

# **Ethical issues in forensic and secure environments**

A toolkit for doctors



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## Card 1: Introduction to medicine within forensic and secure environments

Doctors working in forensic settings owe the same ethical duties to their patients as all other doctors, and, as with other doctors, their primary professional obligation is to their patients. Those who may be accused or convicted of crime, or who may be claimants of crime, are entitled to the same high standards of independent and impartial medical care and treatment as any other patient. In addition to their ordinary ethical obligations to patients, forensic practitioners also have a professional role in supporting the criminal justice system. They are frequently involved in the complex medical and forensic examination of suspected victims or perpetrators of crime, often leading to the provision of evidence to the courts. Forensic physicians may also be called upon to assess the fitness of individuals for detention or interview.

There may be times when these different roles or professional obligations come into conflict. An obligation to respect patient confidentiality may conflict with the obligation to disclose information for forensic purposes. Although to some degree all doctors recognise the presence of duties additional to those they owe to individual patients, for forensic physicians, they can at times be more pronounced. Although forensic physicians have developed considerable expertise at managing these dual or competing obligations, they can still lead to confusion.

Forensic physicians work with particularly vulnerable patient populations. They frequently treat and examine patients with mental disorders, or patients under the influence of or dependent upon alcohol or other drugs, often at points of crisis in their lives. Managing violent, aggressive or intoxicated patients can present challenges, including how to balance obligations to patients with concern for personal safety and wellbeing. The sensitive management of claimants of crime, particularly violent crime such as rape or other forms of sexual abuse, requires specific skills and can raise ethical issues.

People entering the criminal justice system often come from abusive backgrounds, and there is always a risk that they will experience abuse in institutional settings. At times, part of a forensic physician's role is to advocate on behalf of their patients. This includes identifying where patients are at risk and taking all reasonable efforts to protect and promote their human rights. Forensic physicians have a duty to speak out where they identify abusive practice or behaviour, but this can sometimes present challenges in closed institutions.

This toolkit is designed to help forensic physicians navigate the main areas of ethical concern they are likely to encounter in their practice. A sound grasp of ethical principles can clarify doctors' decision-making and in this toolkit, we outline these basic principles and give advice on how they can be interpreted in practice. Although this toolkit is designed primarily to support doctors, we hope it will also provide useful guidance to other health professionals, and those in management roles in the criminal justice system who work alongside forensic physicians. The toolkit applies to the whole of the United Kingdom, and any differences between the devolved nations are highlighted throughout. This resource is not intended to be a comprehensive guide to ethical questions arising for forensic physicians. It signposts the ethical factors they need to consider when making decisions. In the final section we list other sources of more detailed guidance. When facing difficult ethical dilemmas, forensic physicians are strongly advised to seek more comprehensive guidance or further advice from the BMA, the GMC or their medical defence organisation.

# 2

## Card 2: Guiding principles

All doctors practising in the UK, including forensic physicians, are bound by the obligations laid down by the GMC in Good Medical Practice and its supporting guidance. Forensic physicians, therefore, owe the same fundamental ethical duties to their patients as all other doctors. However, the relationship between forensic physicians and their patients is slightly different to the ordinary doctor-patient relationship. For example, a forensic physician is contracted or subcontracted to the police to provide forensic and therapeutic services but, as a doctor, retains a clear duty of care to the person being examined or treated. In addition to the basic duties on all doctors, forensic physicians should:

- remember their duty of care for individuals, even where health assessments take place for reasons other than the provision of treatment
- ensure that patients are informed of the nature and extent of any dual obligations and the impact they may have on their rights and interests
- provide care that is, at least, of a comparable standard to that provided in the community
- seek informed consent, even if, as with an intimate body search for suspected concealed weapons, the law does not require it to be obtained
- respect the rights of patients to have access to appropriate information about treatment options.
- respect patient confidentiality and inform patients at the time they provide information if it will be used for purposes other than their care – they should also know what those purposes are likely to be and whether they can opt out
- respect patients' human rights and be sensitive to the ways in which they may be compromised.
- maintain robust standards of professional and clinical independence
- identify where services or conditions are inadequate and may pose a threat to health and raise concerns as appropriate
- be sensitive to the needs of patients with vulnerabilities and guard against inappropriate forms of discrimination.

# 3

## Card 3: Working with dual obligations

Many health professionals have obligations, either express or implied, to other parties or to the wider society that may conflict with their ability to focus exclusively on the interests of their patients. For most health professionals, these obligations are usually in the background. For forensic physicians it can be different. Alongside duties to patients, forensic physicians have obligations to the criminal justice system and the safety of the public, including staff caring for potentially violent patients with mental disorders.

The care and treatment of patients can therefore at times sit uncomfortably alongside the requirement to gather evidence for forensic purposes. Although there is not always tension here, there may be instances when their forensic role will not be in the interests of the individual, and conflicts, real or perceived, may arise.

Working with these dual obligations and ensuring patient interests are appropriately protected is a core part of the role of the forensic physician. Occasionally however, the pressure of institutional demands has resulted in the interests of patients, and the professional and clinical independence of doctors, being undermined. The culture of certain institutions, particularly closed institutions, can be insidiously coercive, particularly where forensic physicians are professionally isolated.

Forensic physicians also have unique opportunities to protect and promote the rights of vulnerable individuals in the criminal justice system. Professional independence and clinical objectivity are powerful tools to help identify both deliberate abuse and poor practice that can, over time, become abusive.

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### Scenario

At the request of solicitors, you examine a patient who has a history of using firearms in order to provide a report for use at a Mental Health Tribunal. Based on what he tells you, you judge the risk to others to be considerable, ongoing, and active. You discover that your report is not to be made available to the Tribunal and the Tribunal is unlikely to get access to the information you have. Do you breach confidence to provide evidence to the Tribunal of a serious risk to the public?

Ordinarily, consent for the disclosure of confidential information requires either the consent of the individual to whom it refers, or some other legal authority. Case law has clearly established, however, that where the public interest in disclosure outweighs both the individual's right to confidentiality, and the public interest in a confidential health service, information can be disclosed without consent, and even in the face of a competent refusal. This will usually be where disclosure is required to prevent or mitigate a risk of serious harm to others.

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### Managing dual obligations in practice

Given that dual loyalties are widespread in medicine, and in certain circumstances unavoidable, attention has turned to how best they can be managed. Those who practise in forensic and secure environments have developed considerable expertise in this area. Keeping in mind the basic principles given above is an essential first step to responding constructively to the tensions that arise in practice. In addition, the following points should be considered:

- where forensic physicians have direct obligations to third parties, they should ensure their patients are aware of the nature of those obligations and their implications for the patient

# 3

- forensic physicians retain a duty of care to their patients, irrespective of their duties to third parties, and are bound by the same ethical and legal obligations as all doctors
- forensic physicians must maintain the highest standards of professional and clinical independence and impartiality
- a patient's right to consent should be respected, even where it is not a legal requirement
- forensic physicians owe their patients a duty of confidentiality and information should not normally be disclosed without the patient's knowledge and consent
- forensic physicians have a duty to speak out when they identify services that are substandard or pose a threat to the health or wellbeing of their patients

# 4

## Card 4: Consent to examination and treatment

### General issues

Patients do not lose their fundamental rights to make medical decisions for themselves because they may be victims or complainants of crime. Individuals in custodial settings have the same rights to consent or refuse medical care and treatment as all other patients. For any intervention, such as intimate body searches for concealed weapons, which does not require consent in law, doctors should seek consent if the patient has capacity. A refusal should be respected. Adults should be assumed to have the capacity to consent and refuse unless it is demonstrated otherwise. Children and young people who are competent and informed can also consent to treatment on their own behalf, although there are some restrictions on their ability to refuse. Special efforts may be required to explain treatment decisions to people with learning disabilities or other form of cognitive impairment, or those who do not have English as a first language.

In all cases forensic physicians should identify themselves to the person to be examined. When seeking consent for examination, doctors should clearly explain their role and their obligations to the police or court, and their significance. Before any information is volunteered, they should clarify that part of their role is to collect evidence for the police and no assurances can be given that confidentiality will be maintained.

### Consent for examination of complainants of crime

The examination of complainants of crime, both to secure evidence and to provide any necessary medical care and treatment, is a vital part of the role of forensic physicians. Evidential examination is different in aim and procedure from clinical examination as its purpose is to elicit material evidence regarding a possible criminal charge. Where a serious crime, such as rape or assault, has taken place, there can be considerable pressure to act quickly to protect others. The time limits for obtaining supporting evidence and full information about the alleged crime mean that examinations must be carried out promptly. Complainants may be distressed, confused, injured and in pain. In these circumstances, care must be taken to ensure that consent for examination is informed and unpressurised. Although the police have made great efforts to provide support to vulnerable individuals, including victims of sexual violence, a subject's presence cannot, by itself, be taken to imply consent. For consent to be valid, the individual needs to know what the examination will involve, and be aware that forensic information, and any other information that may affect the outcome of the case, will be passed to the police. Sensitive discussion with the complainant is essential and where possible, patients' preferences regarding the gender of the examining doctor should be respected, particularly where sexual crimes are involved.

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

Examination of people in custody can be undertaken for several reasons: for the provision of care, to assess fitness for detention or interview, or for the identification of involvement in crime. Although it is lawful for some intimate body searches to be undertaken without consent – see card 11 below – the BMA and the FFLM (Faculty of Forensic and Legal Medicine) believe that doctors should only participate where the individual has given consent. Where the individual lacks the capacity to consent, doctors should only proceed where the investigation would be in the person's best interests.

The ability to give consent can be compromised by factors such as illness, distress, or the effects of drugs or alcohol. In these circumstances it may be necessary to assess the individual's decision-making capacity. Where possible, delaying any treatment or intervention until the patient regains the capacity



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to consent should be considered. Forensic physicians need to be sensitive to the possibility that detention will make some people feel under pressure to acquiesce, although this does not by itself render choices invalid. Where individuals refuse to consent, the examination should not proceed, and the refusal should be recorded in the forensic physician's notes. Doctors should remain alert to the impact of any underlying pathology on the detainee's co-operation.

There are times when information taken for one purpose may later be relevant for a separate purpose. A person with minor injuries may, for example, be examined to see if she is fit to be held in custody but it might emerge later that she sustained the injuries assaulting someone. Although she may have consented to the original examination, she might have been more reluctant if she had known the later uses to which it would be put. Patients should be informed that confidentiality is not absolute in these circumstances. Where forensic physicians have concerns that data may be used for different purposes, they should request renewed consent for its disclosure from the patient.

## Consent for examination of minors

Minors are a particularly vulnerable group in detention settings and special care needs to be taken when examining them. Ordinarily, competent young people have the same rights to consent to examination as adults. In England and Wales, for people under 16 no forensic examination or samples should be undertaken without the consent of the young person and someone with parental responsibility. The relatives of minors can be present at the examination if the young person agrees. In Scotland, where a young person is competent, they can consent to any medical examination, including for forensic purposes.

For those aged 16 and 17, any forensic examination requires the informed consent of the young person. Wherever possible, the consent of someone with parental responsibility should also be sought.

In addition to ensuring that valid consent has been received, forensic physicians need to ensure that the relevant legal considerations are met regarding the admissibility of evidence in court. In relation to consent to obtain intimate samples, appropriate consent in England and Wales is defined in relation to the Police and Criminal Evidence Act 1984 as:

- the consent of a person who has attained the age of 18 years
- the consent of the individual and their parent or guardian if the person is between 14 and 16 years old; or
- for someone under the age of 14, the consent of a parent or guardian.

Consent for examination for non-forensic purposes of children and young people should be sought in the ordinary way. A young person under 16 can consent to treatment provided they are competent to understand the nature, purpose and possible consequences of the treatment proposed. A young person under the age of 16 may not always be able to refuse treatment, particularly when it is for a serious condition and, from a clinical perspective, is demonstrably in their best interests. If in doubt, legal advice should be sought.

# 5

## Card 5: Privacy and confidentiality

The reality of life in custodial settings can obviously put the privacy of detainees under stress. The duty to respect the privacy of detainees is, however, not only a professional obligation; it is also a requirement of both the common law and the Human Rights Act. Any necessary infringement of detainees' privacy must therefore be both legitimate and proportionate.

The need to preserve the patient's privacy and dignity during examination or treatment must be balanced against the risk of danger to the forensic physician and the requirement to ensure patients' clinical needs are met. Some detainees have a history of violence or may become violent when detained. In some cases, the police may advise the doctor to exercise caution. The normal practice is to examine the detainee with protection – normally a police officer within discreet proximity. Ideally the police officer should be out of immediate earshot, although this may not always be possible.

Where lengthy interviews of unpredictable subjects are required, for example psychiatric examinations in a prison setting, it may be necessary to have staff quite close to maintain safety. Where this is not obvious to the subject, it should be made clear that the interview is not confidential.

Given the nature of custodial settings, forensic practitioners can come under informal pressure to divulge sensitive medical information to police officers and other staff. Curiosity and concern can lead to a desire by non-medical staff to find out more information about detainees. Although the closeness of working relationships in custodial settings can make such requests appear natural, professional duties of confidentiality are unchanged.

### Use of chaperones

When examining a person of the opposite sex, or in relation to any intimate examination, a chaperone should ideally be present. In addition, a detainee, victim or police officer may request a chaperone. The presence of a person employed by the police, however, could present problems of confidentiality. The Codes of Practice issued under the Criminal Procedure and Investigations Act specifically state that any police officer, or any other police employee, involved in a case has a duty to record events and to pass this information to the prosecutor. This duty extends to the chaperone. Doctors must therefore weigh up considerations of safety and confidentiality with this in mind.

### Confidentiality

As with privacy, to which it is closely linked, the confidentiality of patients may be constrained in forensic settings. The primary purpose of most examinations conducted by forensic physicians is to obtain evidence for a possible prosecution, although the evidence may, of course, be used by the defence.

Given the purposes for which data are collected, guarantees of confidentiality cannot be given, and people who are examined – both complainants and suspects – should be clear about the uses that may be made of their information. Forensic physicians should state at the outset that part of their job is to collect evidence for the police. They should also explain that they are required to disclose information obtained during the examination that might affect the outcome of the case.

Having said this, although reports that forensic physicians prepare for criminal proceedings must be given to the police, any information obtained for therapeutic purposes that does not amount to forensic evidence, and is not relevant to the criminal case, is subject to the usual rules of confidentiality.

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## **Confidentiality – the basics**

All patients have a right to expect that information about them will be held in confidence by their doctors, irrespective of their age or condition, unless there is a compelling reason for disclosure. Confidentiality is both a legal and professional obligation, rooted in the law and binding professional obligations. It is central to trust between doctors and patients.

Duties of confidentiality are not absolute. Confidential information can be disclosed where patients consent to the disclosure, where the disclosure is required by law, or where the public interest in disclosure is sufficiently strong.

Consent for disclosure will only be valid where patients are provided with sufficient information to make an informed decision. This will include what information is to be disclosed, the purposes of the disclosure and who it will be disclosed to.

If the patient withholds consent, or consent cannot be obtained, disclosure may only be made where there is lawful authority, such as a court order or other statutory justification. As mentioned above, exceptionally, disclosure can be made without the consent of a patient where it is necessary to protect the patient, or someone else, from risk of serious harm.

If the police or the Crown Prosecution Service (Procurator Fiscal in Scotland and Public Prosecution Service in Northern Ireland) request access to the therapeutic information, the individual's written consent should be sought. If they refuse, or only consent to partial disclosure, that decision must be respected unless a judge orders full disclosure. Disclosure may relate to hand-written notes made at the time the detainee was seen. In court, forensic physicians should state why the information should not be disclosed or why they think it would not affect the outcome of the case. If, however, a court order is issued, the patient should be notified and the information disclosed.

## **Custody records and confidentiality**

Concerns are sometimes expressed that forensic physicians record inappropriate medical details, such as the HIV status of detainees on custody records, without the patient's consent. This would be a breach of the physician's duty of confidentiality. Where information needs to be passed to the police about the individual's health and their need to be given medication or kept under observation, only the information necessary to fulfil this requirement should be disclosed. Where such information is provided, however, clear instructions should be given. All other information should be recorded in confidential medical notes.

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

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Detained persons are entitled to have their medical records and information kept away from non-healthcare staff unless there is a compelling reason not to do so. As in custody suites, information and instructions should be given to staff in appropriate form and separately from the running medical records.

## Sharing information with the police

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

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## Scenario

The police request to see the medical records you hold of a former patient in order to investigate a past serious crime they may have committed. They are asking to see the entire medical record in case it contains anything relevant to the crime. What do you do?

Ordinarily, consent from a person is required before any disclosure of their confidential information. In this instance, consent from the patient should therefore be sought, unless overriding reasons exist. In some circumstances, where, for example, the information may be necessary to prevent, or to prosecute, a serious crime, information can be disclosed in the public interest without consent, or in the face of a competent refusal. Only information relevant to the purposes for which it is required should be released. The police should therefore be asked to specify what information they are looking for, so that you can identify any relevant parts of the records to disclose.

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## Sharing information with other healthcare providers

As with other areas of medical practice, it is important for forensic physicians and prison medical officers to share information about their patients with other providers of healthcare where necessary and appropriate. This includes ensuring that a confidential record of any medical treatment provided, or requested, by the forensic physician while the individual is in police custody, accompanies the individual on transfer. Where another doctor, such as a psychiatrist, has been consulted or has seen the patient, this should be included in the notes. These should contain information about suspected mental disorders, physical illness, substance abuse, suicidal ideation or self-harm. Medical information should be in a sealed envelope marked 'confidential' and attached to the personal escort record (PER) form. Prison GPs, GPs and prison medical officers are encouraged to communicate with each other, with the detainee's consent, to obtain confirmation of the detainee's medical history. Forensic physicians working in a group or on a rota should ensure that appropriate procedures are in place for exchanging information when handing over the care of detainees to other health professionals.

# 5

## Assessing risk and personal escort record (PER) forms

A comprehensive risk assessment should be undertaken in relation to all detainees entering police custody. Responsibility for ensuring that this assessment is undertaken rests with the custody officer but, on the following issues, the forensic physician is likely to be asked to contribute:

- physical or mental health conditions
- medication issues
- drug or alcohol misuse
- suicidal ideation or any history of self-harm.

As part of the risk assessment, every person entering police custody must be asked a series of questions.

- Do you have any illness or injury?
- Have you seen a doctor or been to a hospital for this illness or injury?
- Are you taking or have you been prescribed any tablets or medication?
- If so, what are they and what are they for?
- Are you suffering from any mental health problems including depression?
- Have you ever tried to harm yourself?

Based on the answers to these questions, the custody officer will determine whether a healthcare professional, such as a forensic physician, needs to be called or whether the detainee should be given additional monitoring or observation.

In addition to recording risk-assessment information in the custody record, similar information must be included on a PER form, which must accompany every detainee who is moved from a police station to another location, such as to court or prison. It is not normal practice to record medical information on the face of the PER form, unless that is essential to ensure the health and safety of the detainee or others. It is not, for example, appropriate to record a detained person's HIV status on the form itself. However, communicable diseases that are transmissible through normal contact should be recorded on the form to safeguard those who come into contact with the detainee.

Information about a detained person's ongoing need for medical care, observation, examination or medication should be included on the PER form or in open attachments. Confidential medical information, however, should be attached to the PER form in a sealed envelope and marked 'confidential'. In this way confidentiality will be maintained but the information will be available in an emergency or for those taking over the medical care of the detainee. Similar procedures are in place in Scotland and Northern Ireland.

# 6

## Card 6: The medical role in control and restraint

### General principles

- Detained persons are entitled to the same standards of healthcare as the rest of society. This includes respect for their dignity and privacy.
- There should be a presumption that detainees are examined and treated without restraints, with the presence of a chaperone and without police officers, unless there is a high risk of escape or the detainee presents a threat to themselves, forensic health professionals or others.
- All decisions about restraint must be made on an individual basis, following discussions between the police officers and forensic professional to assess the level of risk in each case.

### The medical role in control and restraint

Where restraint is essential in dealing with detainees' medical needs, health professionals need to be involved. If, however, restraint or control measures are invoked for the purposes of maintaining order or discipline, this should not involve health staff. Restraint should only ever be used as an act of care and control, not as punishment or a convenience. The use of restraint can result in psychological morbidity, demoralisation and feelings of humiliation.

There is a presumption that detained individuals should be examined and treated without restraints. In some circumstances, there may be a high risk of escape, or the detained individual presents a threat to the safety of themselves or others. Any decision to restrain someone for the purposes of medical care or treatment must follow an individual assessment of the level of risk in each case. Its use must be effective, necessary, and proportionate to the risk posed by the patient, and applied for the shortest possible period.

NICE has issued [guidance](#) that practitioners should refer to regarding medical involvement in restraint, including chemical interventions to control patients. It states that rapid tranquillisation should only be performed where equipment for cardiopulmonary resuscitation is present and there are trained staff to use it. [Guidance](#) on managing acute behavioural disturbance is also available from the FFLM.

In secure psychiatric settings the use of restraint, both by staff and by mechanical equipment may be used when absolutely necessary, such as giving medication against an incapacitous patient's will, protecting a disturbed or distressed patient, or for the safety of those around a distressed individual. Where the purposes of restraint are linked to the health and wellbeing of patients, medical staff will ordinarily be involved, including assessing the patient for potential injuries following restraint.

### Restraint and control measures in custody

On some occasions, it may become necessary for police or other custody officers to use control and restraint measures to manage a violent or aggressive individual. Since this decision is not a medical act, doctors and other members of healthcare staff must have no role in this process. This includes supervising, overseeing, or advising on the use of restraint on a particular person.

All individuals must be offered the opportunity to speak with a doctor or another member of the healthcare team after every incident of restraint. This should include assessment and treatment of any physical injuries sustained, as well as the offer of emotional support.

Various international bodies have raised concerns about the prolonged or inappropriate use of restraint, including the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

# 6

(CPT). They advise that the use of physical restraint against violent detainees requires safeguards, and that:

- restraint should never be prolonged or applied as a punishment
- a record should be kept of every use of restraint or force against detainees
- detainees who have been subjected to force should be examined, and if necessary treated by a doctor as soon as possible
- if possible, medical examination should be conducted out of sight and hearing of non-medical personnel, a note should be made of findings and this should be available to the detainee
- effective inspection and complaints procedures must be in place. Detainees should be aware of the avenues of complaint open to them.

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## Scenario

You are on call for the local police station when you are approached by one of the custody officers. An individual who is well known to them has been brought in, and based on previous experiences they believe they will be required to restrain him to prevent serious violence to staff. He asks whether you can advise on the safest way to restrain the individual, and whether you can be present at the time to ensure that they are not causing serious injury.

You should explain that unless restraint is necessary for you to be able to examine and treat the individual, you cannot play a role in supervising, overseeing, or advising on its use. You should request to see the patient after any use of restraint to check for and treat any injury. If the patient still poses a risk to yourself or other members of staff, they can continue to be restrained while you assess and treat, but that decision must be made on the basis of the immediate risk posed – not just because they have a history of being violent or aggressive.

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# 7

## Card 7: The use of segregation or solitary confinement

### Basic principles

- The use of solitary confinement must be kept to a minimum.
- The use of solitary confinement must be proportionate to the harm it is designed to prevent or mitigate.
- Any use of solitary confinement must be lawful and the decision to use it taken by a competent authority.
- Full records must be kept of all decisions to use solitary confinement.
- There must be no automatic restrictions on, or withdrawals of, other rights owed to the individual, such as rights to visits, make telephone calls or access to resources normally available to detained persons.

The BMA, the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health are opposed to the use of solitary confinement for children and young people and wish to see the practice abolished and prohibited.

### What is solitary confinement?

There is a wide range of terms used in detention settings for the practice of isolating detained persons. These include segregation, solitary confinement, single separation, cellular confinement and 'time out'. The Nelson Mandela rules define solitary confinement as the confinement of detained persons for 22 hours or more a day without meaningful human contact. They define prolonged solitary confinement as any such confinement lasting for 15 days or more.

Solitary confinement is used for many purposes in detention settings: diffusing tension and possible conflicts, to prevent harm to both index detained persons and others, the safe management of difficult detainees and the management of detained persons belonging to particular groups, as well as for administrative purposes and punishment.

### Solitary confinement and health

Solitary confinement, even for limited periods, presents significant risks to physical and mental health. This is particularly so where the individual has pre-existing mental or physical health problems – both of which are prevalent in custodial settings. The impact on health increases with the length of confinement. Critically, those subject to solitary confinement have a considerably higher rate of suicide than the general prison population.<sup>1</sup>

### The medical role in solitary confinement

There will be times where it is in the interests of detainees to be kept apart from others. Given the ability for solitary confinement to undermine the health of detainees, doctors and other health professionals have a clear role to play in monitoring the health of those subject to it, particularly where it may be necessary for therapeutic reasons or the detainee's own protection. If, however, detainees are confined to maintain order or discipline, this should not ordinarily involve health staff – although all detainees must have access to a doctor. Particular problems arise where doctors are called upon to certify that an individual is 'fit' to withstand solitary confinement. In the BMA's view, doctors should not participate in certifying fitness for solitary confinement but should speak out if they think solitary confinement is undermining the health of a detainee.

<sup>1</sup> Brinkley-Rubinstein L, Sivaraman J, Rosen DL, et al. Association of Restrictive Housing During Incarceration With Mortality After Release. *JAMA Netw Open*. 2019;2(10):e1912516. doi:10.1001/jamanetworkopen.2019.12516.





Doctors should also visit individuals in solitary confinement regularly, for the duration of their confinement – typically, on a daily basis – and raise concerns about any deterioration in health identified.

The BMA has produced standalone guidance for doctors working in the youth justice system on the medical role in solitary confinement. The basic principles are also applicable to doctors working elsewhere in the criminal justice system. This is available to [download](#).

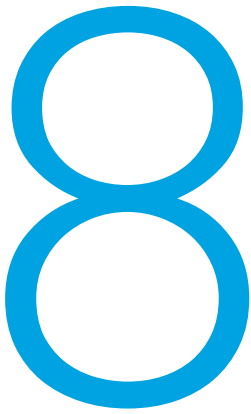
### **Solitary confinement and fundamental rights**

Although the use of solitary confinement is widespread, its ability to undermine the mental, physical and social wellbeing of those subject to it raises concern both for health professionals and those concerned with potential violations of fundamental rights in detention settings. A range of international instruments state that solitary confinement should only be used in exceptional circumstances. Both the UN Human Rights Committee and the European Committee for the Prevention of Torture have expressed concerns that in some circumstances solitary confinement may amount to inhuman and degrading treatment.

### **Children and young people**

As children and young people are still in the crucial stages of developing socially, psychologically, and neurologically, solitary confinement can have a particularly profound impact on their health and wellbeing. For these reasons, there is a growing international consensus that solitary confinement should never be used on children and young people.

The BMA, the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health are opposed to the use of solitary confinement for children and young people and would like to see the practice abolished and prohibited.



## Card 8: Managing risk and looking after yourself

No matter where they work, all health professionals have a right to a professional life that is without fear of physical, psychological or verbal violence or assault of any kind. The GMC states that: 'If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or make other suitable alternative arrangements for providing treatment.'<sup>2</sup>

The nature of the patient population group served by forensic physicians means that they may be more at risk of violence and abuse than their community or hospital-based colleagues. The role of forensic physicians can be pressured and the nature of some of the cases they respond to can be distressing. It is vital, therefore, that forensic physicians take all necessary steps to protect and promote their safety and wellbeing.

Working with custody staff to assess the risks presented by patients on a case-by-case basis is essential. A risk assessment enables physicians to strike the required balance between ensuring safety and respecting the rights and needs of patients. Although ideally consultations between forensic physicians and their patients should be in circumstances that maximise confidentiality, where patients present a risk some adaptation may be needed. In certain instances, a police officer may have to be discreetly present. If the risk is very significant some form of restraint may need to be used. Although this may be less than ideal clinically, it is vital that detainees receive necessary health care, and compromises to ensure health staff are protected may be required. It is essential that employing organisations provide training to all health professionals on reducing risk.

Risks can also be lowered by ensuring that consulting rooms are properly designed and equipped. Forensic physicians need to make sure the medical examination room is safe for both parties. For example, checking that furniture does not impede exit from the room, obvious potential weapons are removed, and you are aware of how to raise the alarm, if needed.

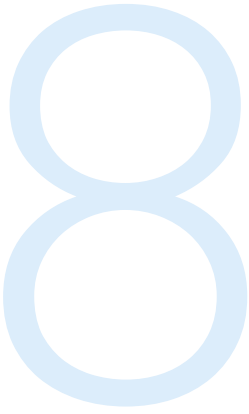
Aggression, confusion and violence can frequently be linked to underlying mental or physical pathologies or to alcohol or drug misuse. Part of a forensic physician's role is to identify any clinical contributors to this behaviour and to manage them appropriately.

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### Scenario

You are asked to assess a disturbed patient in hospital – she has been repeatedly head-banging the door to her locked room. The patient is HIV positive and you have never met her before. You are told there are insufficient staff to enter the room as a minimum of five staff trained in restraint need to be called from another ward. You are then informed the patient has become abusive, more disturbed, fashioned a weapon and opened her head wound further. The patient is bleeding profusely over her face and upper body. More staff have not arrived yet. What should you do?

This patient clearly needs immediate medical attention but also poses a very high risk to your health and safety and that of other staff. You should take all available steps to minimise the risk before providing treatment or make other suitable arrangements for providing treatment. You should collect a full history of events from witnessing staff, including the nature of injuries seen and the



signs and symptoms of serious head injuries. Until it is safe to gain access to the patient, you should view and try to speak with her through the door window and analyse behaviour on any available live CCTV footage.

You should fully and safely document the assessment from a distance and make note of the limitations and reasons preventing a more comprehensive medical examination. If the patient is seriously disturbed, you may need to enter with a 'shields team', and staff will need to take steps to minimise the risk of exposure to blood products and blood-borne viruses using full PPE (personal protective equipment).

Any use of restraint must be proportional to the risk the patient presents and exercised for the minimum amount of time required to achieve the relevant medical objectives.

Critical Incident Stress Debriefing or other formal organisational support should be available to assist all staff in dealing with the physical or psychological symptoms associated with trauma exposure. Debriefing allows those involved with the incident to process the event, reflect on its impact and be given assistance in steps to protect personal wellbeing.

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In addition to direct threats to wellbeing, doctors working in custodial settings should not underestimate the impact of the pressures of providing care in these contexts on their personal and professional wellbeing. Working in situations that can undermine the health and welfare of patients, being subject to the ongoing tensions of dual loyalties, and the sometimes challenging needs of the patient population can all have an effect. Sadly, there have been occasions when doctors have placed institutional demands before the interests of patients, leading to a loss of clinical independence and, at times, poor and even abusive practice. Doctors should remain alert to the subtle effects of institutional pressures and their ability to undermine independent professional judgment. Where doctors have concerns, they should raise these with colleagues, the BMA or their medical defence organisation.

# 9

## Card 9: Standards of care

As a basic principle, detainees are entitled to NHS standards of care. Providing healthcare in police cells and other custodial settings nonetheless presents several challenges, particularly for detainees suffering from a range of conditions, including drug and alcohol withdrawal, mental illness, head injury, epilepsy or diabetes. The care and treatment of detainees with special health needs are addressed later in the toolkit.

Police cells are not designed to hold people for sustained periods. They lack the necessary facilities to promote and maintain the ordinary wellbeing of detainees, such as access to open spaces and opportunities for exercise. Many police stations have inadequate washing and bathing facilities as well as insufficient lighting, heating and ventilation. The impact of confinement in these conditions on the wellbeing of inmates, particularly if it is prolonged, must be considered by forensic physicians. Where the facilities are clearly detrimental to the wellbeing of inmates, this must be raised with the relevant senior police officer.

The same principle may apply in prison settings where a disturbed mentally ill detained person is entitled to the same standard of basic care as they might expect if they were in hospital. This should include reasonable efforts being made to ensure that their personal hygiene is attended to and that their room is cleaned with reasonable frequency if they are unable to maintain its cleanliness themselves. A doctor involved in such a detained person's case would be expected to comment upon such issues and to escalate them if no action is taken.

The administration of medicines in police stations is an area of specific concern and the FFLM has produced detailed guidance on this issue. Depending upon the model of healthcare provision in custody suites, doctors are sometimes required to leave medicines with the custody officer for detainees to take later. The use of hospital-type medication charts can be helpful, provided custody staff are appropriately trained.

### Facilities for examination

The forensic physician's room should be a dedicated facility similar to consultation rooms used in general practice. It should be designed and laid out to reassure detainees that they will be treated with impartiality and appropriate respect for their confidentiality. Given the circumstances in which forensic physicians work, security precautions will be necessary. This may include bars on windows and alarm buttons. Doors must be equipped with locks that can be operated from the outside to reduce the likelihood of the doctor being taken hostage. Police officers must be within hailing distance. A telephone is essential, but as with other pieces of office equipment, care should be taken as it does have the potential to be used as a weapon – please see card 8.

# 10

## Card 10: Identifying abuse and raising concerns

Historically, forensic physicians have made a significant contribution to the protection of vulnerable people. They have supported the victims of crime, and their forensic skills have been used to glean evidence of crime to aid prosecution. Some forensic doctors are skilled, for example, in the identification of torture and its sequelae or in forensic anthropology, and have helped bring the practices of abusive regimes to international attention.

In custodial settings, clinical independence and professional detachment can bring genuine benefits to detainees, particularly where there is a risk that their rights may be undermined. Custodial institutions, with their focus on security and criminal justice, can be corrosive of the rights and wellbeing of detainees, which makes the role of physicians even more important.

All doctors have a duty to speak out where they believe that their patients are at risk as a result of substandard services or poor practice. The GMC states:

*You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.*

*If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.*

*If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.*

Where doctors have concerns about substandard services or poor practice, problems should be addressed as early as possible, either through formal discussion or local mechanisms. It is generally preferable to attend to problems as close as possible to their source, but they still need to be addressed robustly. Forensic physicians should identify local procedures for raising concerns and where there are threats to patient safety or wellbeing, action must be taken. Advice can be sought from the BMA or from medical defence bodies. More detailed guidance on raising concerns is published by the BMA.<sup>3</sup>

3 <https://www.bma.org.uk/advice/employment/raising-concerns/guide-to-raising-concerns>.



## Card 11: Intimate body searches for non-medical purposes

An intimate body search is defined as a physical examination of a person's body orifices, other than the mouth. Although forensic physicians are sometimes asked to perform intimate body searches, and in some circumstances consent is not a legal requirement, where the individual can make an informed decision, doctors should not perform examinations without consent. When seeking consent in a forensic setting, attention must be given to the impact of factors that may compromise or undermine an individual's ability to consent. These may include:

- the effect of illness, fear, fatigue, distress or of drugs or alcohol
- the lack of privacy in the consultation that may lead to reluctance on behalf of the patient to ask questions
- the individual may consent to procedures in the mistaken belief that it will lead to early release.

The existence of these factors does not by itself necessarily prevent individuals giving consent, but it is important for the forensic physician takes them into account. Although some professionals may refuse to undertake intimate body searches, it is worth considering that an individual may have no choice as to whether a search will be made but may prefer to be searched by a qualified medical professional rather than a custody or prison officer.

Doctors working in, or contracted to, an institution where intimate searches are likely to be undertaken should seek agreement with the appropriate officers that, except in emergencies, the doctor will always be called, and attend, when an intimate search is proposed. It does not commit the doctor to carrying out the search but it does enable them to talk to the detainee to establish their wishes and ensure that where consent is given, it is based on a proper understanding of what is involved.

Rarely, an intimate search may be justified to save a person's life, even where they have declined to consent. The individual may, for example, collapse and there may be reasonable grounds to believe that they may be carrying toxic substances. In this instance, it ceases to be a forensic search and can be justified in the individual's best interests, even where they lack the capacity to consent. Please note that this would not take place in a custody suite.

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### Scenario

An adult male has been detained in police custody on suspicion of possession of Class A drugs with intent to supply. The police believe he may have drugs concealed in his rectum. A police inspector has given consent for an intimate body search and she is quite insistent you, the duty forensic physician, undertake the search stating that 'I have given a lawful authorisation for the search, we are taking the detainee to the emergency department and you must come and do it'. What should you do?

You must resist the inspector's pressure and explain to her that you need to obtain informed consent from the detainee and then, and only then, will you undertake the intimate search. If the detainee refuses, you should record this in the notes and discuss other options, such as low-dose CT, ultrasound or x-ray, extended detention in police custody, and finally make a management plan to ensure the detainee's safe detention in custody.

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# 12

## Card 12: Taking samples

Forensic physicians are sometimes asked to take samples from detainees or from victims of crime for identification or toxicology purposes. As with all such interventions, forensic physicians need to seek the informed consent of competent individuals before proceeding.

Legally there is a distinction between intimate and non-intimate samples. Intimate samples are defined as:

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

Only registered dentists can take dental impressions. Except for urine, intimate samples can only be taken by medical practitioners or other registered healthcare professionals where authorised by an officer of at least the rank of inspector, and with the written consent of the detainee. The authorising police officer must have a reasonable belief that taking the sample will confirm or disprove the detainee's involvement in a recordable offence.

Detainees should be informed that if consent to taking an intimate sample is declined without good cause, a court may infer that the refusal may amount to corroborating evidence.

Non-intimate samples are defined as:

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

Ordinarily, police officers take non-intimate samples, although forensic physicians may also be asked. Again, they require the written consent of the detainee. If consent is withheld the sample can be taken with the authorisation of a relevant senior officer, but in the BMA's view, samples should not be taken by forensic physicians without consent.

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### Scenario

A 21-year-old man is detained on suspicion of rape, the alleged event having occurred 6 days earlier. The investigating officer requests that you take penile swabs from him but you are concerned that this is well outside the forensic window. What should you do?

You should speak with the investigating officer and explain that the forensic window for taking penile swabs is 3 days (72 hours) and taking these swabs in this situation would not only be very intrusive but would be of no forensic value so long after the alleged event. You should therefore refuse to take the samples and in explaining your reasons to the officer you may find it helpful to draw the officer's attention to the forensic sampling guidance produced by the Faculty of Forensic and Legal Medicine: <https://fflm.ac.uk/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-3/>

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# 13

## Card 13: Taking blood samples from incapacitated drivers

The Police Reform Act 2002 and The Criminal Justice (Northern Ireland) Order 2005 permit taking blood from incapacitated adults across the four nations. This puts them on the same footing in testing for drug and alcohol levels as people with capacity. The main points of the law follow.

- A blood specimen may be taken for future testing for alcohol or other drugs from a person who has been involved in an accident and is unable to give consent where a police constable believes the person to be incapable of giving consent for medical reasons (no definition of 'medical reasons' is given in the law).
- A forensic physician must be asked to take the sample unless this is not reasonably practicable, in which case another healthcare professional may be asked. A request may not be made of a doctor who has any responsibility for the clinical care of the patient. A specimen can only be taken by the doctor to whom the request is made; the task cannot be delegated.
- It is a requirement of the legislation that, before the specimen is taken, the doctor in charge of the patient's care has been notified of the intention to take blood and has not objected on the grounds that such action would be prejudicial to the patient's care.
- The specimen may not be tested until the person regains competence and gives valid consent for it to be tested.
- A person who fails to give permission for the testing of a specimen, without reasonable excuse, is guilty of an offence.
- The police have no powers to take and test blood specimens that were taken as part of the patient's care in hospital.

### Assessing capacity

Legally, it is the responsibility of the police constable to establish whether the person has or lacks capacity. Nevertheless, before taking a sample, doctors should ensure that the individual lacks capacity to consent and therefore falls within the remit of the legislation.

The relevant legal test of capacity is that the driver is: '...conscious of what he or she is doing and has heard and fully understood the request for his consent.'

Doctors will want to consider whether the person:

- understands what the request involves, and why the specimen is being sought
- understands any risks associated with the specimen being taken
- understands the consequences of refusing to give consent
- can retain the information for long enough to make an effective decision
- can weigh the information in the balance; and
- can make a free choice.

Decisions about a person's capacity may have particular implications where the person refuses to agree to a specimen being taken, since refusal without 'reasonable excuse' will lead to a charge of 'failure to provide a specimen'. Lack of mental capacity might be a 'reasonable excuse' and it is therefore important that doctors document their decisions about mental capacity carefully.



# 13

## The forensic physician

As mentioned above, the decision about whether a person has capacity to give consent to the forensic specimen being taken rests with the police constable. A doctor could not be charged with assault if they, in good faith, took a specimen without consent if the requesting police constable was satisfied that the relevant legal conditions were met. Ethically and professionally, however, it is essential that the doctor taking a specimen is satisfied that the person either:

- (a) is competent and has given valid consent; or
- (b) lacks the capacity to give consent but taking a specimen is nevertheless lawful.

Under the legislation, the police cannot require a doctor to take a specimen, it is merely lawful for a doctor to agree to do so.

The BMA and FFLM believe that forensic physicians should refuse to take a specimen in certain circumstances.

- There are medical reasons why a specimen should not be taken or to do so would be detrimental to the patient's care and treatment.
- The patient refuses or resists, since it is not ethically acceptable for doctors to use force or restraint. Whether such patients would be treated as 'competent' and be convicted for refusing to provide a specimen is a matter for a court to decide at a later date. It is therefore important that doctors document their decisions and their assessment of capacity carefully.

The person is expected to recover capacity within a short period of time, for example if they are temporarily incapacitated for the purpose of a clinical investigation. The doctor taking the specimen should determine from the treating doctor whether this is likely to be the case.

A driver cannot be penalised if the doctor does not consider it appropriate to take a specimen. Under the legislation, a blood specimen may be taken from an incapacitated patient in a hospital or, exceptionally, in a police station, although this is unlikely to be the case. If a situation arose where a specimen was taken in a police station, and the purpose of taking the sample was to test for drugs, the doctor must be satisfied that the condition of the person required to provide the specimen might be drug-related. This is not a requirement when the sample is taken in hospital.

## The treating doctor

Where the driver is a patient in hospital, as will usually be the case, the doctor in immediate charge of the patient's clinical care, who may be a junior doctor or consultant, must be informed if a specimen is required. It is not the role of the treating doctor to determine whether the patient has capacity to give consent or to consider whether taking the specimen is lawful. Their role is restricted to objecting where taking a specimen would be prejudicial to the proper care and treatment of the patient. For example, if doing so would introduce unacceptable delay to treatment, or peripheral access is difficult. Junior doctors may want to seek advice from a more senior colleague. It should not be necessary to reveal detailed clinical information about the patient to the doctor taking the specimen.

# 14

## Card 14: Assessing fitness for detention and other purposes

In addition to any necessary therapeutic assessment and treatment, assessing the fitness of individuals for detention or for interview is a critical role for forensic physicians. Any person who is detained must have a comprehensive health assessment, based upon the criteria set out by the FFLM, to determine whether it is medically appropriate for them to be detained. As highlighted throughout this toolkit, consent is required before any medical examination that involves touching of the patient. Where a patient refuses to consent, a visual assessment of the patient should be made. The implications of a refusal to be examined should, as far as possible, be carefully discussed with the patient.

Assessing individuals for detention and interview can highlight the forensic physicians' dual loyalties. The medical requirement to ensure, as far as possible, the health and wellbeing of the individual, can be in tension with the needs of criminal justice. It is vital, therefore, that forensic physicians are able to make a thorough, objective and independent assessment of the detainee's condition. During the assessment, forensic physicians should keep in mind the requirement to call for an Appropriate Adult where the individual is a juvenile, is mentally vulnerable or appears to be suffering from a mental disorder. Although responsibility for calling for an Appropriate Adult rests with the custody officer, forensic physicians should ensure they pass them information relevant to the decision.

Before detainees are interviewed by police officers, forensic physicians need to ensure that they are sufficiently fit, both mentally and physically. Dual loyalties can also be significant here. As part of the assessment process, forensic physicians need to identify:

- that the individual is sufficiently mentally competent to understand and answer questions
- whether the individual is mentally ill or vulnerable and requires the presence of an Appropriate Adult during the interview
- whether the individual requires any special provisions during the interview.

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### Scenario

You are the duty Forensic Physician and are in the custody medical room at the local police station and have been asked to see a woman who has been arrested on suspicion of harassment. You ask the custody staff to bring her to the medical room and they soon return advising you that the detainee has refused to see you stating she 'does not want to see a biased police doctor'. What should you do?

You should go down to the cell with a member of custody staff and explain who you are and that you are an independent doctor and not a 'police doctor'. You should make clear that your role is to assist her medically, but that she has the right not to see you and to refuse a medical assessment – although the option of a medical assessment will remain open. At the same time, you should assess her capacity and be satisfied that, should she choose to do so, she has capacity to refuse an examination and to remain in police custody. You should record this in your medical records and give written and verbal advice to the custody officer accordingly.

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# 15

## Card 15: Patients with particular vulnerabilities

### The mentally ill

People with mental disorders make up a considerable percentage of the detained population. They encounter the criminal justice system for a variety of reasons, many unlinked to serious crime. Some may have committed nuisance offences with the intention of obtaining shelter, warmth and food in police custody or in prison. Police stations and prisons are not ideal places to care for and treat individuals with mental disorders. Where people are suffering from mental disorders and it is not in the public interest to prosecute, it is desirable to consider available alternatives, such as cautioning or admission to hospital.

There is a range of mechanisms through which mentally disordered offenders can be diverted into the health system. A decision to prosecute is clearly not one for forensic physicians, and they should therefore avoid being drawn into this process. It is not appropriate to comment on whether a detained person should be considered for prosecution, even if invited or encouraged. That is a decision for the criminal justice authorities to make according to well defined mechanisms. When choosing whether to prosecute, the police and Crown Prosecution Service, or the Procurator Fiscal in Scotland, will balance the needs of the defendant against the public interest.

Forensic physicians should consider the importance of the medical needs of offenders with mental disorders and that wherever appropriate, and consistent with the public interest, judicial proceedings should be avoided. Custody officers are required to immediately call a forensic physician or healthcare professional if a person brought to or detained in a police station appears to be suffering from a mental disorder.

Forensic physicians are also frequently required to assess fitness for interview, advise on the need for an Appropriate Adult, and provide medical advice for the police on the individual's mental health. All of these assessments may contribute towards a decision about whether to prosecute. Some offenders never enter the judicial system but are referred straight to hospital, without being arrested or taken to the police station. Police have legal powers to remove individuals with mental disorders to a place of safety if they seem to need immediate need of care and control. Evidence suggests, however, that there is some reluctance among the police to use these powers, relying instead on standard powers of arrest. The inevitable consequence is that more people with mental disorders, arrested for minor offences, attend police stations and need to be seen by forensic physicians. If a forensic physician believes that immediate diversion to a health facility would be appropriate, they should let the custody officer know.

The PACE (Police and Criminal Evidence) Act provides safeguards for vulnerable people, including those with mental illness, being interviewed by the police.

If an individual with a mental disorder is not to be further detained, consideration must also be given, as appropriate, to their fitness to be released.

### Patients with alcohol-related problems

Forensic physicians see large numbers of patients with alcohol-related problems. Consultations will frequently involve both forensic and therapeutic examinations as well as assessments for fitness to be detained.

The police are generally cautious in dealing with intoxicated detainees and some custody officers have expressed concern about patients dying while in their care. There are considerable risks involved in the management of patients dependent on, or under the influence of, alcohol in police custody.

# 15

Forensic physicians may not be in a position to constantly observe intoxicated patients needing regular review. Since alcohol withdrawal can be dangerous, consideration should be given to hospital referral, where appropriate. Referral to an accident and emergency department is not suitable, and instead referral should be made to the emergency medical team of the local hospital. Where there is any suspicion that the patient may have received a significant head injury, the patient should immediately be referred to hospital irrespective of their alcohol consumption.

Recommendations for improving the care and management of intoxicated detainees include: the installation of closed-circuit TV in certain cells to enable remote supervision of vulnerable detainees; having medically trained personnel in custody suites during peak periods; and greater use of detoxification centres.

In an effort to reduce alcohol-related incidents among certain groups, forensic physicians should consider the use of 'brief interventions' in the custody setting. These usually involve:

- an alcohol intake assessment
- the provision of information on hazardous or harmful drinking
- offering clear advice, including the provision of booklets and details of local services
- attempts to understand the triggers for drinking and discussion with a view to setting realistic goals for alcohol consumption management.

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

## Patients who misuse drugs

The police have legal powers to test individuals who are detained for certain trigger offences, such as street robbery or burglary, for heroin, crack and cocaine. Those who test positive must participate in a compulsory drug assessment by specialist drugs workers to determine the extent of their drug problem and help them into treatment and other support, even if they not charged. Those who fail to provide a sample or comply with a required assessment can be fined or imprisoned.

Those with substance use disorders in police custody have rights to the same high standards of healthcare as those in the community. Timely and accurate assessment of both substance dependencies, including the nature and degree of dependency, need for medical support, and any underlying physical or psychiatric morbidity, is essential.

There has been significant change to the delivery of drug-dependency services in the UK, and some local variation exists. Healthcare professionals should know whether there is access to [Criminal Justice Integrated Team \(CJIT\)](#) workers locally who are members of a multi-disciplinary team providing support, advice, brief and structured interventions to individuals with substance use disorders within the criminal justice system.

Joint [guidance](#) on the clinical management of those with substance disorders in police custody is available from the FFLM and The Royal College of psychiatrists.

# 15

## Patients suffering pre-existing medical conditions

Some detainees arrive in detention suffering from pre-existing medical conditions. Police cells are not ideal settings in which to manage these and in some circumstances, referral to hospital may be necessary.

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

Seizures are a common complaint amongst detained persons, and are often associated with a history of alcohol, or other drug-related withdrawal. It is usually straightforward to manage in police custody – unless the detained person is an ‘unstable’ epileptic, when hospital admission will be indicated. Police officers should put the patient in the recovery position in the event of a fit, and contact a healthcare professional, or transfer the detained to hospital. A patient having more than one fit, or their first fit, should be referred to hospital.

## Patients with head injuries

Head injuries, particularly when associated with alcohol consumption, are potentially dangerous cases to manage in police stations and are a common cause of death in police custody. Although custody officers are advised to rouse and speak with the drunk detainees every 30 minutes, it is unreasonable to expect non-medically trained police officers to keep close clinical observation over detainees with a head injury. If there are no embedded healthcare professionals in the custody suites, custody officers must be given clear instructions about what to look out for and when to call a forensic physician. The FFLM advises that a head-injured patient should be referred to hospital if **any** of the following are present (a head injury is defined as any trauma to the head other than superficial facial injuries):

- any loss of consciousness (knocked out) as a result of the injury, from which the person has now recovered
- amnesia for events before or after the injury problems with memory
- persistent headache since the injury
- any vomiting episodes since the injury
- any previous brain surgery
- any history of bleeding or clotting disorders
- current anticoagulant therapy
- current drug or alcohol intoxication
- there are any safeguarding concerns for example, possible non-accidental injury or a vulnerable person is affected
- irritability or altered behaviour, particularly in infants and children aged under 5 years easily distracted, not themselves, no concentration, no interest in things around them
- unconsciousness or lack of full consciousness for example, problems keeping eyes open
- any focal neurological deficit since the injury
- problems restricted to a particular part of the body or a particular activity, for example, difficulties with understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking
- any suspicion of a skull fracture or penetrating head injury Signs include clear fluid running from the ears or nose, black eye with no associated damage around the eyes, bleeding from one or both ears, bruising behind one or both ears, penetrating injury signs, visible trauma to the scalp or skull of concern to the HCP
- any seizure (‘convulsion’ or ‘fit’) since the injury

# 15

- a high-energy head injury For example, pedestrian struck by motor vehicle, occupant ejected from motor vehicle, fall from a height of greater than 1 metre or more than 5 stairs, diving accident, high-speed motor vehicle collision, rollover motor accident, accident involving motorised recreational vehicles, bicycle collision, or any other potentially high-energy mechanism.

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

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## Scenario

A patient in prison has been declining food and fluid for the last 14 days. He has also been refusing his antidepressant. He now refuses all observations and looks dehydrated. How should you respond?

Adults with the capacity to make the decision have the right to refuse treatment – and food and fluids – even where it may lead to serious harm. It is important to try as far as possible to explore the reasons for refusal with the patient, making it clear the likely impact of his choices. If the issue cannot be resolved, it would be advisable to undertake a formal capacity assessment, or to commission one from a psychiatrist, to identify whether he has an impairment or disturbance of cognition that renders him incapable of deciding for himself. He will be incapable if a) he has such an impairment or disturbance and b) as a result, he cannot do any of the following: 1) understand the decision, 2) retain that information long enough to, 3) use it to come to a decision that 4) he can communicate back to you, by any means. It may be beneficial to seek treatment from a healthcare team independent of the criminal justice system, so have a low threshold for offering an external hospital transfer.

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# 16

## Card 16: Providing medical care to people detained under anti-terrorism legislation

The care and treatment of people detained under anti-terrorism legislation can present particular ethical and human rights challenges. Currently, under the amended Terrorism Act 2000, people can be detained without charge for up to 14 days.

Extended detention in police cells can have implications for the wellbeing and medical care of those detained. Police cells are ill-suited for sustained periods of confinement, lacking facilities for exercise and access to open spaces and to fresh air. They are not ideal for those suffering from serious medical conditions. Confinement for long periods can also increase vulnerability to abuse.

Where people are detained under anti-terrorism laws, forensic physicians should ensure that they have a medical examination on arrival to ensure their fitness for detention and interview. There should also be a complete examination of the surface of the body to note any injuries. Given the possibility of hunger strikes their weight should also be measured. The assessment should identify any physical or mental health problems and a care management plan should be agreed. In addition, forensic physicians should ensure that those detained under anti-terrorism legislation:

- have a further medical examination before release, and before and after being removed from the premises; this should again include a completed body surface examination to record any injuries
- be offered a daily medical and welfare examination by a forensic physician
- have a careful assessment of their medical and welfare needs, including any special dietary, hygiene, exercise, privacy or religious needs.

Managing the health and wellbeing of those detained in this way can be challenging and time-consuming. Ideally there should be a pool of experienced doctors of all genders willing to provide support in those areas where these detainees are frequently seen.

Any healthcare professional who is aware of, or suspects that any detainee is being abused, must report it as a matter of urgency to the appropriate authorities.

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### Scenario

You are requested to conduct a fitness for detention assessment for a man who has just been detained under the Terrorism Act on suspicion of bomb-making. He informs you that he was forced into assisting with the alleged events and states that he did this under duress and was beaten by others the day before. He states that he has several 'tram-line' bruises to his right thigh as a result of this. However, you have also been advised by the custody officer that he resisted arrest and was struck once with a police baton by a police officer.

With his consent you should examine him and document the injury on a body diagram. Whilst this might be a plausible explanation for his injury and might form part of a defence, there are other possible causations, including use of force by the police. You should advise the custody officer verbally and in writing that he has an injury and recommend that his injury should be photographed.

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# 17

## Card 17: Acting as professional and expert witnesses

Doctors can act as various types of witnesses, entering the court as either ordinary, professional or expert witnesses. Ordinary witnesses are asked to report what they have seen or heard. Doctors acting as professional witnesses are asked to comment on matters of medical fact, usually in relation to patients they have seen or treated. Experts, on the other hand, are invited to say what they have seen and heard, and express an opinion based on all available evidence.

When doctors are instructed as expert witnesses, their primary duty is to assist the court on specialist or technical matters within their expertise. Detached objectivity is always required and it is not the role of the expert to plead any particular side of the case. Doctors should remember that their opinion may be challenged in court, and that their evidence and reasoning may be subject to searching cross-examination. If there is a range of expert opinion on the subject at hand, doctors should summarise this and indicate the basis for their own opinion.

When preparing a report as an expert witness, doctors should ensure they clearly understand what is being asked of them and request all relevant information such as any pleadings, witness statements, investigation reports or previous medical records. Doctors should restrict their testimony and opinions to issues that lie within their professional competence, and are based on the available information. It is therefore important to clearly state if evidence has not been seen which is believed to be relevant, or if the opinion given is preliminary.

Where doctors are asked to undertake medical examinations for the preparation of a report, they should make it clear to the patient that the examination is not for therapeutic purposes. Consent must be sought both for the examination and for the subsequent disclosure of information.

As a general principle, doctors should not accept instruction where there is an actual or potential conflict of interest. Should a conflict of interest arise during the preparation of a report, the doctor must notify all concerned and, if appropriate, stand back from the case.



# 18

## Card 18: Important sources of further information and support

The British Medical Association has an extensive range of ethical guidance for doctors. <https://www.bma.org.uk/advice/employment/ethics>.

The Faculty of Forensic and Legal Medicine (FFLM) of the Royal College of Physicians is an essential source of advice and support. <https://fflm.ac.uk/>.

The General Medical Council (GMC). Guidance on good medical practice for all doctors is available here: <https://www.gmc-uk.org/ethical-guidance>.

Healthcare for Offenders. Government guidance on offender health care. <https://www.gov.uk/guidance/healthcare-for-offenders>.

The Royal College of General Practitioners (RCGP) has a secure environments group (SEG). <https://www.rcgp.org.uk/clinical-and-research/about/clinical-news/2019/february/healthcare-in-secure-environments.aspx>.

**BMA**

British Medical Association, BMA House,  
Tavistock Square, London WC1H 9JP  
[bma.org.uk](http://bma.org.uk)

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