]DPP v Stanley [1999] 1 A.C. 406 at 421

whenever the suspect contrived to utter a form of words suggesting a claim for medical immunity. The police officer cannot have the power to rule upon a medical issue, but he must have the power to form a view on whether such an issue has been raised at all, for otherwise the medical practitioner would be troubled by excuses which have nothing to do with the expertise, which is the reason for his being given a part to play under section [7(4)][151] "

The serious infringement of the subject's ordinary liberties is regulated in this instance by Section 7(4) Road Traffic Act 1988

a specimen of blood is not to be required if the medical practitioner who is asked to take it is of the opinion that, for medical reasons, it cannot or should not be taken; or if a health care professional asked to take is of the like opinion and there is no contrary opinion from a medical practitioner[152].

This is where the Police Surgeon becomes involved. The law does not specifically refer to the Police Surgeon but uses the proper term Registered Medical Practitioner. There is also provision for a healthcare professional working in the custody suite to take the sample.

The officer must then ask the motorist if there are any medical reasons why a blood specimen could not, or should not be taken as found in Edge[153]. A motorist's dislike of needles is a *prima facie*[154] medical reason and it is the responsibility of the Medical Practitioner and not the Police Officer to judge the validity of the the reason - a repugnance [of needles] of sufficient degree is capable of being a medical reason for not providing a sample for example Johnson[155].

Helpfully Andrews produced this ruling:

[151]DPP v Stanley [1999] 1 A.C. 406 at 421
[152]Section 7(4) Road Traffic Act 1988
[153]Edge v. DPP [1993] RTR, 146, 7 December 1992, QBD, DC
[154]*At first face*
[155]Johnson v. West Yorkshire Metropolitan Police [1986] RTR 167, [1986] Crim LR 64, 31 July 1985, QBD (DC)

> *Different doctors may come to different conclusions and .. the legislation was [never] intended to throw into the litigation arena, debate the correctness or otherwise of medical opinion. The requirement is that opinion be obtained. Whether the opinion is right or wrong seems to me to be, under the Act, irrelevant*[156].

Despite the dominance of medical opinion, the officer is still obliged to consider the request of the motorist not to give blood. In Joseph[157] the officer did not consider Joseph's claim that it was contrary to his Rastafarian religion to give a sample of blood. There is however, no obligation on the part of the officer to enquire if there is a medical reason to provide a sample. This is illustrated in Grix[158] when the motorist blandly refused to provide a specimen of blood. In a similar case, Gibbons[159], the motorist's answer to a request from the sergeant to provide a sample of blood to be taken by a doctor "*You are not going to examine me*", was found not to offer any possible medical reasons why a specimen of blood could not or should not be taken. There was no attempt by the motorist to put forward any medical reason to the Medical Practitioner. A refusal to be examined does not then amount to a medical reason.

A representation that the motorist takes tablets should be taken into account by the officer. When requesting blood, the individual should have been allowed to provide a sample of urine, as in Wade[160]. Similarly, a representation "*I do take tablets*", Donnelly[161], was found sufficient for the officer to give consideration that a specimen of urine be provided. An appeal against the decisions of the magistrates to dismiss a motorist's defence that tablets and a spray, was on reflection or perhaps more likely after new solicitors had been appointed, a medical reason why blood should not have been taken was not upheld in Kinsella[162].

[156]Andrews v. DPP [1992] RTR1 at 10; The Times, 2 May 1991, 1 May 1991, QBD (DC)
[157]Joseph v. DPP [2003] EWHC 3078 (Admin), [2004] RTR 341, 24 November 2003 QBD (DC)
[158]Grix v. Chief Constable of Kent [1987] RTR 193, 12 March 1987, QBD (DC)
[159]Gibbons (Stuart Michael) [2001] EWHC 385 (Admin), (2001) 165 JP 812 10 May 2001 QBD (Admin)
[160]Wade v. DPP [1966] RTR 177, 6 February 1994 QBD (DC)
[161]Donnelly (Ronald Francis) [1998] RTR 188, 10 March 1987 QBD (DC)
[162]Kinsella v. DPP [2002] EWHC 545 (Admin), unreported, 13 March 2002, QBD (DC)

Meade[163] is an example of a case where the failure to implement the House of Lords decision in Warren, resulted in the case being lost[164] because the form of words used by the police officer did not afford the motorist the opportunity to proffer any medical reasons in support of the refusal to provide a specimen of blood.

This House of Lords decision emphasises the importance of the motorist being allowed to claim a medical reason not to provide blood. It seems that procedure is all, overruling common sense and the sentiments expressed by Lord Harwich that the law requires re-drafting because of the wholly unmeritorious avenues of escape from prosecution appear very pertinent. In some cases common sense applies. In Garrett[165], the doctor was called to take a specimen of blood but when the vein collapsed, a medical reason, the claim by Garrett that urine should not have been requested was dismissed. Wythe[166], a tattooed diabetic, taking two injections a day agreed to blood being taken out of his finger but not out of his arm. The officer took this as a refusal but the appeal by the DPP was lost because it was found that the officer did not delay making his request for blood until the defendant had been examined by the doctor. It was accepted that the objection was weak but the principle that is it not for the officer to substitute his opinion for the opinion of a Medical Practitioner.

[163]Meade v. DPP [1993] RTR 151, 8 December 1992, QBD (DC)
[164]DPP v. Warren [1993] A.C. 319, [1992] 3 WLR 814, [1992] 4 All ER 865, [1993] RTR 58 5 November 1992 HL
[165]DPP v. Garrett [1955] RTR 302, 31 January 1995, QBD (DC)
[166]DPP v. Wythe [1996] RTR 137, 19 July 1995 QBD (DC)

Reason	Accepted	Case
I don't like needles but I'm not giving anything anyway	✔	DPP v. Jackson
Dislike of needles is a *prima facie*	✔	Johnson v. West Yorkshire Metropolitan Police
Rastafarian religion	✔	Joseph v. DPP
You are not going to examine me	✖	DPP v. Gibbons (Stuart Michael)
Takes tablets and a spray	✖	Kinsella v. DPP
Take tablets	✔	Wade v. DPP, DPP v. Donnelly
Only blood from finger	✔	DPP v. Wythe
Mixing of samples from two puncture	✖	Dear v. DPP

Table 3.11: List of reasons why blood cannot or should not be taken

Urine is the least preferred option because it can be a time consuming process taking upwards of an hour. There is a greater chance of manipulation of the specimen and analysis of urine is the least reliable of all the specimens. Provisions of urine specimen can be accepted under Section 7(5) of the 1988 Road Traffic Act

> *A specimen of urine shall be provided within one hour of the requirement for its provision being made and after the provision of a previous specimen of urine*[167].

The sample collection procedure requires the motorist to empty the bladder and then within an hour provide a second sample. This is the one that is sent for analysis after being divided into two aliquots, one being given to the motorist to allow for independent analysis.

In Over[168], the motorist provided the second sample one minute after providing the first. An appeal that the second sample was a continuation of the first was

[167] 7(5) Road Traffic Act 1988
[168] Over v. Musker [1985] RTR 84, 1 March 1984, QBD (DC)

not upheld. Whereas in Nugent[169], the motorist who was unable to provide breath because of a cold and a doctor was satisfied that a needle phobia existed, urine was accepted. Nugent appealed against conviction on the grounds that two further specimens of urine were provided after discarding the first. The court found that one sample was provided at the request of the doctor and one at the request of the sergeant. It was the sergeant's requested sample that they tested and it was found to contain alcohol in excess of the prescribed limit and the defendant was convicted.

Section 9 of the 1988 Road Traffic Act provides the mechanism for persons in hospital. Clearly, it is not possible to provide an evidential sample of breath and so a sample of blood is the preferred option. There are additional difficulties involving the welfare of the motorist, such that, before a sample of blood can be taken the hospital doctor in charge of the case must be given the opportunity to state if in taking a sample of blood, the care of the patient would be prejudiced. The correct procedure was outlined in Duffy[170], a case where blood samples taken were deemed inadmissible because the officer had not told the motorist, who at the time, was a patient in the intensive care unit, that specimens of breath could not be taken or to offer the motorist the opportunity to proffer medical reasons why blood samples could not be taken.

As a note of caution for the Police Surgeon, the case of Beatrice[171] was lost because it was the Police Surgeon who had advised the motorist of the risk of prosecution rather than a police officer.

Cyclists, persons in charge of animals on the road or motorists suspected of driving under the influence of drugs are assessed by impairment testing. Driving whilst under the influence of drugs is an offence under section 4 of the Road Traffic Act 1988, since the prescribed limits of section 11(2)(a)(b)(c) cannot apply, the Police Surgeon will be asked to provide an opinion as to whether there is a condition that might be due to drink or drugs, in doing so the police surgeon will apply a series of impairment tests.

[169]Nugent v. Ridley[1987]RTR 412, [1987] Crim LR 640, 25 February 1987, QBD (DC)
[170]DPP v. Duffy [1994] 1 W.L.R. 1107
[171]Beatrice v. DPP [2004] EWHC 2416 (admin), unreported, 6 October 2004, QBD (DC)

3.6 Evidence presentation

A key function of the Police Surgeon is to present the findings of the examination. At the simplest level this means verbally reporting to the custody sergeant that the detainee is fit for detention or fit for interview and to make recommendations about the level of observation required during the detainee's period of detention. The Police Surgeon needs to respect the confidentiality of the medical content of the examination, releasing only that information that is needed by the custody officer for the detainee's safety. The Police Surgeon then updates the custody record in writing.

The Crown Prosecution or the Coroner's Officer may request a statement that should be prepared in accordance with Section 9 of the Criminal Justice Act 1967[172] or Rule 70 of the Magistrates Court Rules 1981[173], or Section 102 of the Magistrates Courts Act 1980[174]. A Section 9 statement is a statement of fact, an explanation of medical terms. For example, an abrasion or graze results from skin rubbing against a hard surface. A section 9 statement is designed to be read to the court, it is produced by the Police Surgeon and is a description of the findings of the medical assessment. If the statement is not subject to contention, the police surgeon is unlikely to be called to court to present the findings verbally. However, when a Police Surgeon is asked to give evidence in court it is as a professional witness.

Request to present evidence orally to the court can be used as a quality marker. Police Surgeons frequently finding themselves in court verbally presenting their evidence, are probably producing poor statements or conducting flawed assessments. Police Surgeons submitting adequate Section 9 statements may not be called to court and consequently may not have much experience of giving evidence in court.

Taking assault as an example, from the prosecutor's perspective Section 9 statements produced by the Police Surgeon are deficient because information concerning

[172]Criminal Justice Act 1967
[173]Magistrates Court Rules 1981
[174]Magistrates Courts Act 1980

causation is limited. The Police Surgeon conducts assessments for fitness for detention, fitness for interview and records the presence of injuries before the police interview. It is important that when recording the process of the presence of injures, it does not influence the Police interview or prime or rehearse the detainees response to questions that would be asked at interview. The Police Surgeon should receive a briefing from the custody sergeant or the interviewing officer, but the full details of the incident may not emerge until the interview takes place.

The lack of information concerning causation would be overcome if the Police Surgeon, rather than writing a Section 9 statement, wrote an expert report. In the case of injuries, rather than stating that the injury is consistent with a basic mechanism for example, direct blunt trauma, it would be possible to express an opinion using the statements collected by the Police.

Summary

In this Chapter some of the tensions that operate in Clinical Forensic Medicine have been outlined; these include the dichotomy between the doctor's ethical responsibilities to the patient and duties to the Criminal Justice System; the questionable differentiation between victim and assailant as well as differences in the interpretation of driving law when considering drink driving. These elements support the notion that the Police Surgeon applies specialist knowledge rather than practising general practice in a custodial environment[175].

All this leads to the current debate between the Faculty of Forensic and Legal Medicine and the General Medical Council concerning acceptance of Clinical Forensic Medicine as a specialty, or whether the most appropriate way forward should be the application of a credentialisation process to the practitioner. This is discused further in Chapter 4.

[175] *Compare this with Prison Medical Officers who are General Practitioners working in a custodial environment. This being the basis for the NHS taking over the care of prisoners from the Prison Medical Service.*

Chapter 4

The Challenges to Clinical Forensic Medicine

Introduction

The rise of Clinical Forensic Medicine was charted in Chapter 1 from the earliest investigations of the circumstances surrounding death, to doctors employed by the police in effect providing employee benefits that in modern parlance was part of a police officer's remuneration package, through to those doctors who collect medical evidence for the courts. The role is established and with the formation of the Faculty of Forensic and Legal Medicine, the role has been recognised.

Chapter 2 illustrated some of the specific issues with which a Police Surgeon should be familiar with examples based on the practice of clinical forensic medicine in the custody setting. It is perhaps too early to obtain the view of the courts as to whether the introduction of Healthcare Professionals by the private providers has increased the quality of evidence adduced or that the changes have made custody a safer place. It is pertinent to note that some 31 out of 39 Police Forces in England no longer use independent medical contractors, that is directly contracted police surgeons.

When the Faculty of Forensic and Legal Medicine replaced the Association of Forensic Physicians, formerly the Association of Police Surgeons, the associative functions

were derogated to an annual conference and a message board on the website of the Faculty of Forensic and Legal Medicine. The representative role of the Association was lost entirely. The Faculty of Forensic and Legal Medicine is in a difficult position: the declared aims were focused on quality and standards and consequently any associative activity would be *ultra vires*[1] of the Faculty. Whilst the Association of Forensic Physicians provided some material, for example pro-formas, the association did not undertake a thorough review of all the activities associated with Clinical Forensic Medicine. Consequently, the interest of the Faculty of Forensic and Legal Medicine is wider than the interests of the former members of the Association of Forensic Physicians. Simply because the Faculty is now the professional home of all those practicing legal medicine, the medically qualified legal advisors working for the various protection organizations through which doctors acquire professional indemnity. The medically qualified coroner, a grouping that might be expected to fall away if the Coroners and Justice Act 2009 is ever fully implemented, as well as Forensic Practitioners, which includes medically and non-medically qualified professionals working in custody suites and sexual assault referral centres.

The Faculty has developed an outline of the core competencies[2] required of a Police Surgeon, the curriculum for training, examination for entry to the Faculty, the regime for continuing professional development[3] and appraisal. These actions by the Faculty of Forensic and Legal Medicine will be worthless unless the practice of Clinical Forensic Medicine continues. The only logical way the practice can continue to progress is that it becomes recognised either as a specialty or that its practitioners are in some way accredited. This problem was discussed by Stark and Norfolk[4]when considering the training requirements of Police Surgeons. It is such discussion that will be the concern of the remainder of this chapter.

[1] *Beyond powers of a company / organisation*

[2] fflm.ac.uk/upload/documents/1178717694.doc

[3] fflm.ac.uk/upload/documents/1242897661.pdf

[4] Margaret M Stark and Guy A Norfolk, "Training in clinical forensic medicine in the UK - Perceptions of current regulatory standards", Journal of Clinical Forensic Medicine 18 (2011), pp. 264-275.

4.1 The Current position

Over the last 5 years, an increasing number of Police Forces have effectively outsourced their forensic medical requirements to private companies, such as G4S Forensic and Medical Services, rather than using Independent Medical Contractors.

The private contractors place Healthcare Professionals, nurses or paramedics, in custody suites, dealing with the clinical elements of each case. That is the well-being of the detainee and conducting limited forensic assessments of fitness for detention and interview.

The Police Surgeon makes assessments that require opinion or which the law stipulates should be performed by a Registered Medical Practitioner, for example those involving the Mental Health Act[5]and impairment assessments under the Road Traffic Act[6].

[5]Mental Health Act 1983 as amended by the Mental Health Act 2007
[6]Road Traffic Act 1988

Police Force	Provider	Police Force	Provider
Avon & Somerset	MEDACS	Lincolnshire	G4S FMS
Bedfordshire	G4S FMS	Merseyside	MEDACS
Cambridgeshire	G4S FMS	Metropolitan Police Service	Police Employed Nurses,Police Surgeons
Cheshire	Reliance	Norfolk	G4S FMS
City of London	MEDACS	North Yorkshire	MEDACS
Cleveland	Reliance	Northamptonshire	Police Surgeons
Cumbria	MEDACS	Northumbria	Reliance
Derbyshire	Derbyshire Health United	Nottinghamshire	MEDACS
Devon & Cornwall	SERCO	South Yorkshire	MEDACS
Dorset	Harmoni For Health	Staffordshire	Police Surgeons
Durham	Reliance	Suffolk	G4S FMS
Essex	G4S FMS	Surrey	NHS Trust Paramedics, Police Surgeons
Gloucester	G4S FMS	Sussex	Reliance
GMP (Manchester)	MEDACS	Thames Valley	Police Surgeons
Hampshire	G4S FMS	Warwickshire	Police Surgeons
Hertfordshire	G4S FMS	West Mercia	Police Surgeons
Humberside	MEDACS	West Midlands	Primecare
Kent	Police Employed Nurses, Police Surgeons	West Yorkshire	SERCO
Lancashire	MEDACS	Wiltshire	G4S FMS
Leicestershire	MEDACS		

Table 4.1: Providers of Forensic Medical Services 2011, England

Chief Officers of the respective forces may feel reassured that the placement of nurses or paramedics in custody suites in some way enhances safety and there might be a reduction in some of the training requirements of custody staff particularly, in the recognition and management of medical issues presented in custody suites.

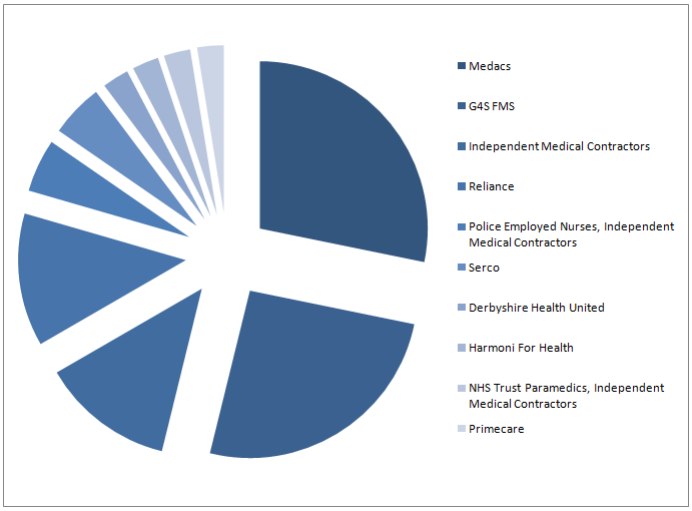

Figure 4.1.1: Providers of Forensic Medical Services

The evidence does not support the assumption that custody is a safer place for the presence of a Healthcare Professional, although the analysis of death in custody presented in Chapter 2, showed a decline in deaths in custody. The greatest fall occurred between 1998 and 2000 (60%) followed by a second dip between 2005 and 2008 (50%). The private companies were only operating during part of that time. The reduction in the number of cases of positional asphyxia resulting from better training in the use of restraint techniques is thought to account for most of the fall in deaths in custody. Disappointingly, the misdiagnosis of head injury as drunkenness has not been resolved by placing Healthcare Professionals in Custody Suites.

The private providers distinguish between clinical need and forensic need. For example the pro-forma used by G4S Forensic and Medical Services asks the detainees to consent firstly to medical services and secondly to forensic assessment[7], so that an assessment with a forensic element requires two signatures. Some might argue that any assessment has some forensic significance and such a separation is of little value.

Subjectively, the pre-employment training provided by G4S Forensic and Medical Services Ltd, was weighted to clinical issues such as the management of common medical conditions present in detainees in custody, what questions the coroner would

[7]G4S Medical Record Form

ask of the Healthcare Professionals, or what comments the coroner would make in respect of the company's services rather than what the courts need to know in terms of forensic findings[8]. This contrasts with the training provided by institutions such as the University of Central Lancashire[9], where greater emphasis is placed on the legal and forensic issues that operate in Forensic Medicine although their audience is medically qualified.

4.2 Clinical Forensic Medicine as a specialty

There is an argument that Clinical Forensic Medicine be established as a medical specialty and that Forensic Practitioners are regarded as specialists. The General Medical Council introduced a specialty register on the 1st January 1997, the implication of which was that all new consultants appointed to the NHS needed to be on the Specialist Register[10]. Specialists can be added to the Specialist Register after completing a period of specialist training and an award of a Certificate of Completion of Specialist Training, CCST. The GMC has taken over this role from the Postgraduate Medical Education and Training Board (PMETB) and certifies such training. Entry to the specialty register then is predicated on training and the presence of a consultancy in the NHS.

The work and focus of the GMC is directed to the needs of the NHS. This is understandable because of the all pervading nature and size of the NHS. The effect is that regulation of medical practice outside of the NHS is predicated on the solutions provided for the operation of medicine within the NHS. New specialties are more readily recognized if that specialty fulfills a role within the NHS and in particular if the new service is consultant led.

[8] *Personal reflection G4S FMS Induction Training 18-20 April 2010*

[9] PGDip in Forensic and Legal Medicine

[10] The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010

Specialty	*Royal College or Faculty*	Specialty	*Royal College or Faculty*
Allergy	*Royal Colleges of Physicians*	Medical Virology	*Royal College Pathologists*
Acute Internal Medicine	*Royal Colleges of Physicians*	Medical Oncology	*Royal Colleges of Physicians*
Anaesthetics	*Royal College Anaesthetists*	Medical Ophthalmology	*Royal Colleges of Physicians*
Audiological Medicine	*Royal Colleges of Physicians*	Neurology	*Royal Colleges of Physicians*
Cardiology	*Royal Colleges of Physicians*	Neurosurgery	*Committee Surgical Training*
Cardiothoracic Surgery	*Committee Surgical Training*	Nuclear Medicine	*Royal Colleges of Physicians*
Chemical Pathology	*Royal College of Pathologists*	Obstetrics & Gynae	*Roy Coll Obs & Gynae*
Child & Adl Psychiatry	*Royal College of Psychiatrists*	Occupational Medicine	*Fac of Occupational Medicine*
Clinical Genetics	*Royal Colleges of Physicians*	Old Age Psychiatry	*Royal College of Psychiatrists*
Clinical Neurophys	*Royal Colleges of Physicians*	Ophthalmology	*Roy College Ophthalmologists*
Clinical Oncology	*Royal College of Radiologists*	Oral & Maxillofacial Surg	*Committee Surgical Training*
Clinical Pharm & Ther	*Royal Colleges of Physicians*	Otolaryngology	*Committee Surgical Training*
Clinical Radiology	*Royal College of Radiologists*	Paediatric Cardiology	*Royal Colleges of Physicians*
Dermatology	*Royal Colleges of Physicians*	Paediatric Emerg Med	*College Emergency Medicine*
Emergency Medicine	*College Emergency Medicine*	Paediatric Surgery	*Committee Surgical Training*
Endocrinology & Diab	*Royal Colleges of Physicians*	Paediatrics	*Roy Coll Paed & Child Health*
Forensic Psychiatry	*Royal College of Psychiatrists*	Palliative Medicine	*Royal Colleges of Physicians*
Gastroenterology	*Royal Colleges of Physicians*	Pharmaceutical Medicine	*Royal Colleges of Physicians*
General (Int) Med	*Royal Colleges of Physicians*	Plastic Surgery	*Committee Surgical Training*
General Practice	*Roy Coll of General Practition*	Psychiatry Learn Disab	*Royal College of Psychiatrists*
General Psychiatry	*Royal College of Psychiatrists*	Psychotherapy	*Royal College of Psychiatrists*
General Surgery	*Committee Surgical Training*	Public Health Medicine	*Faculty of Public Health*
Genito-Urinary Med	*Royal Colleges of Physicians*	Rehabilitation Medicine	*Royal Colleges of Physicians*
Geriatric Medicine	*Royal Colleges of Physicians*	Renal Medicine	*Royal Colleges of Physicians*
Haematology	*Royal Colleges of Physicians*	Respiratory Medicine	*Royal Colleges of Physicians*
Histopathology	*Royal College of Pathologists*	Rheumatology	*Royal Colleges of Physicians*
Immunology	*Royal Colleges of Physicians*	Sport & Exercise Med	*Royal Colleges of Physicians*
Infectious Diseases	*Royal Colleges of Physicians*	Trauma & Ortho Surg	*Committee Surgical Training*
Intensive Care Med	*Royal College Anaesthetists*	Tropical Medicine	*Royal Colleges of Physicians*
Medical Microbiology	*Royal College of Pathologists*	Urology	*Committee Surgical Training*

Table 4.2: The 60 Recognised Medical Specialties

Clinical Forensic Medicine is not the only unrecognised specialty but unlike others such as Pain Medicine or Stroke Medicine, Clinical Forensic Medicine is a broad

subject comprising of four "*sub-specialties*," the Medical Coroner, the Medico-legal Advisor, and the Forensic Practitioner in effect the Sexual Assault Examiner and the Police Surgeon or as the Faculty terms it the Forensic Physician. There could be further diversification if the Medical Examiners introduced by the 2009 Coroners and Justice Act found a professional home in the Faculty of Forensic and Legal Medicine.

Specialty	Sub-specialty	Faculty	College
Clinical Forensic Medicine	Medico-Legal Advisor	Faculty Forensic Legal Medicine	Royal College Physicians
Clinical Forensic Medicine	General Forensic Medicine	Faculty Forensic Legal Medicine	Royal College Physicians
Clinical Forensic Medicine	Sexual Assault Medicine	Faculty Forensic Legal Medicine	Royal College Physicians
Clinical Forensic Medicine	Medical coroner	Faculty Forensic Legal Medicine	Royal College Physicians

Table 4.3: Forensic Medicine

Some specialties such as General Practice can be defined in terms of a list of domains that mirror the principles of Good Medical Practice, as proscribed by the General Medical Council and which underpin the work of those Medical Practitioners working in that field. Other specialties, for example Forensic Pathology, are defined by a matrix of domains, in this case General and Forensic pathology, against the attributes that are required of the competent practitioner. Such listings when documented are termed the blueprint for the specialty.

4.3 Steps to achieve sub-specialty status

The General Medical Council has developed a 3 step process for the formation of a new sub-specialty. The first step requires that any application be submitted by a Royal College or Faculty and that the name of the specialty is unique. Clinical Forensic Medicine would be an acceptable name and it is a term that is not widely used in Europe where Legal Medicine appears to be preferred. Of greatest significance to the process of forming a sub-specialty of Clinical Forensic Medicine is that there is evidence of a current demand or a prediction of future demand for practitioners by the NHS.

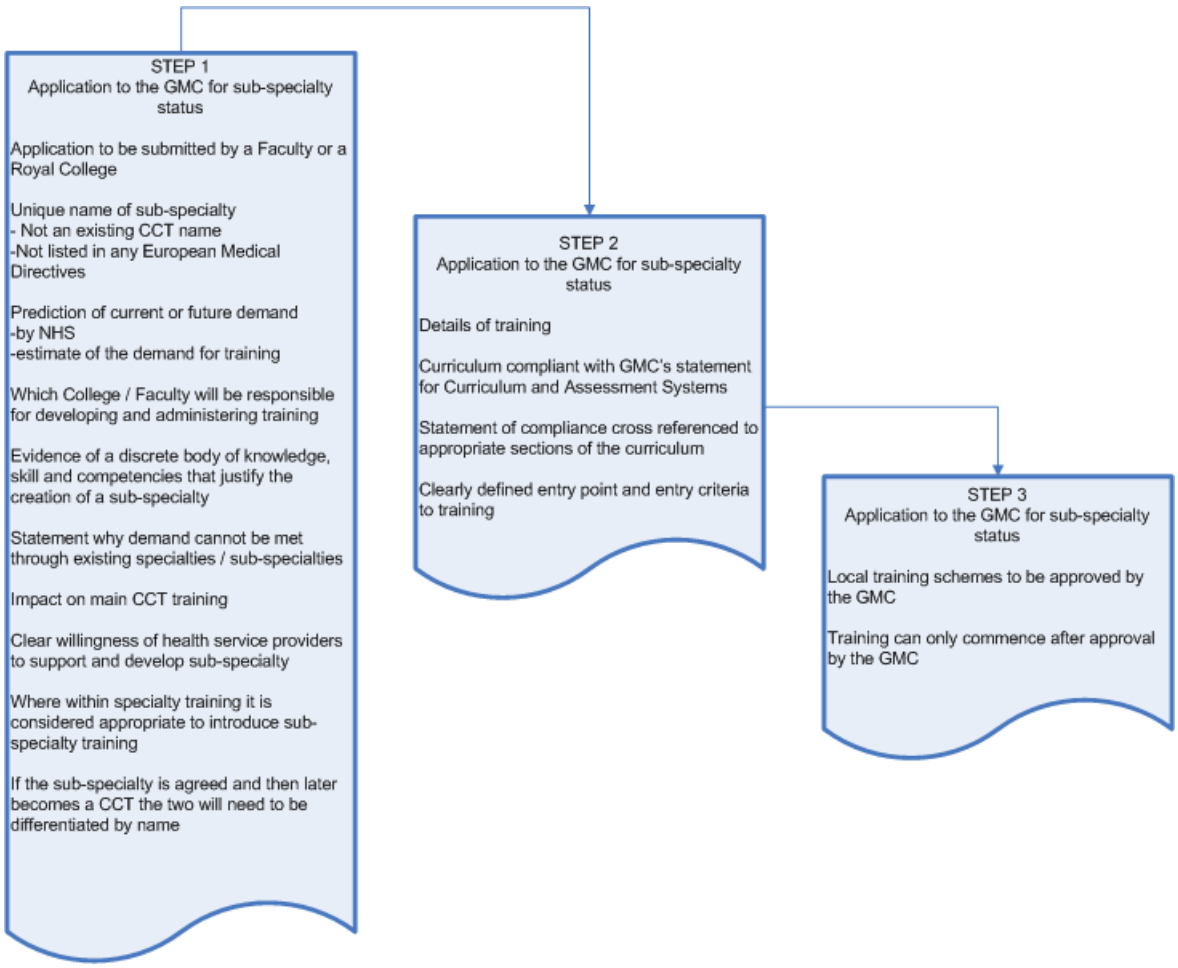

Figure 4.3.1: Steps required for Approval of a Sub-specialty

* Derived from www.gmc-uk.org/Protocol_for_approving_new_sub_specialities_and_decommissioning_those_n0_longer _required_Sept_2006__Dec_09.pdf_30847232.pdf

There is a precedent, Prison Medical Services were taken over by the NHS on the grounds that prisoners should receive the same level of medical care that is offered to the general population and that care should be delivered by General Practice Medical Teams operating through Primary Care Trusts.

At the British Medical Association's 2009 meeting the Representative Body voted in favour of the transferral of forensic medical services from UK police forces to the NHS[11]. Adopting the key message:

- ▷ *That the current management of police forensic medical services does, in some areas, not allow an individual being held in police custody to receive an equiv-*

[11]http://www.bma.org.uk/representation/branch_committees/forensic_medicine/transferralofforensicservice

alent level of healthcare to that they would receive within the National Health Service.

- ▷ *That the detainee more often than not has much greater healthcare needs and therefore requires immediate access to an appropriately trained doctor who has the relevant experience in treating such individuals within a custodial environment.*

- ▷ *That outsourcing forensic medical services to private companies provides even greater variances in the levels of accessible healthcare. Transferring the service to the NHS would ensure standards are regulated and the care and treatment of individuals are kept in-line with national policy.*

The messages may contain a hint of self-interest and are not as clear as stated. There is no requirement to diagnose or manage medical conditions over a long period of time. No account is taken of the stakeholders that are involved, the Criminal Justice System, the Association of Chief Police Officers, representing the police, the private providers consisting of a disparate group of companies each with conflicting interests, the detainees who are not represented and the existing private contractors, the Police Surgeons. Consequently, the case for the NHS to take over Clinical Forensic Medicine is difficult to make. Without the NHS operating Clinical Forensic Medical Services there can be no evidence of a demand for the sub-specialty. The evidence for demand not being met could come from the Criminal Justice System and Association of Chief Police Officer if standards are shown to have fallen since services were privatised.

Any application needs a lead organisation. This is a role that the Faculty of Forensic and Legal Medicine should undertake, but other organisations will need to support the Faculty of Forensic and Legal Medicine. These include the Royal College of General Practitioners, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatric and Child Health, the Royal College of Psychiatrists and the Royal College of Pathologists.

This large number of interested Royal Colleges reflects the varied backgrounds of Police Surgeons and the breadth of this area of practice. If General Practice was

the only entry point to Clinical Forensic Medicine all Police Surgeons would need to possess a Certificate of Completed Specialist Training in General Practice. A background in Paediatrics would be of immense value to Police Surgeons undertaking child examinations or a background in Obstetrics and Gynaecology would be ideal for sexual assault examiners. Some Pathologists that have entered Clinical Forensic Medicine rather than Forensic Pathology bring a particular understanding to injury and death.

If the Faculty of Forensic and Legal Medicine were to pursue sub-specialty status for Clinical Forensic Medicine, there needs to be an understanding with the other Medical Royal Colleges to determine at what point in their training programs training in Clinical Forensic Medicine can be undertaken. For example, does a paediatrician require possession of the Paediatrics CCST or whether Part 1 of the Membership Examination would suffice. From this perspective obtaining such agreements would seem to be a simple task but it is likely that it will require long and detailed negotiations. If such agreements could be successfully implemented then those Colleges that sign up would strengthen the case that could be presented to the GMC by the Faculty of Forensic and Legal Medicine.

If specialty status were granted there could also be difficulties. The implications of specialty status for Police Surgeon are that only trained Police Surgeons could undertake the work. In Chapter 1 the issues regarding London Police Surgeons was discussed, principally that in the Metropolitan Police where only 40.3% of Police Surgeons possess a higher qualification in Forensic Medicine. The Metropolitan Police is unlikely to support any initiative whereby the provision of Forensic Medical Services is subject to evidence of competency as demonstrated by possession of a post graduate diploma when so many of the existing Police Surgeons are operating without one, or where Tier 1 doctors cannot operate without being supervised by a Tier 2 doctor.

If specialty status were granted then practical issues arise concerning entry to the specialty. Training grades will need to be introduced just as in General Practice

where registrars occupy a training role for a short period of time. Such a hierarchy would add to the cost of Clinical Forensic Medicine competence measured by a postgraduate qualification is of course important but Police Surgeons also need experience both of life as well as medical expertise.

The essential element of the second step to be taken in application for creation of a sub-specialty is development of a curriculum that integrates with training, examination, professional development that can be audited through an appraisal system.

4.4 The blueprint for Clinical Forensic Medicine

The Faculty of Forensic and Legal Medicine has produced a document outlining the core competencies required for re-licensing and revalidation[12]. The competencies so identified are replicated in the appraisal documentation. These core competencies are a starting point in the construction of a blueprint for Clinical Forensic Medicine.

Such a blueprint in the case of Clinical Forensic Medicine has a wide scope with one section covering the general principles and separate elements covering Sexual Assault Examiners, Medico-Legal Advisors, Medical Coroners and Police Surgeons working in Custody Medicine. These domains and attributes effectively define the specialty.

[12]http://fflm.ac.uk/education/cpd/

Attribute	All	General Forensic Medicine	Custodial Medicine
Is fully registered with the GMC & ensures that professional standards applicable to their work,	✔	✔	✔
Works within their professional competence & delivers objectives to agreed standards.	✔	✔	✔
Demonstrates good professional judgment by making sound & reasoned decisions	✔	✔	✔
Demonstrates a clear pragmatic approach to effective & cost effective use of resources.	✔	✔	✔
Demonstrates a current understanding of the context of their professional work		✔	✔
Be able to take a full & competent history from an individual to inform assessment.		✔	✔
Be able to assess & diagnose the physical & mental health status of individuals.		✔	✔
Be able to provide first aid & basic life support.		✔	✔
Be competent & able to prescribe appropriate medication		✔	✔
Be able to provide good clinical management of patients,		✔	✔
Be able to provide health education interventions.		✔	✔
Have the ability to assess adequately alcohol/drug intoxication & withdrawal		✔	✔
Make precise documentation of injuries & be able to interpret them.		✔	✔
Demonstrates a full understanding of when & how to take all relevant forensic samples		✔	✔
Possess a good understanding of consent & confidentiality as they apply to the dual therapeutic & forensic roles of their work.		✔	✔
Have a good understanding of systems & procedures for safeguarding children, young people & vulnerable individuals		✔	✔
Keep clear, accurate & full contemporaneous patient records		✔	✔
Be able to prepare statements for the courts & give evidence in court effectively		✔	✔

Table 4.4: Domains and attributes for Clinical Forensic Medicine

Attribute	Custodial Medicine
Demonstrates a good understanding of PACE & other relevant legislation; have knowledge of recognised clinical standards & guidelines;	✔
Make an adequate assessment of the patient's fitness to be detained, interviewed, charged, transferred or released	✔
Make an adequate assessment of the patient's need for an appropriate adult & demonstrate an understanding of the functions of the appropriate adult scheme.	✔
Have knowledge of the legal & medical requirements involved in intimate searches	✔
Demonstrates a good understanding of mental health legislation & be able to undertake or facilitate a Mental Health Act Assessment.	✔
Show a full understanding of all aspects of relevant road traffic legislation & conduct any examination required under that legislation	✔
Demonstrate a full understanding of the clinical & forensic aspects of dying & death; be able to pronounce life extinct at a scene; & give an opinion on whether there are any suspicious circumstances.	✔
Be able to protect yourself & others from the risk of violence & aggression	✔
Demonstrate a full understanding of police restraint methods,	✔
Have a full knowledge of the medical & forensic issues as they relate to police service employees	✔

Table 4.5: Attributes for Custodial Medicine

The third step in the process is the development of local training schemes that operate under the auspices of local deaneries. There is a notable caveat in the GMC sub-specialty formation guidance that training cannot be recognised retrospectively. The Faculty is building links with Deaneries for example, appraiser training has been developed with the Workforce Deanery.

Applications requesting establishment of Specialty status have been unsuccessful as reported by Professor Ian Wall in 2009[13]. A letter more recently from Dr. George Fernie, President of the Faculty of Forensic and Legal Medicine in response to consultation on the Future Regulation of Medical Education and Training in 2010[14] ends with a demand that Forensic and Legal Medicine is accorded specialty status. The pursuit of specialty status may be more productive if the Faculty were to follow the 3 step process and accepted that it is a two-stage process where specialty status

[13]fflm.ac.uk/upload/documents/1256205657.pdf
[14]fflm.ac.uk/upload/documents/1266589233.pdf

is preceded by sub-specialty status.

4.5 Credentialing Forensic Physicians

The alternative to inaugurating a new specialty is the notion of credentialing which developed in North America, arising from attempts to measure competencies and standards as well as measure requirements and effectiveness of training[15]. The North American perception is that credentialing is a poorly defined term and can mean anything from checking a medical practitioners registration through to revalidation. The work of the PMETB placed the UK meaning as an assessment of the individual's ability to meet criteria that range from training to demonstration of competencies in delivering services or performing procedures[16]. The Tooke report in 2008[17] alerted the authorities to the need for postgraduate education and training to retain the high esteem that UK medicine had been held. Lord Darzi, became a supporter of credentialing:

> *we will develop plans to introduce modular credentialing for the medical workforce over the coming decade. This means the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience*[18]

The aims of credentialing became established as:

> *to protect the public by establishing and ensuring a minimum acceptable standard of quality and performance for doctors*

[15]J Allegrante, "Towards International Collaboration on Credentialing in Health Promotion and Health Education: The Galway Consensus Conference", Health Educ Behav 36 (2009), pp. 427.
[16]Jenkins J. 2nd Modular Credentialing Event. PMETB. 2009
[17]Aspiring to Excellence. Independent Inquiry into Modernising Medical Careers–Tooke Report 2008
[18]High quality care for all: NHS Next Stage Review Final Report. Department of Health 2008

improve or strengthen institutions and programs of professional preparation through systems of external peer review and increased public accountability, and

to promote continued professional development of the workforce in an effort to strengthen public health capacity[19].

The Tooke Inquiry[20] recommended that the GMC create a robust database of the registered certified status of all doctors practising in the UK that should include an inventory of the skill base of those in training for a specialty. This led to the formation of specialist registers and proposed a course of training and re-validation that continued after the award of a CCST, with the aim of increasing the trust of the public and authorities in the competence of the doctor. There are fears that credentialing would undermine the status of the specialist[21].

Six areas of practice that were not already a specialty were identified where credentialing could be piloted.

Specialty	Sub-specialty	Faculty	College
Pre-hospital care		Faculty of Pain Medicine	Royal College Anaesthetists
Musculoskeletal Medicine			Roy Colleges of Physicians
Cosmetic Surgery			Roy Colleges of Physicians
Breast Disease Management			
Remote and Rural Medicine			
Clinical Forensic Medicine	General Forensic Med.	Faculty Forensic Legal Medicine	Royal College Physicians
Clinical Forensic Medicine	Sexual Assault Medicine	Faculty Forensic Legal Medicine	Royal College Physicians
Clinical Forensic Medicine	Medico-Legal Advisor	Faculty Forensic Legal Medicine	Royal College Physicians
Clinical Forensic Medicine	Medical coroner	Faculty Forensic Legal Medicine	Royal College Physicians

Table 4.6: Unrecognised specialties considered for credentialing

In the Credentialing Steering Group's report to the Postgraduate Medical Training Board[22]. Crendentialisation was suggested because requests by the Faculty of

[19]Postgraduate Medical Education Training Board, "Credentialing Steering Group Report" 2010
[20]Tooke Inquiry into Modernising Medical Careers, 2008
[21]White O. Modular Credentialing: The views of the Academy Trainee Doctors Group. Academy of Medical Royal Colleges. 2009
[22]Postgraduate Medical Education Training Board, "Credentialing Steering Group Report" 2010

Forensic and Legal Medicine for specialty recognition had been declined by the Department of Health and the Postgraduate Medical Training Board. The Department of Health had followed the pathway taken by the General Medical Council that the practice of Forensic and Legal Medicine should develop as a sub-specialty of an existing CCST rather than a specialty in its own right. The Steering Group concluded that the sensitivity and the potential ramifications of the areas of practice surrounding Forensic and Legal Medicine, justified that practitioners working in this area are appropriately trained and accredited. The Steering Group felt that the Faculty of Forensic and Legal Medicine Membership Examination may be a contributory step in the credentialing of Forensic and Legal Medicine in the international arena of Postgraduate Medical Education and may provide a professional standard against which physicians working outside the United Kingdom can measure their level of attainment. The group was keen to point out that possession of the MFFLM exam was a step in training and was not an end point, or a replacement for an ongoing rigorous evaluation of the curriculum and quality assurance safeguards that are inherent in an educational program of continuous professional development.

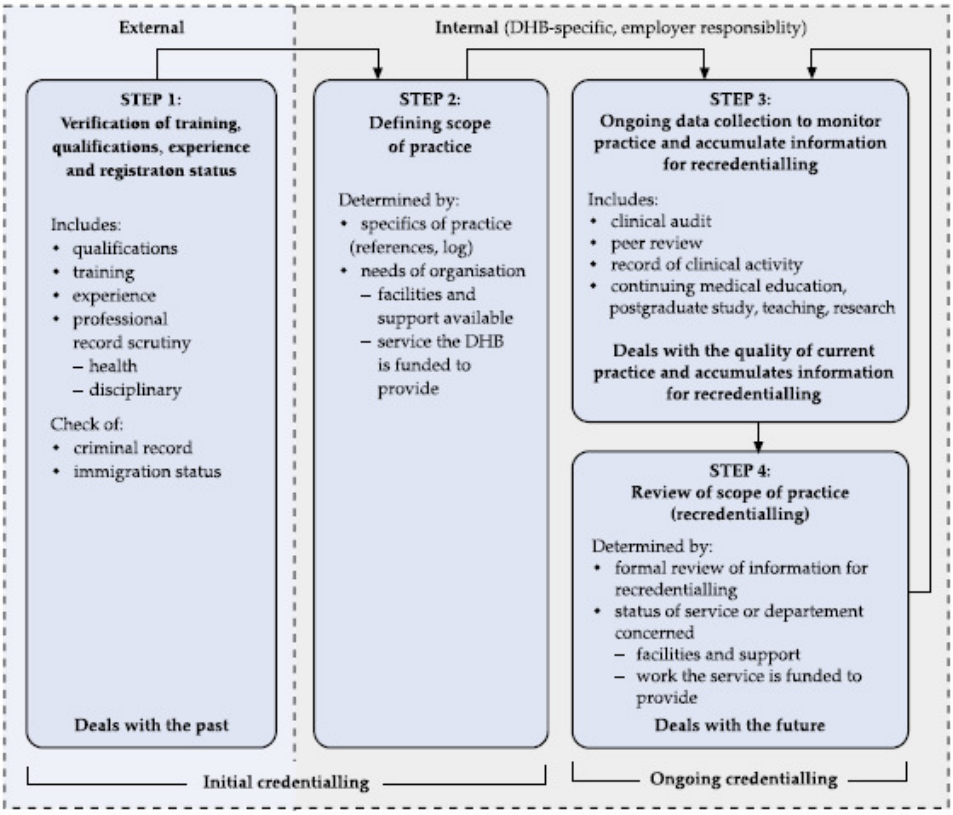

Figure 4.5.1: 4 Step credentialing process

*www.gmc-uk.org/10__Annex_A__PMETB_Final_Credentialing_Report_.pdf_36057958.pdf

4.6 Alternative Modes of Practice

Primary Care and other National Health Service Trusts might be encouraged to bid to provide Forensic Medical Services to the Police. Clearly if the private providers can make a profit any trust with a commercial instinct could use its administrative resources and existing workforce to provide similar services to those provided by the privates companies without any cost to their budget. The risk to the Primary Care Trust is that the Police Surgeons would need to be qualified and trained and expect better remuneration which places the Primary Care Trustat a disadvantage when tendering for such work. The outcome of such an approach could satisfy the General Medical Council's requirement when considering granting sub-specialty status that there is a demand from within the National Health Service for specialists. The alliance of Forensic Medicine with the National Health Service could introduce lines of accountability that could compromise the independence of Forensic Medicine.

Forensic Pathologists practice in groups and hold the subject lead when considering evidence gained for forensic purposes, for example the interpretation of injuries and their causation as well as death investigation. Consequently, there is a case that Police Surgeons could benefit from working with Forensic Pathologists and it is possible to imagine the formation of Forensic Departments that would deal with the full extent of Forensic Medicine, from arrest to the grave. This could strengthen the quality of Forensic Medicine but may weaken the independence of the Forensic Pathologists.

The requirements of the tendering process employed by Police Forces such as demonstration of financial resilience and administrative or back office functions, inhibits the provision of groups of Police Surgeons from tendering to provide Forensic Medical Services. Whereas the large providers such as G4S Forensic and Medical Services have economy of scale in terms of operating call centres and providing Human Resources and payroll function smaller groupings could operate more efficiently. Such groups would be more likely to provide a doctor-led service which might provide better reports for the courts.

Chapter 5

Conclusion

The central question of whether clinical forensic medicine and whether medical practitioners working in this are are specialists has been addressed in terms of the historical basis of the role of Police Surgeon or Forensic Physician as that practitioner is now called.

The Faculty of Forensic and Legal Medicine believe that Clinical Forensic Medicine is a medical specialty because the Faculty is bidding to obtain specialty status. The Credentialing Steering Group's report to the Postgraduate Medical Training Board[1]also recognised the special nature of Clinical Forensic Medicine when it recommend that this was a suitable area of practice in which to pilot credentialing of clinicians.

The role has existed by statute since the Metropolitan Police Act of 1829 and has developed since then until the last 10 years or so when healthcare professionals carried out some of the roles that had previously been undertaken by a registered medical practitioner.

The data provided by the General Medical Council shows the recent finding that medical practitioners are being referred to the disciplinary process, mainly for performance issues suggesting that the role requires application of working practices

[1]Postgraduate Medical Training Board, "Credentialing Steering Group" (2010)

that meet a measurable standard. The finding that only 40.3% of Police Doctors in London possess a postgraduate diploma in Forensic Medicine suggests that the standard required to practice Clinical Forensic Medicine is either low or can be acquired through experience. A subsidiary question to the Metropolitan Police might have revealed the average length of service of their police surgeons, thereby obtaining a proxy of experience.

The Faculty of Forensic and Legal Medicine by defining the domains and attributes of Clinical Forensic Medicine have identified that elements of knowledge required to undertake the role of Forensic Physician. The Faculty does not appear to have followed the steps set out by the General Medical Council to obtain approval for specialty recognition. The criteria that there is current or future demand by the NHS for Forensic Physicians is unlikely to be met and credentialing seems the only alternative for recognition of a specialist medical practitioner trained in Forensic Medicine. This appears to have been accepted in a paper co-authored by the first president of the Faculty of Forensic and Legal Medicine[2].

The specialist role is highlighted by the material reviewed in Chapter 2 which gives a view of the legal basis of Clinical Forensic Medicine. However, tensions permeate this area of practice, for example, the victim of assault data suggests that the distinction between victim and assailant can be blurred. Similarly the comments made by Nolan J that the motorist could still choose blood suggests that there remains some confusion about drinking and driving. However, the greatest influence affecting the work of the Forensic Physician is the dichotomy between a patient requiring medical attention and a detainee who is asked to submit to gathering of evidence for use in the Criminal Justice System.

It could be argued that this piece of research has been written from the perspective of one working as a Police employed individual contractor and consequently it is biased. Others might argue that the real questions is not whether Clinical Forensic

[2]Margaret M Stark and Guy A Norfolk, "Training in clinical forensic medicine in the UK-Perceptions of current regulatory standards", Journal of Clinical Forensic Medicine 18 (2011), pp. 264-275.

Medicine is a specialty or whether Forensic Physicians are specialists but whether the service provided by the private operators delivers the medical evidence required by the Criminal Justice System, how current standards can be measured, what training is required for healthcare professionals and medical practitioners, and how the interface between doctor and healthcare professional should operate.

Bibliography