the doctor’s bill
the provision of forensic medical services to the police
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# The Need for Review

The forensic medical service needs to change to meet the complex demands of modern policing.

# Current Arrangements for the Provision of Forensic Medical Services

Current arrangements are under strain in many areas and are not delivering value for money.

# Improving Forensic Medical Services

Improvements are possible within the current framework, but more radical options for delivering forensic medical services should also be considered.
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First published in March 1998 by the Audit Commission for Local Authorities and the National Health Service in England and Wales, 1 Vincent Square, London SW1P 2PN

Printed in the UK for the Audit Commission by Belmont Press

ISBN 1 86240 084 9
Preface

Forensic medical services have a relatively minor impact on police forces in financial terms, but they can have a significant impact in the operation of police custody suites, and indeed on the workings of the criminal justice system. Moreover, demand for police surgeons to attend police stations – and thus the cost of the service – has been rising steadily. Developments such as the rise in drug abuse, techniques such as DNA analysis and the use of CS sprays signal that this demand will continue to increase.

This report considers whether a service that has developed piecemeal over the last 150 years is able to meet the complex demands of policing in the 1990s and beyond. Signs of strain are beginning to emerge in some areas. First, some forces are struggling to recruit and retain sufficient doctors to act as police surgeons; and those that have enough doctors on their books often face difficulties in securing prompt attendance to particular scenes. Second, the quality of the service provided to direct customers – the prisoners – and indirectly, to forces, is variable. Third, forensic medical services lack a coherent management framework – there is no standard approach to recruitment, contractual arrangements, training or quality assurance, and forces lack the information that they need to ensure that they are getting value for money.

The report identifies immediate remedies to some of the problems and shortcomings, but also raises two more radical issues. One is that many of the tasks undertaken by police surgeons – for example, dressing minor cuts and taking blood samples – are routine in nature and in almost any other setting would be carried out by a nurse or other health practitioner. The report recognises that departing from this approach entails a degree of risk but may be justified on cost-effectiveness grounds. It therefore suggests that the Home Office reviews the current legal requirement that all of these tasks are carried out by doctors. The second departure from conventional approaches is to suggest that some forces may be better served by replacing the individual contract basis of provision with an outsourced contract for the entire forensic medical service.

The report is based on fieldwork in six police forces and visits to two others; the study team comprised Kate Flannery and Helen Oxtoby, with consultancy support from John Saunders, formerly of Suffolk Constabulary. An Advisory Group of practitioners and other interested parties, the membership of which is detailed in the Appendix, provided valuable assistance and professional insight. The study has also benefited from excellent co-operation from the forces visited, the Home Office and the Association of Police Surgeons; and from individuals and organisations who offered their advice and comments on drafts of this report. The Commission is grateful for these contributions but, as always, responsibility for the conclusions and recommendations rest with it alone.
The Need for Review

Forensic medical services have developed piecemeal over the last 150 years. The volume of work has increased significantly, and the nature of the tasks carried out by police surgeons has changed. A review is needed to ensure that this important service can meet the complex demands of policing in the 1990s and beyond.
This scenario... highlights the important role that police surgeons play in police stations and at other scenes to which police officers are called.

1. On a Saturday night in a busy town centre police station, the eight detention cells are full. Among those detained are two men who were arrested after fighting broke out in a nearby pub; one of the area’s most persistent burglars has been charged with attempting to break into a chemist’s shop; a woman driver has been breathalysed at the roadside and is suspected to be over the legal limit for alcohol; and patrol officers have brought in a man whom they believe is suffering from a mental disorder and should be detained for his own safety.

The custody officer has some critical decisions to make. Are the two pub brawlers fit to be interviewed, or are they too drunk to understand the questions put to them? The burglar is a drug addict and claims to be suffering withdrawal symptoms – should he be sent to hospital? Should the suspected drunk driver be required to provide a specimen of blood or urine to confirm whether she is over the limit? And how should the mentally disordered man be dealt with? The custody officer is guided in his decisions by the Police and Criminal Evidence Act 1984 (PACE). This covers not just the essential bureaucracy of arrest and detention – making sure, for example, that prisoners are advised of their rights and that proper records are kept of key decisions – but also the circumstances in which medical attention is required [BOX A, overleaf].

2. Given the circumstances described above, the custody officer makes an immediate decision to call a doctor to carry out the blood test on the suspected drunken driver, and to assess the medical condition of the remaining prisoners whose state has given cause for concern. The doctor he calls is the police surgeon,1 typically a general practitioner who has agreed to provide an on-call service to the police force in return for a fee. A rota system operates in most areas, and the custody officer calls the doctor scheduled to be on call that evening. However, the doctor has already been called out by the police to examine the body of a person who has died suddenly; he is on the other side of town and will not be able to attend the station for at least two hours. Time is of the essence because the blood-alcohol reading of the breathalysed driver is dropping all the time, and so the custody officer rings several other police surgeons until he finds one who can come straight to the station.

This scenario is commonplace within busy custody areas. It highlights the important role that police surgeons play in police stations and at other scenes to which police officers are called. It also highlights some of the pressures that are discussed in this report – the growth in the number of detentions that require the services of a police surgeon, the critical nature of the decisions made by custody officers, and problems around the availability of doctors to provide forensic medical services.

1 In some forces, notably the Metropolitan Police Service (MPS) and other large metropolitan forces, police surgeons are referred to as forensic medical examiners, or FMEs.
The role of the police surgeon has evolved over decades, beginning with the appointment in 1830 of a doctor to examine potential recruits to the newly established Metropolitan Police force. Up until 1948 and the creation of the National Health Service (NHS), their principal role was to act as physician to police officers and their families. When these patient care responsibilities transferred to the NHS, the focus of police surgeons’ work moved to the police station, attending to the general medical needs of prisoners and carrying out forensic examinations (that is, those which assist the police and the courts in the investigation of crime) of crime victims, suspects and witnesses.

5. The role of the police surgeon has evolved over decades, beginning with the appointment in 1830 of a doctor to examine potential recruits to the newly established Metropolitan Police force. Up until 1948 and the creation of the National Health Service (NHS), their principal role was to act as physician to police officers and their families. When these patient care responsibilities transferred to the NHS, the focus of police surgeons’ work moved to the police station, attending to the general medical needs of prisoners and carrying out forensic examinations (that is, those which assist the police and the courts in the investigation of crime) of crime victims, suspects and witnesses.
Two recent pieces of legislation have increased the need for police officers to call upon the services of police surgeons. The first was the Road Safety Act 1967, which introduced the breathalyser test for suspected drunk drivers and the confirmatory tests of blood or urine taken at the police station. A police officer can oversee the submission of a urine sample but, under the terms of the Act, a blood test must be administered by a medical practitioner. Providing an opinion on whether a person was intoxicated had always been a core task of police surgeons, but the increase in both car journeys and police activity around drunk driving following the 1967 Act meant that, by the early 1970s, the bulk of surgeons’ visits to police stations related to blood tests of suspected drunk drivers [EXHIBIT 1]. Even more significant was the introduction of PACE, with its comprehensive rules on examining and treating persons in custody. Whereas in 1974 the examination of prisoners – other than to take a blood sample – typically absorbed less than 10 per cent of surgeons’ time, by the late 1980s this task predominated. Two further factors are having an impact upon the work of police surgeons and custody sergeants: the increasing reliance upon community-based care for mentally ill people, and the growth of a drug culture.

These developments have led to changes in the nature of police surgeons’ work rather than the absolute volume. Precise insights into trends of demand or workload patterns are not available because most forces do not, for example, analyse the number of call-outs or their nature. Typically, the cost of the police surgeons’ service is the principal measure of changes in the volume of work; it stands at some £20 million in 1996/97, compared to around £12 million in 1991/92.

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EXHIBIT 1

Changes in the work undertaken by police surgeons, 1974 to 1997

Examination of prisoners has become the most significant element of police surgeons’ workload.

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Source: The Role of Police Surgeons, RCCJ Research Study No. 6 (Ref. 2) and Audit Commission fieldwork
This sum relates almost entirely to the fees and expenses paid to individual doctors: the balance comprises training costs, administration and facilities at police stations (although these costs are rarely broken down as separate budgetary items). Police surgeons are paid a retainer – an annual amount to compensate them for being ‘on call’ – plus fees for each call-out and travelling expenses as appropriate [BOX B]. The details of this financial framework are agreed nationally in a formal negotiation process between the Local Government Management Board, which represents police authorities, and a subcommittee of the British Medical Association representing surgeons’ interests. The retainer is currently set at £2,490 for full police surgeons and £490 for deputies: call-out fees range from £21.50 to £66, depending upon the time of day or night and the type of work undertaken. Expenditure varies between forces, both in the total amount spent – ranging from £5 million spent last year by the Metropolitan Police Service to £35,000 by the City of London – and the average amount spent per surgeon, which varied last year from around £2,000 per year to more than £40,000.

Thus the cost of the forensic medical service borne by an individual force will be a product principally of the number of times that it calls out a police surgeon, together with the nature of the examination undertaken and the number of doctors on the books who qualify for the annual retainer. In fact, the precise number of doctors providing police surgeon services in England and Wales is not known. Recent research undertaken by the Home Office (Ref. 3) found that some 900 doctors are appointed on a contractual basis and receive an annual retainer. These provide the bulk of the service to the police. Most forces also use non-retained doctors, either as cover for their retained surgeons, as specialists (for example, in mental health) or simply to increase the number of doctors upon whom they can call in an emergency. In some areas, it is common for one GP in a practice to be the retained police surgeon but for police work to be shared among all doctors in the practice.
The fee structure not only compensates doctors for the anti-social nature of night call-outs, but also reflects the fact that some aspects of the work are intrinsically more complex than others. Tasks fall into two principal categories, with the first category attracting a higher fee rate:

- **forensic examinations**: assisting the police in ‘the proof of cases’, making statements and in some cases giving evidence in court. Such forensic work includes taking blood samples from people suspected of driving while intoxicated; examining police officers and detained persons where there has been an allegation of assault; attending the scene of an unexpected death to confirm/exclude suspicious death; and examining suspects or victims – for example, where a sexual offence is being investigated. (To avoid cross-contamination, the same police surgeon would not examine both suspect and victim in a particular case.)

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**BOX B**

The national fee structure for police surgeons

1. **Availability fees (per year)**

<table>
<thead>
<tr>
<th>Surgeon Role</th>
<th>Fees</th>
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<tbody>
<tr>
<td>Full surgeon</td>
<td>£2,490</td>
</tr>
<tr>
<td>Deputy surgeon</td>
<td>£490</td>
</tr>
<tr>
<td>Seniority supplement</td>
<td>£840</td>
</tr>
</tbody>
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2. **Attendance fees (per examination)**

<table>
<thead>
<tr>
<th></th>
<th>‘A’ rate (forensic examinations)</th>
<th>‘B’ rate (non-forensic cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First case in call-out</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day</td>
<td>£44.00</td>
<td>£32.30</td>
</tr>
<tr>
<td>Night</td>
<td>£66.00</td>
<td>£48.50</td>
</tr>
<tr>
<td><strong>Subsequent cases in call-out</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day</td>
<td>£29.30</td>
<td>£21.50</td>
</tr>
<tr>
<td>Night</td>
<td>£44.00</td>
<td>£32.30</td>
</tr>
</tbody>
</table>

An additional fee is payable if the doctor is required to submit a written report of his findings. Travel expenses are also paid.

*Source: Local Government Management Board*

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1. These rates are subject to change, pending the outcome of current negotiation.
The provision of medical services to police forces is under the spotlight

The need for review

11. At first glance, a service costing some £20 million a year out of a total police service budget of £7 billion may not seem to merit intensive scrutiny, even though the cost has been rising each year for the last decade or more. But there are three main reasons why the provision of medical services to police forces is under the spotlight:

- The continuing spread of alcohol and drug abuse, the introduction of incapacitant sprays to assist in maintaining public order and technological developments such as DNA analysis are just three factors pointing to further growth in demand for police surgeons to attend police stations and other scenes. If doctors are unable or unwilling to act as police surgeons in sufficient numbers to meet this demand, police forces will experience increasing difficulty in fulfilling their statutory and other obligations in respect of detained persons.

- Forensic medical services are a key interface between the police and the public, and can have a significant impact on the workings of the criminal justice system. It has been noted that ‘the most modest interaction with a prisoner can result in the doctor concerned having to attend the highest court in the land to give evidence’ (Ref. 2). Although mistakes and tragedies are extremely rare, they do occur – there have been almost 400 deaths in police custody since 1990, and in every case the actions of any custody officers and police surgeons involved are subject to minutely detailed investigation.

- Despite their importance, forensic medical services have traditionally escaped managerial scrutiny. The performance management culture that has taken root in police forces has, however, led some chief officers to ask whether current arrangements are operationally efficient, offer value for money and guarantee that appropriate quality standards are maintained.

12. Forensic medical services have developed piecemeal over the last 150 years, and will need to evolve further to meet the complex demands of policing in the 1990s and beyond. What improvements might address the problems that exist in the current arrangements? And are there alternative forms of provision that might fit the bill more effectively?
Current Arrangements for the Provision of Forensic Medical Services

Signs of strain are beginning to show in forensic medical services. Some forces are struggling to recruit police surgeons, while others face difficulties in securing prompt attendance to particular scenes. The quality of service is variable, although much of it reaches consistently high standards, and forces need to incorporate this work into their performance management systems.
13. Identifying the scope for improvement in the current arrangements should start with the front line for forensic medical services – the custody suite. There are two principal ‘clients’ for the medical services provided in police stations. One is the prisoner, who has either requested to see a doctor or a decision has been taken on his or her behalf that medical attention is advisable. The other is the force itself, which requires input from medical practitioners both to ensure that it is fulfilling its statutory obligations under PACE, and to pursue criminal investigations. Difficulties in meeting the growing demand for police surgeons, ensuring the quality of service on offer and monitoring performance are experienced most acutely in this operational ‘nerve centre’ of the police station. In particular:

- the increasing demand for forensic medical services is largely, but not entirely, outside the custody officer’s control;
- in some areas it is difficult to recruit and retain sufficient numbers of police surgeons to meet demand;
- even when there are sufficient doctors under contract to cope with the overall workload, problems occasionally arise over attendance to particular call-outs because of rostering problems or the specialist nature of the examination;
- custody areas are often ill-equipped to meet the medical needs of prisoners;
- communication and feedback between custody officers and police surgeons do not always meet the high standards required for prisoner safety;
- the work of police surgeons is not governed by a management framework that covers contractual arrangements and quality assurance; and;
- police forces lack the performance information necessary to ensure that they are getting value for money or to inform decisions about alternative arrangements.

**The exercise of discretion**

14. Forensic medical services are demand-led, largely in response to the provisions of PACE. But the PACE Codes of Practice are not wholly prescriptive – they have to be interpreted, and the exercise of discretion can lead to marked variations in the demand for police surgeons to attend stations. Forces with similar numbers of persons in custody – for which the number of persons arrested is a reasonable proxy – are spending very different sums on calling out police surgeons [EXHIBIT 2]. This analysis is supported by other research. For example, a limited sample of records carried out in 1992 suggested that doctors working in the Metropolitan Police area were called out to see one prisoner in four, while the average in provincial stations was one call-out for every nine prisoners (Ref. 2).¹

¹ Information provided by three forces for the first part of 1997 shows a range of one call-out for every ten prisoners (Suffolk) to one call-out for every 20 prisoners in Devon and Cornwall.
EXHIBIT 2

Link between police surgeon costs and number of arrests

In some forces, the lack of correlation between demand and expenditure on police surgeons suggests that discretion is exercised by custody officers to very different degrees.

Note: Force B has more than three times the number of arrests (a proxy for the number of detained persons) than Force A, but spends almost 50 per cent less on police surgeons.

Source: Home Office data on arrests and PRG report on police surgeon costs; excludes London

15. One explanation offered for this variation was that the Metropolitan Police Service (MPS) limited the discretion of custody officers more than the other forces; for example, a police surgeon had to be called before an asthmatic prisoner was allowed to use an inhaler. Another review, this time conducted by a force research team, highlighted a number of cases where several visits were made to the same prisoner during one period of detention. In the opinion of the force’s principal police surgeons, repeat visits should be a rare occurrence but custody officers need guidance on how to handle such situations; advising the doctor of the likely length of detention is key information that is not always requested or passed on.

16. Experience and expertise are factors that affect the confidence of custody officers in exercising discretion. The custody officer role is important and specialised but it is also stressful, and tends to be an unpopular posting. One fieldwork force is promoting sergeants into custody posts (that is, custody is their first assignment as a sergeant) or using acting sergeants in the role in order to overcome a lack of enthusiasm for the work. This approach runs counter to received wisdom. National promotion systems identify patrol sergeant as the first role for newly promoted officers; ideally, they should gain experience in this and other roles before moving to custody duties. In general, it is common for officers to spend a relatively short time in the role – often 12 months or less – before they are moved on. Although this may have benefits for the individual officer’s welfare, such rapid rotation means that valuable expertise is lost to the role while new custody officers ascend the learning curve. Although only anecdotal evidence backs up the point, police surgeons indicate that inexperienced custody officers are less likely to exercise discretion in deciding whether a particular situation merits calling out a doctor.

1 Police promotion examinations seek to test whether candidates have the competencies appropriate to the rank.
A lack of experience and expertise in carrying out the custody role can be overcome at least in part by appropriate and timely training. But custody officers are often in place many months before they receive training, and most courses make scant reference to the kind of medical issues that they will confront on a daily basis. Often there is no specific course dealing with custody issues; it is just a bolt-on to general sergeants’ training. Although it is not an essential requirement of the job, some custody officers interviewed pointed to a lack of training in first aid (or lapsed qualifications) as an omission.

One area where custody officers very quickly accumulate experience, and where discretion is an important issue, concerns prisoners who are intoxicated or under the influence of drugs. Examination of a sample of custody records in the fieldwork forces confirmed a point that came up in many interviews with police surgeons and custody officers: there is a growing problem posed by detainees who are under the influence of alcohol or drugs (or both) when arrested, irrespective of the offence for which they are subsequently detained. Trends are difficult to substantiate in the absence of detailed and robust comparative data extending over the last ten years or so, but in more than half of the cases sampled, drug or alcohol abuse was the main or sole reason for the surgeon’s attendance.

There are three reasons why this growing incidence of drug and alcohol abuse among those detained in police custody is relevant:

- **Drug and alcohol abuse is an important element in the rising demand for police surgeons, and thus the rising cost:** many persistent criminals are drug abusers (Ref. 4), and evidence from custody records suggests that they request a police surgeon almost as soon as they are detained in the hope of getting some form of medication such as methadone;

- **The care of such detainees is a considerable burden for custody officers:** because they cannot be interviewed or released until they are sober, the prisoners are in the cells for many hours. Depending on their state of intoxication, they need to be kept under close supervision and perhaps roused at frequent intervals. In a busy custody suite the drain on officers’ time, and the mental pressure involved, is significant;

- **Deaths in custody:** forthcoming research (Ref. 5) on the circumstances of detainees’ deaths is likely to highlight the risk of keeping intoxicated people in police cells, a setting which is very often inadequate for their medical supervision and care.

Custody officers are often confronted by difficult decisions in respect of intoxicated prisoners – they see enough of them to recognise the symptoms, and are reluctant to call out a police surgeon simply to confirm intoxication. PACE guidance states that it is, in fact, the responsibility of the custody officer to decide whether a detained person is unfit for interview through drink alone, and the views of a doctor should not normally be necessary. It also states that a person who appears to be drunk ‘may have sustained injury (particularly head injury)’. Given these
seemingly contradictory messages, it is hardly surprising that many custody officers err on the side of caution and call out a doctor just in case. But force reviews are revealing practices that have become customary but may not be justified. For example, one force recently instructed custody officers that ‘there is no longer any requirement for police surgeons to visit drunken prisoners after four hours of detention’. In doing so it has saved many thousands of pounds with no evidence of detrimental consequences to prisoners.

Problems with recruitment and retention of police surgeons

21. The vast majority of police surgeons are general practitioners (GPs) who combine police work with their own patient list. The motivation for some doctors to become a police surgeon is financial, as in busy areas surgeons can earn many thousands of pounds. For others it is the intrinsic nature of police surgeon work – and the forensic aspect in particular – that motivates them. In a few cases, doctors make themselves available out of a sense of public duty but would actually prefer not to have to undertake the work. The Home Office guideline for the number of police surgeons that forces should aim for is one per 100,000 population [EXHIBIT 4].

1 This had become a force-wide practice but was not a PACE requirement.

EXHIBIT 4

Police surgeons per 100,000 population, 1996

All forces bar one meet the Home Office target of at least one surgeon per 100,000 population.

Retained surgeons per 100,000 population

Source: Police Research Group
However, the average picture conceals significant variation on the ground. In some force areas doctors are queuing up to be police surgeons, while other areas struggle to get sufficient recruits to make the system work efficiently. Busy urban areas experience few difficulties in recruiting and retaining surgeons, because the fee earnings enable GPs to pay for locum cover while they take on police work and still make a reasonable profit, or in some cases become ‘full-time’ police surgeons. For example, police surgeons are called out 400 times a month in central Birmingham, providing an average monthly fee income of just over £5,000 for each of the surgeons on the rota. And there are enough doctors on the rota, including full-timers who take a significant proportion of night call-outs, to ensure that being on call is not too onerous.

The situation in rural (and some less densely populated urban) areas is very different. Here, a small number of surgeons typically cover a large geographical area; they may be on call several nights or more a week but are called out relatively infrequently. They thus have the pressure of being on call and may have to travel long distances to attend a police station, but receive considerably less in fees than their urban counterparts. In one part of Hampshire, for example, surgeons are each called out eight times a month on average and can expect to earn around £400 in fees. In the past, surgeons have tolerated the situation because they were on call anyway as a GP. But the move away from single or small practices to larger co-operative practices has been accompanied by changes in on-call rotas, with individual GPs covering fewer nights. Understandably, some police surgeons are now reluctant to tolerate anti-social duty rotas and disturbed nights for a small retainer and low levels of fee income.

In one of the fieldwork forces, the problem of police surgeon availability has almost reached crisis point, with one surgeon covering an area of several hundred square miles. Where recruitment or retention problems lead forces to call upon the services of local doctors who are not police surgeons, lack of forensic experience can sometimes cause difficulty when a case comes to court.
Retention and recruitment difficulties in one force area

The North Wales Police division of Gwynedd covers an area of 982 square miles, and serves a population of 113,000. The division includes remote areas such as the Snowdonia National Park which, although having a low static population, experience a large influx of summer visitors. There are three custody centres in the area, located at Caernarfon, Dolgellau and Pwllheli. There are currently four retained police surgeons providing cover to the three custody centres and the CID. The Caernarfon surgeon recently withdrew from police work; a retired local doctor has offered his services in an emergency until a permanent replacement is found.

Travel distances between custody centres mean that all four retained surgeons are effectively on call for the police 24 hours a day. This situation is unsatisfactory, both for existing police surgeons and force management. The Divisional Commander recently contacted all 18 surgeries in the Caernarfon, Bangor and South Anglesey areas but none of the doctors at those practices wished to become an appointed police surgeon. Doctors generally consider the commitment required to outweigh the financial returns, particularly now that night co-operative schemes have dramatically reduced the number of nights that they remain on duty for their own patients.

As a result, North Wales Police is experiencing serious difficulties in meeting the requirements of PACE regarding medical services to detainees. Because a police surgeon is not available, police officers sometimes have to transport prisoners to and from the custody suite to the nearest hospital for medical assessment and treatment, a considerable drain on police time. Where the detainee is mentally disordered, police officers often stay at the hospital to alleviate the concerns of medical staff. Unfortunately, the situation looks set to worsen. One of the remaining surgeons has indicated that he would prefer not to undertake police surgeon duties at all. In the circumstances and as an act of service to the community, he is prepared to accept some call-outs, but not after midnight or for forensic sexual assault examinations. The force is sympathetic to his position, but it is obviously concerned about the implications for the quality of the medical service and the inefficient use of police time.

Source: Fieldwork
Problems with call-outs and staffing specialist examinations

25. The issue of availability is a major pressure point in some areas: how confident can a custody officer be that a police surgeon will attend quickly when needed? The answer depends in part upon the size of the pool, but also on the effectiveness of call-out rotas. The rota system for police surgeon availability does not always work smoothly, and occasionally custody officers have to make numerous telephone calls before they succeed in reaching a doctor who is able and willing to attend the station. In one instance in a fieldwork force, 12 police surgeons were contacted before one could be found who was able and willing to examine a rape victim. This represents poor quality of service for an already traumatised victim and hinders the prospect of a swift investigation. In another force, the two doctors covering one particular police district were unwilling to sign up to a rota, and it was left to the custody officer to decide which doctor to call as the need arose.

26. Although the decision to call out a police surgeon always rests with the custody officer, in some forces the actual telephone calls to doctors on the rota are made by control room staff. This alleviates the custody officer’s burden, but almost always reduces the quality of the information passed to the surgeon about the particular circumstances (such as the urgency of the situation), and may contribute to delays in attendance. One fieldwork force had experienced a number of occasions where two doctors were called for the same incident, one by control room staff and the other by the custody officer concerned. Some police surgeons are willing to give advice in routine cases over the telephone – for example, agreeing that a prisoner can use labelled medication which was in his or her possession at the time of arrest – while others are not. Analysis of available information confirms a point made in interviews by custody officers and surgeons; namely, that current call-out procedures produce an uneven distribution of workload between surgeons that has no rational basis.

27. Problems caused by limited availability of police surgeons for routine call-outs are potentially more serious when the examination requires a degree of specialist expertise – notably, in relation to alleged sexual offences, suspected cases of child abuse and the detention of people with mental health problems.

28. Female victims of alleged sexual assault are, in line with Home Office guidance, offered the option of being examined by a female doctor (Ref. 6). However, the majority of retained police surgeons – some 77 per cent – are male. In many areas women doctors are reluctant to offer their services as police surgeons, partly because of their personal circumstances – for example, childcare responsibilities make night call-outs difficult – and partly because the nature of the routine work in police cells is unattractive. Some police areas cannot, therefore, offer female victims examination by a female doctor, or can do so only by calling a surgeon from another police area with the potential delay that this entails. One
fieldwork force uses the services of female doctors who have not received any police surgeon training (including giving evidence in court), raising concerns about the quality of their work for evidential purposes should the case go to trial. A solution adopted in another force area is to recruit several female police surgeons as de facto specialists, who attend relatively few call-outs other than sexual offences. But this policy denies their colleagues – who may still be called upon in emergencies – the opportunity to develop their forensic and court skills.

The second specialist area of police surgeons’ work relates to allegations of child abuse, particularly sexual abuse. These cases require extremely careful handling – the actions of police officers, social workers and police surgeons are often subject to intense public scrutiny. In some police areas, child abuse examinations are not carried out by police surgeons but by paediatricians. The advantage of being specialists in examining children may, however, be offset by their lack of forensic expertise and experience of giving evidence in court. It is common practice in other areas for police surgeons to conduct such examinations alone, although only a minority – estimated at 15 per cent – have had specialist training. A third approach, deemed by many experts to be best practice, is for a paediatrician and police surgeon to conduct a joint examination. As well as improving the chances of an accurate diagnosis, this practice has the benefit of reducing the likelihood of the child concerned having to undergo more than one examination.

The third demand for specialist examinations, and an increasing problem for both police officers and police surgeons, is the detention of people with mental health problems. Sometimes police officers arrest someone for an offence who then exhibits signs of mental disturbance; on other occasions they decide that a person needs to be detained because they are a risk to themselves or others and invoke the provisions of Section 136 of the Mental Health Act 1983. On both counts, a police surgeon (or other doctor) and an approved social worker must be called to assess the person’s mental state, evaluate risks such as a suicidal tendency, and then determine an appropriate course of action. In some cases it may be necessary to arrange for the compulsory admission of a detainee under the provisions of the Mental Health Act. The Code of Practice of the Mental Health Act recommends that, wherever possible, the doctor conducting the initial assessment should be approved under Section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder. Recent research suggests that, in fact, only 10 per cent of police surgeons are Section 12 approved, a factor that may contribute to delays in assessing mentally ill persons who are brought into police custody.
Typical procedure for dealing with mentally disordered people in police custody

The police surgeon may be involved at two points in the process.

- **s136**
  - Beat officer detains person under Mental Health Act (person in public place appearing mentally disordered, a risk to self or others)
  - Has person committed an offence or are they violent or aggressive?
  - **NO**
  - Person taken to hospital as ‘place of safety’
  - **YES**
  - Compulsory admission to hospital (‘sectioned’)

- **NON- s136**
  - Custody officer has concerns about the mental health of someone in custody
  - **CALL OUT POLICE SURGEON**
  - Police surgeon examines. Is the person mentally disordered and in need of full assessment?
  - **NO**
  - Detainee remains in police custody
  - **YES**
  - Assessment by an approved social worker and a s12 approved doctor (who may be the police surgeon). Should the detainee be sectioned?
  - **NO**
  - Detainee remains in police custody
  - **YES**

**Note:** Compulsory admission to hospital under s2 or s3 requires two doctors, one of whom must be s12 approved. Emergency admission under s4 requires only one doctor who, if practicable, should know the patient and be s12 approved.

*Source: Codes of Practice, Mental Health Act 1983 (Ref. 7) and fieldwork*
Custody officers and police surgeons interviewed in fieldwork forces all pointed to an increase in the number of mentally ill people being detained – one unforeseen consequence of care in the community policies. Often these people are known to the psychiatric service – the Mental Health and Criminal Justice Liaison scheme in Merseyside found that 80 per cent of mentally disordered offenders passing through police stations and courts were known ‘clients’. Unfortunately, there is often no obvious place where police officers can take those acting ‘strange in manner’ other than a police station. Research carried out in Northumbria Police recorded the details of police contact with mentally disordered persons in four command areas over a six-month period. Of 1,071 contacts, the majority required no action but some 266 were taken into police custody, either under Section 136 provisions or as a result of committing an offence, often of a minor nature. Half of these people were seen by a police surgeon. There is, however, a fundamental concern about police custody – is a police cell the appropriate ‘place of safety’ to hold someone who is mentally ill? Most practitioners would say it is not, but detention in police cells often represents a preferable option to, for example, a hospital casualty department.

Ensuring quality in the custody suite

Even where forces and police surgeons have resolved problems around availability, rostering and meeting the demands of specialist examinations, the quality of service experienced by detained persons may be affected by inadequate conditions in the custody area and poor communication between custody officers and doctors.

Inadequate facilities in custody suites

The majority of custody suites were built long before the provisions of PACE came into effect, and these older stations pose problems for police officers and surgeons. Many cell blocks do not have facilities suitable for monitoring the condition of detained people who are intoxicated or suffering from mental illness. Some blocks do not have any cells with low bunks which limit any injury caused by falling; few custody suites have observation cells near the desk; and a combination of financial constraints and concerns over privacy mean that most suites do not have any cells with closed-circuit television (CCTV) facility. A detained person requiring frequent observation would normally be seen once every 30 minutes, but a prisoner can come to serious – possibly fatal – harm in that time.

Inspector Richard Berry, Northumbria Police, unpublished research for M. Phil. thesis
34. Doctors require a clean, quiet examination room that is adequately equipped (including appropriate provision for the disposal of clinical waste such as used syringes). Although most stations visited provided reasonable basic facilities, pressure on space in custody suites sometimes means that the examination room also houses equipment such as intoximeters or photocopiers, or doubles as storage space or the fingerprinting facility. It is common, but not universal, practice for one officer to have responsibility for ensuring that the examination room is adequately stocked. One doctor interviewed during the study expressed frustration that a lack of basic equipment meant that he could not, for example, do simple suturing in the station – instead, the prisoner was escorted by two police officers to the nearest casualty unit.

**Poor communication and feedback**

35. One area of dissatisfaction raised in the interviews is the way that advice or instructions are sometimes communicated to custody officers following a police surgeon’s examination of a prisoner. For example, prisoners who are intoxicated (through drugs, alcohol or both) may also have head injuries; a critical concern is the need to determine whether or not prisoners slip into unconsciousness, at which point their lives may be in danger. A further complication is that prisoners may be dealt with by a number of different custody officers and seen by more than one doctor during their time in custody. In this situation it is vital that the recording of an examination outcome is legible and unambiguous, a point stressed in advice from the Police Complaints Authority (Ref. 8).1

36. Practice varies as to how police surgeons report the results of examinations and provide instructions to custody officers on symptoms to look out for or care requirements such as rousing the prisoner at specified intervals. In some forces, doctors merely write brief details on the custody record. Other forces use a dedicated form, stating the examination findings (for example, the reasons why a person is or is not fit to detain) and instructions for administering prescribed medication. Even where forms are used, they typically give no guidance on the issues that a police surgeon should address – mental state, suicidal tendency, frequency of visits required or a prisoner’s special needs. Finally, some custody officers reported that the advice set out in the custody record was indecipherable, lacking in detail, or too technically worded for a lay person to understand.

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1 The Police Complaints Authority recently made a number of recommendations on improving the medical care of people in custody following the death of a prisoner in circumstances aggravated by poor communication between police surgeons and custody officers (Ref. 8).
37. Fieldwork interviews revealed a degree of mutual respect between custody officers and police surgeons, and there is no reason to introduce bureaucratic processes into what is clearly a good working relationship. Nonetheless, forces are missing opportunities to improve communication and encourage feedback about events that could prove to be useful learning experiences. Nor is debriefing a common practice within police forces, except after a critical incident. One consequence is that people ‘muddle along’ with less than satisfactory situations or procedures because there is no obvious forum to explore alternatives. Another potentially valuable source of feedback that is even less well used is communication between prisoners and police surgeons. None of the fieldwork forces was aware of any systematic effort to canvass the views of prisoners about the service provided by police surgeons. While they are not typical ‘customers’, there is no reason to assume that prisoners may not offer some useful insights into how the service might be improved.

38. Some of these problems can be resolved by those managing the custody function, but others reflect, and to some extent derive from, wider problems in the overall structure for providing medical services to police forces. The piecemeal development of forensic medical services is illustrated by the significant variations in the management frameworks that exist in the 43 police forces covering England and Wales. It might, in fact, be more accurate to describe the service as ‘unmanaged’. For example, while some forces have formal contracts with police surgeons, others rely upon little more than ‘gentleman’s agreements’; the average earnings per surgeon vary by a factor of 20; and access to training differs widely. Existing deficiencies need to be understood and addressed if the problems building up at the operational level are to be tackled successfully. In particular, forces need to:

- formalise contractual arrangements and measures to guarantee police surgeon availability;
- strengthen managerial and financial procedures; and
- establish quality assurance procedures, including minimum standards of training and experience in the key areas of police surgeons’ work.

The absence of a robust management framework

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Contractual arrangements and availability

39. Police surgeons are not employees but independent contractors of services, and forces increasingly use formal contracts to set out the terms and conditions under which police surgeons supply their services. But a significant minority of forces – 28 per cent, according to the Home Office survey in 1996 – still have no such written agreements. Furthermore, the content of existing contracts differs widely; some include only the most basic provisions on issues such as training requirements, age limits (some police surgeons are over 70) and participation in/adherence to a rota system to ensure availability and adequate back-up. Few forces have any sanctions to apply in cases where surgeons are unwilling to respond to a call-out, or where the delay in responding is unacceptably long. If such
call-out provisions are not incorporated into contracts, problems can be left unresolved and fester.

40. Organising the surgeons’ rota is also something of a headache; practice varies as to who takes responsibility for drawing it up, although police officers are rarely involved. This task often falls to ‘head of service’ senior surgeons, where they exist, but it is more typically agreed among a group of surgeons covering a particular geographical area. Although calling doctors out in the middle of the night might be expected to meet most resistance or be difficult for them to manage, fieldwork interviews suggested that the worst problems concern morning or tea-time call-outs, when GPs are most likely to be busy with their surgeries.

Managerial and financial procedures

41. The principal point of contact between police forces and surgeons is the custody officer, who initiates most of the call-outs. In some cases doctors will liaise with detectives or other officers about evidence in a criminal case. Occasionally they will have contact with finance staff over payment of fees and expenses, or with staff in the training section. And there may be occasional discussion with ACPO-rank officers about policy matters relating to the police surgeon service. A single point of contact, exercising a co-ordinating role, is rare. Approaches to forces to identify the officer overseeing police surgeons often met a response of ‘there isn’t such a person’ (or where there was, most people did not know who it was).

42. The absence of a central, co-ordinating function does not at first glance appear to affect day-to-day operations. Working relationships between doctors and custody officers are widely reported to be excellent, fees tend to be paid accurately and promptly, and most surgeons feel reasonably satisfied with the training that is offered to them. But the lack of a main point of contact does mean that most forces have no strategic view of medical services that are vital to the effective running of custody suites. No one at the centre takes an interest unless the force hits a crisis, such as an inability to recruit doctors, or when costs seem to be rising out of control. This latter issue of seemingly inexorable increases in spending – even though surgeons’ fees are a small percentage of total budgets – has led a few forces to review current procedures.

43. All forces pay surgeons in line with the national agreement, although one or two have introduced supplements – for example, when a surgeon covers more than one police area. The retainer element is stable and predictable because it relates directly to the number of surgeons on the books, but the bulk of the service’s cost arises from call-out fees. Forces find it difficult to budget for what is essentially a demand-led service; and because most budgets are not devolved, the custody officer making the decision to incur expenditure is not responsible for the financial consequences.
The study examined procedures in six provincial forces for authorising and paying police surgeons; in the good practice forces, the audit trail is short and relatively simple (EXHIBIT 6). There is, however, one fundamental flaw from an audit point of view – only the surgeon knows what was required by way of therapeutic examination and treatment, and what was actually done. As one interviewee commented, ‘the system is unauditable at the point of delivery’. Combined with the fact that any ‘fee for service’ system contains incentives to generate work, this flaw allows scope for abuse. A sample of custody records and surgeons’ claims revealed that one-quarter of examinations under the provisions of the Road Traffic Act entailed a ‘comprehensive’ examination rather than a straightforward blood sample – the former attracting a higher fee rate than the latter. It was not always clear from the records why a comprehensive examination was conducted – for example, that it had been specifically requested by a police officer. Nevertheless, in view of the particular characteristics of the prisoner population, one-quarter may not represent an unreasonable proportion.

Quality assurance

Police surgeons’ contracts invariably lack the detailed specification widely associated with work contracts, and there are few agreed protocols or service standards to ensure consistency and quality. As GPs they are used to working within a clear ethical framework that is underpinned by a confidential doctor-patient relationship. They are not accountable to anyone for what happens once the door of the police station examination room closes, nor is there any random sampling or checking of the advice that they give custody officers. Only rarely is a senior police surgeon asked to exercise oversight or to co-ordinate policy and practice among surgeons.

It is not, therefore, surprising that anomalies exist or that occasional problems arise. For example, some forces and surgeons are concerned about giving methadone to drug addicts in custody – word spreads very quickly and regular ‘customers’ of the custody suite ask to see a doctor as soon as they are detained in the hope of getting access to methadone. This syndrome inevitably creates work for custody officers, expense in calling out surgeons, and a hostile reaction from prisoners who are refused the desired drug. But although a force may wish to adopt a policy of restricting methadone provision, it cannot insist that surgeons follow it.

Critical comment on the absence of a quality assurance mechanism does not imply that police surgeons do not work competently and to high quality standards. However, mentoring, peer assessment and audit/inspection are important aids to professional development and the maintenance of standards. Police officers’ work is quality assured in increasingly rigorous ways, as is the work of hospital-based medical staff. There is no persuasive argument to exclude the work of police surgeons, which is funded from the public purse, from similar scrutiny. Linked to such scrutiny are procedures for handling complaints – by or about police surgeons – or for grievances raised by doctors. Every force has formal
The work of police surgeons is viewed within the medical profession as something of a backwater

procedures in respect of police officers and civilian employees, but far fewer have them for police surgeons. It is not uncommon, for example, for a force to have no agreed mechanism for dispensing with the services of an incompetent surgeon.

48. Nor is there an agreed approach to training that is based upon quality standards relevant to the nature of the service and the competencies entailed in delivering it. As registered medical practitioners, police surgeons are deemed to be qualified to perform the tasks required of them by the police without specialist training or additional qualifications. In fact the majority of forces offer a mix of ‘shadowing’ an experienced surgeon on appointment, a short initial course and ad hoc training on specific topics. Approximately 8 per cent of police surgeons hold the specialist qualification most relevant to the work – the Diploma in Medical Jurisprudence (DMJ) – for which they receive an enhanced retainer. Three forces require their police surgeons to hold or be working for a DMJ, although none of the three provides a financial incentive: Devon and Cornwall Constabulary does not stipulate possession of the DMJ but pays for the cost of surgeons who attend the course. Contracts recently drawn up by the Metropolitan Police stipulate core training courses to be attended within two years of appointment and require the DMJ to be obtained within six years.

49. Typically, the training budget for police surgeons is controlled centrally and is relatively small – in those fieldwork forces with dedicated training budgets, it averaged £200 per surgeon in 1996/97. Structured training is, for most surgeons, limited to an initial, one-week course held at Durham, which focuses on core competencies. This costs in the region of £1,000 per place. It can be supplemented by development courses; one run by the Forensic Academic Group in the North (FAGIN) and a similar initiative in the south east and London (SEAL). Individual forces run informal training events – either on medical issues or skills such as giving evidence in court – with varying degrees of success. Many police surgeons find it difficult to attend training sessions unless the force is willing to pay for the necessary locum cover. In other cases, surgeons may simply lack the commitment or motivation to develop their expertise.

50. Some of the difficulties experienced by surgeons in securing access to training, and by forces in encouraging surgeons to attend, reflect an underlying problem – the lack of a career structure for police surgeons. The role of police surgeon goes back many decades; there is a recognised qualification in the DMJ; and a professional association exists (the Association of Police Surgeons, to which about half of all police surgeons belong). And yet the work of police surgeons is viewed within the medical profession as something of a backwater – perhaps because much of it is mundane and undertaken in GPs’ spare time. Clinical forensic medicine is given scant coverage in doctors’ training and, compared with many clinical specialities, the work lacks prestige and glamour (despite the efforts of the TV programme, Dangerfield!). Fifteen years’ service as a police surgeon earns an individual the title of ‘senior police surgeon’ and a slightly larger retainer, but offers no career advancement as such.
The cost to police forces of forensic medical services is increasing annually and is a cause for concern. But forces face a major difficulty in attempting to control costs – they lack sufficient information about the nature of the service on which to base a rational assessment of how to manage demand or model forms of supply. The recent Home Office review (Ref. 3) was the first attempt to map comprehensively the extent of police surgeons’ work and the cost of the service, but one key finding was that ‘most forces ... rarely monitor and analyse the usage and cost (by type of activity) of police surgeons at a force or divisional level in a systematic way’. Police forces are not required to collect this data as a matter of course and there is no standardisation in, for example, defining the role of the police surgeon.

Information that could provide useful management and operational information does exist, albeit not always in sufficient detail. But some forces with an IT facility do not use it, while in many others information has to be extracted manually. There is little imperative to do this work given other pressures on research time. Yet without information on the number of call-outs, the reasons why medical attention is needed and the reliability of individual doctor’s responses, forces are poorly placed to predict and manage demand, and quality assurance is almost impossible. Assessments of value for money are problematic in the absence of robust comparative data, both within and between forces.

In the current absence of available analysis, a sample of custody records was examined in each of the six fieldwork forces. This examination sought to identify the reason why a surgeon was called out, their response time, the average length of examination, average fee charged and any inaccuracies in payment of this fee. The analysis confirmed that assessment of fitness to detain or interview is the principal task for surgeons – interviewing a prisoner who is unfit through drink or drugs, to the extent that they are unable to appreciate the significance of the questions put to them about an alleged offence, will not produce evidence that will stand up in court. Interestingly, there is no formal definition of fitness for interview; research conducted for the Royal Commission (Ref. 2) noted that the criteria used in determination varied from doctor to doctor.

There is also considerable variation in the extent to which written reports or statements, formalising examination findings and advice, are provided. Some surgeons provide them automatically, but in fact they are often not required. Northamptonshire Police estimated that some 90 per cent of statements provided as a matter of course by their police surgeons were not needed for evidential purposes. Merseyside Police analysed records covering a three-month period in 1993 and found almost a fourfold variation across the force, with one division paying for a doctor’s statement after one examination in five even though only a fraction of these were ultimately required for court. Unless forces conduct such analyses, variations may not come to light and the need for review of procedures will go unnoticed.
Conclusion

55. The picture painted above is one of a dedicated, professional service provided by police surgeons, and good working relationships between surgeons and custody officers. However, the current arrangements for forensic medical services have developed piecemeal, and in some areas police forces are experiencing severe problems in service delivery. The growth in demand, the rising costs of the service and the commitment to continuous improvement in the quality of policing all point to a need to review and possibly reshape the provision of these services. The next chapter considers what immediate improvements might be possible and looks forward to potential changes in the nature of the service.
Improving the Forensic Medical Service

Questioning what services are needed and how they are best provided can help police forces to secure reliability, quality and cost-effectiveness in forensic medical services.
56. An obvious starting point for review and improvement is to ask: What services are needed and how are they best provided? Answering these two key questions may lead to some revision of current arrangements to achieve the combination of reliability, quality and cost-effectiveness that forces are seeking. It may, in certain circumstances, be appropriate to consider whether a force might be better served by a different arrangement, such as outsourcing the work. Both issues are explored below.

57. The Police and Criminal Evidence Act, rather than the historical legacy of the way that the police surgeon’s role has developed over the decades, is the critical reference point. The Act governs the treatment of detained persons and the circumstances in which police officers can obtain evidence from prisoners in custody, so as to minimise the risk of unreliable evidence being presented in court. The balance between non-forensic (or therapeutic) and forensic work is a key issue.

58. Non-forensic work predominates, comprising 85 per cent of police surgeon call-outs [EXHIBIT 8]. Almost two-thirds of therapeutic examinations relate to fitness for detention or interview. Although forensic work forms the minority element of workload, it can at times be of critical importance to the pursuit of a criminal investigation. Even so, much of the work is more commonplace and it is therefore legitimate to ask whether all of the work – and in particular, non-diagnostic work – must be undertaken by an experienced doctor.

59. It is difficult to understand why highly trained doctors need to be called out in the middle of the night, at considerable public expense, to treat minor ailments or to take blood samples. Research or some form of peer review into the medical content of police surgeon examinations would help to answer whether a mismatch currently exists between task and role – are police surgeons ‘over-graded’ for some of the work that they are called upon to perform? That police surgeons adopt a cautious approach and emphasise the need for examination by a doctor ‘just in case’ is understandable – there is an element of risk entailed in moving away from doctor-only examinations.

60. Nonetheless, the growth in the use of paramedics in the NHS and the developing role of GP practice nurses indicate that health personnel other than doctors could carry out some tasks such as taking blood samples, and could in other cases screen the need for a police surgeon to be called out [BOX D]. An experienced police surgeon would still need to be available should problems arise, but could delegate certain tasks to other practitioners. Such a change would require a review of PACE and almost certainly a re-definition of the term ‘medical practitioner’.

61. Involving other health professionals is mooted not just in response to the problems of doctor availability experienced in some areas, nor solely as a means to securing better value for money – although both are goals worth pursuing. Developing a forensic medical team approach could also focus doctors’ expertise on the forensic aspects of the work and, in

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**What services are needed?**

EXHIBIT 8

**Forensic and therapeutic components of surgeons’ work**

Forensic examinations represent about 15 per cent of police surgeons’ work.

<table>
<thead>
<tr>
<th>Forensic</th>
<th>15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-forensic</td>
<td>85%</td>
</tr>
</tbody>
</table>

Source: Home Office Police Research Group (Ref. 3) and Audit Commission fieldwork
### Police surgeons – roles and tasks

<table>
<thead>
<tr>
<th>Task</th>
<th>Could be carried out by*</th>
<th>Police surgeon attendance essential?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination of victim or suspect: sexual assault</td>
<td>Police surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>Examination of police officers: evidential purpose – eg, assault</td>
<td>Police surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>Examination of victim or suspect: non-sexual assaults</td>
<td>Police surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>Examination of victim: child abuse</td>
<td>Police surgeon or paediatrician</td>
<td>No</td>
</tr>
<tr>
<td>RTA comprehensive examination</td>
<td>Police surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>S.136 Mental Health Act assessment</td>
<td>Police surgeon or psychiatrist</td>
<td>Not always</td>
</tr>
<tr>
<td>Certifying death to confirm or exclude suspicious circumstances</td>
<td>Police surgeon or pathologist</td>
<td>Not always</td>
</tr>
<tr>
<td>Fitness to detain</td>
<td>Nurse to screen, or police surgeon</td>
<td>Not always</td>
</tr>
<tr>
<td>RTA blood test</td>
<td>Nurse</td>
<td>No</td>
</tr>
<tr>
<td>RTA urine sample</td>
<td>Custody officer</td>
<td>No</td>
</tr>
<tr>
<td>Intimate search or DNA intimate sample†</td>
<td>Nurse</td>
<td>Not always</td>
</tr>
<tr>
<td>Therapeutic assessment of detained persons</td>
<td>Nurse to screen, or police surgeon</td>
<td>Not always</td>
</tr>
<tr>
<td>Ongoing care/observation</td>
<td>Nurse</td>
<td>Not always</td>
</tr>
<tr>
<td>Therapeutic examination of police officers: injury</td>
<td>Nurse, or own GP, or police surgeon</td>
<td>Not always</td>
</tr>
</tbody>
</table>

* Section 55 of PACE stipulates that intimate searches related to suspected drugs offences must be carried out by a suitably qualified person; this can be a registered nurse. Other types of intimate search can be conducted by police constables, though not on a person of the opposite sex.

* This possible categorisation is put forward to stimulate debate; it has not been subject to any form of medical validation.

Source: Audit Commission
particular, help to resolve some of the difficulties experienced in the specialist areas of sexual assault, child abuse and mentally ill detainees. Clearly, the involvement of nurses could not be justified in every setting. But they could be cost effective in busy custody centres with a high throughput of prisoners who need both initial assessment and ongoing care. It is not possible to estimate, without detailed research, how many screening examinations or treatments might result in a doctor being called out. If doctors have to be paid a retainer to be on call but rarely get called out (the principal source of earnings), police areas which currently do not experience problems in recruitment and retention may find that commitment reduces. It is therefore a tentative suggestion but, if changes to PACE permitted it, one which might merit a pilot scheme.

There are three options for providing the services described in this report. One is to maintain the status quo whereby forces contract with individual doctors – typically GPs. Alternatively they could employ doctors and other staff as appropriate on a full-time basis to carry out the necessary work. A third option would be to outsource the work, specifying what is required and contracting with, for example, a health trust or a consortium to deliver the service. The latter two options are considered later. Assuming that the existing form of provision continues, improvements are needed in:

- managing demand and ensuring the availability of police surgeons;
- quality assurance procedures;
- custody suite facilities and procedures; and
- collecting and using performance information.

**Managing demand and ensuring availability of police surgeons**

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- collecting and using performance information.

**Managing demand and ensuring availability of police surgeons**

63. A starting point for better management of the demand for police surgeons is the framework for their recruitment and remuneration, and the terms and conditions under which they supply their services. The current retainer/fee structure has been the subject of recent review in the national negotiating forum. Fieldwork for this study confirmed the findings of the Police Research Group and others: that there is no ‘national picture’ in terms of recruitment and remuneration for police surgeons. It is more a case of famine in rural areas and feast in the larger towns and cities. A crude measure it might be, but in many rural areas it may be appropriate to pay a higher retainer alongside the existing call-out fee, while in busy urban areas the retainer may be unnecessary (police surgeons here can earn substantial sums while keeping the number of on-call periods to a manageable number). There is little rationale for a standard national approach when circumstances vary considerably in different geographical areas.

64. There is, though, a case for greater standardisation in the form of contracts used to engage police surgeons and recruitment procedures. The practice in some forces of relying upon a letter of engagement, rather than a recognisable contract, offers neither the force nor the individual surgeon adequate protection if things go awry. Forces should consider putting all
of their appointments on a contractual basis, drawing on the best of the current contracts to develop a core set of terms and conditions. It is also unsatisfactory to continue with recruitment methods that are more like ‘Buggin’s turn’ than professional personnel practices. Individuals should be recruited on the basis of a proper job and person specification; where there is a high level of interest from doctors to be police surgeons, there should be open advertisement and competitive selection.

65. Effective management of forensic medical provisions would be assisted if each force designated one officer (regardless of their current job title or location) to co-ordinate the work of:

- monitoring the police surgeon budget;
- ensuring that key management information such as costs or workload is collected, analysed and used to inform managerial decisions;
- developing, in conjunction with police surgeons, policy guidance on matters such as telephone advice or issuing methadone to prisoners who are registered drug addicts;
- liaising with police surgeons on duty rotaS, training needs/provision, and the handling of complaints or disciplinary matters; and
- advising custody officers on how to make cost effective use of police surgeons, and resolving any problems on issues such as delay in attendance.

Although this would not be a full-time role in all but the largest forces (in some fieldwork forces it was undertaken by the head of scientific support), it is important that adequate time and support is allowed for the postholder to fulfil the role effectively.

**BOX E**

**Elements of a core contract for police surgeon services**

<table>
<thead>
<tr>
<th>Length</th>
<th>including retirement age and renewal conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>main types of work to be undertaken, geographical areas covered</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>organising rota, keeping notes, submitting claims on time, etc</td>
</tr>
<tr>
<td>Expected priority</td>
<td>to be given to police duties compared with other commitments; target response times</td>
</tr>
<tr>
<td>Training requirements</td>
<td>eg, hours of approved training to be attended per year, achievement of DMJ (and in what timescale)</td>
</tr>
<tr>
<td>Remuneration</td>
<td>including timing of payments</td>
</tr>
<tr>
<td>Termination arrangements</td>
<td>conditions under which contract may be terminated; period of notice (for both parties)</td>
</tr>
<tr>
<td>Special conditions</td>
<td>eg, on disclosure of information, or acting as a witness for the defence</td>
</tr>
</tbody>
</table>

*Source: Audit Commission analysis of a selection of recent contracts*
Quality assurance procedures

Better co-ordination of the force’s requirements would be a valuable contribution to enhancing quality assurance of police surgeons’ work, particularly if the post described above was mirrored by a co-ordinating and supervising role for a principal police surgeon. Although some of the larger forces, such as the Metropolitan Police and Merseyside, have developed a hierarchical structure – of Principal Forensic Medical Examiners (FMEs) – to manage the work of police surgeons, most rely on a more ad hoc approach. This is increasingly untenable given the pressures caused by rising demand and a need to subject police surgeons’ work to appropriate quality assurance processes. Properly instituted, such processes would play a positive role in providing coaching and mentoring support to new surgeons. Appointing a principal surgeon or a group of principals not only provides a management infrastructure and a means of checking quality of service, but also offers the prospect of a career path for those surgeons who want to specialise in forensic medicine.

[CASE STUDY 1]

A hierarchical structure for managing and quality assuring FMEs

Merseyside Police has 26 forensic medical examiners, five of whom are designated as Principal FME, one for each of the force’s five territorial districts. In addition to the usual tasks of FMEs, the Principal FMEs undertake to:

- ensure the maintenance of a rota which provides adequate forensic and medical cover for the districts to which they are attached;
- liaise with police officers and the FMEs working in that district on matters relating to FME work, and attend regular meetings (four per year) to this end;
- conduct the initial training of newly appointed FMEs and report on their progress, using a pro forma to record what aspects have been covered and to confirm that the new FME is ready to go on the rota;
- provide training input for police courses as required; and
- ensure that custody suite examination rooms are adequately stocked.

Principal FMEs are expected to obtain the DMJ qualification if they do not already possess it, and to spend a minimum of two days each year furthering relevant skills.

Source: Merseyside Police
67. Proper oversight of the training needs of police surgeons – both initial training and continuing professional development – would represent an advance on the current arrangements in many forces. Following the good practice of a few forces in setting minimum training requirements, it would benefit both forces and police surgeons if there were core standards for training and regular training needs analyses. The five-day initial course at Durham, or an equivalent, is generally regarded as a minimum level of training. This could usefully be supplemented by more intense training in specific areas; for example, court skills, mental health and substance abuse, and regular updates on developments in forensic medicine [EXHIBIT 9].

68. Forces should review their current arrangements for ensuring that police surgeons have appropriate access to training and the acquisition of qualifications such as the DMJ and Section 12 (Mental Health Act) approval. They need to recognise that, as most surgeons are GPs, attending training courses during normal working hours is difficult unless locum cover is financed. Attendance at meetings of the Association of Police Surgeons is a useful way for surgeons to keep in touch with new developments and could be regarded as a component of a training programme financed by the force; membership could be made a contractual requirement. Some forces have in the past offered training to police surgeons, with locum reimbursement, but experienced very low take-up of opportunities. It is not unreasonable, particularly where surgeons are earning above an agreed threshold, for the force to stipulate that attendance on certain training courses is a minimum requirement rather than an option.

EXHIBIT 9
Model of police surgeons’ training
Some forces have a structured approach to police surgeons’ development and training.

<table>
<thead>
<tr>
<th>INITIAL</th>
<th>DEVELOPMENTAL</th>
<th>ADVANCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-week residential course in Durham</td>
<td>Attend occasional training organised by force on specific issues - eg, mental health</td>
<td>Attend FAGIN or SEAL courses</td>
</tr>
<tr>
<td>Two months shadowing existing police surgeon</td>
<td>Attend Association of Police Surgeons weekend meetings (twice yearly)</td>
<td>Acquire Diploma in Medical Jurisprudence (DMJ)</td>
</tr>
</tbody>
</table>

Source: Audit Commission
69. The great majority of contacts between police officers and police surgeons are individual exchanges, as and when doctors attend the station or other scenes. Officers and doctors interviewed expressed interest in the idea of a forum to discuss issues of mutual concern and to raise awareness of each other’s role, needs, expectations and limitations; this could be extended into joint awareness training. Topics that could usefully be covered include the exercise of discretion by custody officers, dealing with prisoners who are under the influence of drink or drugs or have mental illness problems, and repeat call-outs to prisoners in the same detention period. Vital improvement in formal communication, such as the recording of a police surgeon’s advice on the outcome of an examination and subsequent care needs, could also flow from such dialogue. The noting and subsequent interpretation of doctors’ instructions place a legal liability on police officers if things go wrong, and there is a strong case for standardising approaches on the basis of current good practice, in respect of custody record information [EXHIBIT 10].

70. Another factor addressed by some forces is the relative isolation that doctors experience; Merseyside and South Yorkshire have found that bringing together groups of police surgeons is beneficial, both in countering this isolation and as a means of professional development.

**EXHIBIT 10**

*Example of a custody record where a police surgeon has been called out*

Doctor’s instructions should be clear and unambiguous.

<table>
<thead>
<tr>
<th>20. Last review of detention conducted</th>
<th>21. Custody record no.</th>
<th>Signature, rank and number</th>
</tr>
</thead>
<tbody>
<tr>
<td>at ......................................</td>
<td>........................</td>
<td></td>
</tr>
</tbody>
</table>

**22. Date/time**

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Details of any action/occurrence involving detained persons</th>
<th>Signature, rank and number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/11/97</td>
<td>DP unsteady on feet and smells strongly of alcohol. Appears to understand questions put to him but claims he feels dizzy. Placed in cell B4. Dr Ward called to assess fitness for detention and interview. ETA 10 mins.</td>
<td>PS 1212 Jenkins</td>
</tr>
<tr>
<td>23.10</td>
<td>Dr Ward arrives. DP taken to police surgeon’s room for examination</td>
<td>PS 1212 Jenkins</td>
</tr>
<tr>
<td>23.50</td>
<td>Visited in cell. DP lying down but awake. Given hot drink</td>
<td>PS 1212 Jenkins</td>
</tr>
<tr>
<td>00.25</td>
<td>DP observed through cell door. Sleeping. Entered cell and placed in recovery position</td>
<td>PS 3022 McG</td>
</tr>
<tr>
<td>00.55</td>
<td>Asleep. Raised and spoken to</td>
<td>PS 3022 McG</td>
</tr>
<tr>
<td>05.30</td>
<td>DP raised and spoken to. Accepted hot meal</td>
<td>PS 3022 McG</td>
</tr>
</tbody>
</table>

*Source: Audit Commission, based on composite good practice examples*
Improving custody suite facilities and procedures

71. Although police surgeons are called to attend many scenes, the custody areas of police stations represent the focal point of forensic medical services. Many are ill-suited for the purpose of medical examinations, and the professionalism with which both surgeons and custody officers discharge their duties is thus all the more commendable. Although current arrangements generally work well, improvements are possible in:

- training;
- length of assignment; and
- the working and therapeutic setting.

72. Training: It is a statement of the obvious that custody officers should, ideally, receive appropriate training before taking on this specialist role. While there will inevitably be occasions when circumstances prevent this, it should be the rule rather than the exception. Less than half of the custody officers interviewed had benefited from training prior to assuming charge of the custody suite. Where training is provided, the coverage of matters relating to police surgeons varies; typically, a police surgeon is invited to explain the role. Most custody officers have not received first aid training or have done so but their qualification has lapsed. Such training could be valuable, both for custody officers and civilian detention officers – not to supplant or second guess the decisions of police surgeons but to assist them in providing ongoing care/observation (for example, for drunken prisoners), and give better quality information to surgeons at the point of the initial call-out.

73. Length of assignment: Everyone agrees that training is a key means of enhancing performance quality. Tenure – a prescribed period in which an individual post should be occupied – is a more contentious issue in many police forces. The benefits of specialisation, experience and continuity need to be balanced with those flowing from rotating personnel – notably, spreading expertise around the force and avoiding perceptions of elitism. In the case of custody officers, there are also concerns about the stressful nature of the duty that need to be taken into account. When balancing these factors to arrive at an appropriate length of assignment, it might be helpful to recognise that:

- the critical nature of a custody officer’s judgements and decisions means that there are considerable benefits in leaving officers in the role long enough for them to acquire experience and expertise; and
- the stress associated with custody work can be mitigated through training at the appropriate time, effective supervision and support, customised guidance on applying PACE, and providing opportunities for discussion/exchange of information between groups of custody officers.
The working and therapeutic setting: As well as being potentially difficult working environments, custody suites rarely provide an ideal setting for confidential medical examinations. Perhaps even more worrying is their unsuitability for housing people who are severely intoxicated or mentally disturbed. The responsibility of monitoring and caring for such prisoners is particularly onerous for custody officers and adds significantly to their stress levels, especially when tragedy strikes in the form of attempted suicide or a death in custody. The reduction in psychiatric hospital beds and all but one or two detoxification centres means that police officers rarely have an option other than the police station as a ‘place of safety’. Hospital casualty units are often equally unsuitable for such people and, if a hospital does accept someone who is unstable and potentially violent, they require a police officer to remain with them. There is thus no saving in police time when a hospital is the first port of call.

Given the prevalence of alcohol, drugs and substance abuse among those arrested on the streets, the rationale for detoxification centres staffed by nurses or other trained staff is becoming more persuasive, especially in larger towns and cities. Recent research carried out in London suggests that a relatively straightforward arrest for being drunk and disorderly costs £200 in police time, including a police surgeon call-out (Ref. 9). Taking a drunk person to a detoxification centre for ‘drying out’ uses up less police time, and there is of course the added advantage that close medical supervision makes such centres a far safer environment for the individuals concerned. In the absence of such facilities, police surgeons and custody suite managers need to reinforce good practice advice on the care of intoxicated or otherwise vulnerable prisoners [BOX F].

BOX F

Care of intoxicated/vulnerable prisoners – good practice points

Custody officers are often called upon to exercise discretion in whether or not to send a prisoner to hospital or to call out a police surgeon. They can be helped to exercise discretion appropriately through clear, simple advice such as the following pointers from the Association of Police Surgeons and the Police Complaints Authority (PCA):

Booking-in: the PCA suggests that each prisoner is asked when they are being booked in to custody:

- Are you currently under treatment by a doctor or psychiatrist?
- When did you last see your doctor/psychiatrist?
- Have you ever attempted suicide or self-harm?

cont./
Alternative ways of dealing with detainees who are substance abusers would alleviate some pressure in custody areas. Some forces are also exploring better systems for addressing the medical needs of mentally ill people who are brought into custody. In particular, they are seeking to divert such individuals from police stations unless they have committed a criminal offence (as opposed to posing a threat to themselves or others), thus speeding up the process of assessment and placement.

The improvement of facilities within custody suites and examination rooms requires, in many cases, a combination of better management and modest investment. A person should be nominated for each cell block whose task it is to maintain an inventory of supplies and equipment for the police surgeon’s room, and to ensure that the room does not become a dumping ground for miscellaneous items unconnected with medical examinations. There are inevitably competing demands for the resources that are needed to improve many outdated custody areas, but forces should consider the potential to free up resources by rationalising dispersed custody centres and also by improving the overall management of their property estate. Where money is available for development, police surgeons should be consulted on the design of any new examination rooms to be built.

**BOX F (cont.)**

**Head injury warning:** One of the most difficult conditions to diagnose is head injury in someone who is intoxicated, and many deaths in custody result from a failure to spot signs of deterioration in a person while they are detained. The Association of Police Surgeons has prepared a standard form of advice (endorsed by ACPO) which requests that, in appropriate cases, custody officers should rouse and speak with the prisoner – obtaining a sensible response – every 30 minutes. If a detained person:

1. becomes unconscious
2. becomes increasingly sleepy
3. complains of increasingly severe headache
4. complains of blurred/double vision
5. vomits
6. has a fit
7. or develops any other unusual symptoms

...the police surgeon must be contacted urgently. If an immediate response cannot be obtained, the custody officer should call at once for an ambulance.

*Source: Association of Police Surgeons (Ref.10)*

**76.** Alternative ways of dealing with detainees who are substance abusers would alleviate some pressure in custody areas. Some forces are also exploring better systems for addressing the medical needs of mentally ill people who are brought into custody. In particular, they are seeking to divert such individuals from police stations unless they have committed a criminal offence (as opposed to posing a threat to themselves or others), thus speeding up the process of assessment and placement.

**77.** The improvement of facilities within custody suites and examination rooms requires, in many cases, a combination of better management and modest investment. A person should be nominated for each cell block whose task it is to maintain an inventory of supplies and equipment for the police surgeon’s room, and to ensure that the room does not become a dumping ground for miscellaneous items unconnected with medical examinations. There are inevitably competing demands for the resources that are needed to improve many outdated custody areas, but forces should consider the potential to free up resources by rationalising dispersed custody centres and also by improving the overall management of their property estate. Where money is available for development, police surgeons should be consulted on the design of any new examination rooms to be built.
As long as custody officers have a responsibility for monitoring vulnerable and intoxicated detainees, they should be given greater support. For example:

- civilian detention staff (appropriately trained) or matrons deployed in busy custody areas;
- at least one cell suitable for observing juveniles or vulnerable prisoners;
- sufficient cells with low-level bunks for intoxicated prisoners; and
- where appropriate, at least one cell equipped with CCTV.

The trend towards rationalising custody suites – creating a few large, often purpose-built suites to cover large areas – makes achievement of these improvements more feasible.\(^I\) It also offers more effective management support for custody officers, reduces the number of complaints against custody officers\(^II\) and could contribute towards a greater ‘professionalisation’ of the role.

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\(^I\) Forces introducing centralised custody suites include Devon and Cornwall, Surrey, South Yorkshire, Avon and Somerset and Merseyside (which aims to replace its current 23 custody centres with 7 purpose-built or refurbished suites).

\(^II\) Analysis in one force showed that the lowest number of complaints per prisoner occurred in its area custody suite, which handles the second largest number of prisoners in the force.
Collection and use of performance information

79. The dearth of accurate information on patterns of demand and the nature of the work undertaken by police surgeons is the single biggest obstacle to ensuring a planned, rationally managed service. Previous Audit Commission reports have been critical of poor management information to support major operational activities such as crime investigation and directed patrol. It is therefore unsurprising that a comparatively minor aspect of police operations does not benefit from computerised analysis to support planning and decision making. Each force must determine its own priorities for developing databases and analytical techniques; realistically, monitoring police surgeon workload and costs may never be high on the research agenda, but nor should it be ignored.

80. Documenting the demand for medical services could help forces to budget more accurately for the service, establish the most efficient rota systems and inform decisions about alternative ways of meeting the demand. Performance information is essential for quality assurance; it might also highlight differences in practices or interpretation of PACE by custody officers. Exploring the possible reasons for variations in the bill for forensic medical services would be much easier if force systems (preferably computerised) could provide a detailed breakdown by activity and costs [EXHIBIT 11, overleaf].

81. The key information needed to manage demand and monitor performance includes:
   • number of call-outs by police area (BCU, division, etc);
   • number of attendances per surgeon and amount claimed in fees;
   • number and nature of statements/reports arising from attendance;
   • cost of the service by police area; and
   • for each call-out:
     – the time of call-out, and the response time of the surgeon;
     – who initiated the call-out – custody officer or prisoner?
     – the reason why a surgeon was called, and outcomes of attendance (including length of visit per person examined).

82. As custody records and other administrative processes are increasingly computerised, it will become easier to extract key data, some of which will come from the custody record. To obtain a complete picture, this information will need to be matched with financial information and comparative analyses from different command areas across the force. The gains in operational effectiveness, and possible financial savings, may be modest by comparison with other aspects of policing but are nonetheless worth pursuing at a time when forces are experiencing financial pressure. Merseyside’s recent rationalisation of police surgeon ‘patches’, and revised instructions to custody officers in relation to drunk detainees, achieved savings of £100,000. Providing such measures do not compromise adherence to PACE, nor diminish the quality of service provided to detained persons or victims of crime, they are a good investment of management time.
83. The traditional approach – whereby a police force or authority enters into individual arrangements for doctors’ services (usually, but not always, formalised by a written contract) – is coming under strain in some areas. A number of forces are beginning to explore alternatives, one of which is to encourage a move towards full-time police-related work; this is beginning to happen in busier areas or, in some cases, with police surgeons covering several force areas. Another option is to bring the service ‘in-house’ by making police surgeons employees rather than contractors. The principal drawback of this option is the cost of recruiting sufficient staff to ensure 24-hour, all year round cover, with the associated on-costs of employees. In addition, doctors themselves have expressed concern that their independence – an important criterion for forensic work – would be compromised if they were to become employees of the police service.
Although several forces have analysed this approach, none has yet put it into effect and it seems unlikely that any will. A more feasible alternative would be to purchase all forensic medical services under a single or several large contracts. The suppliers could be health trusts, a university or other ‘centre of excellence’, a primary care organisation or an agency/consortium created by medical professionals for the specific purpose of fulfilling such a contract [CASE STUDY 3].

A number of advantages could accrue from this approach. 

1. **research and development**: a single organisation to plan service development in an expert environment;

2. **cost**: a fixed budget for the contract period with consequent ease of audit and financial monitoring;

3. **performance standards**: built-in performance targets such as response times, and quality standards monitored by senior practitioners; guaranteed availability of suitably qualified practitioners to take on the more forensically demanding cases;

4. **training**: training agreements made between individual doctors/clinicians and the agency; professional development, career recognition and specialist training a core element of the contract; and

5. **communication**: one channel of communication between the force and the agency; force-wide rota system to be organised and operated by the agency; provision of management information to the force.

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**CASE STUDY 3**

**Provision of mental health services to the prison service in Durham**

An example of a cost-and-volume contract for medical services exists in Durham, where the prison service has contracted Newcastle City Health Trust to provide mental healthcare for prisoners. An estimate was made of the number of cases likely to be dealt with annually, and this formed the basis for determining the cost of providing a comprehensive service. If the actual cost falls within the range of 80 per cent to 120 per cent of the estimated cost, no further expenditure – or refund – is payable. The contract stipulates certain performance targets, such as waiting times for an assessment. This arrangement is seen as far more satisfactory than the previous system of specific psychiatric sessions and ‘spot purchasing’ of additional visits.

*Source: Home Office Working Group on Police Surgeons; Draft Report No. 1, 1997*

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1. This is a summary of points contained in a briefing paper prepared by Dr Stephen Robinson from the University of Manchester, who has kindly allowed the Commission to draw upon his material.
86. Such an agency agreement could be expanded, as appropriate, to include services such as occupational health and hospital referral costs. It also would facilitate relevant research in areas such as alcohol measurement and handling psychiatric illness at the police/public interface. At present, such research is ad hoc and rarely driven by the most pressing needs of police officers or detainees. There is now considerable experience within the public sector in specifying contracted-out services which could inform a proposal along these lines, but a firm recommendation should be based upon a properly evaluated pilot scheme.

87. In rural areas, the volume of police surgeon work may not support the creation of a specialist agency. In the short term, a solution to problems of recruiting and retaining adequately trained surgeons in these areas is more likely to come from changes to the national fee structure. A larger retainer, or guaranteed minimum income in rural areas, would increase competition for police surgeon posts, thereby giving forces more control over the quality of service. In the longer term, agencies operating from urban centres might expand to cover surgeons in neighbouring rural areas.

**Conclusion**

88. The recent record of the police service in responding positively to financial and performance pressures indicates that creative ways will be found to meet the challenges posed by the increasing demand for, and complexity of, forensic medical services. Some improvements are relatively small in scale and can be quickly secured; others will take more time and negotiation. Some forces, and indeed many police surgeons themselves, have an appetite for change as long as it improves the service. Fortunately, there is a solid foundation of goodwill and professionalism upon which to build as forces explore the alternatives open to them.
Postscript ...

On a Saturday night in a busy town centre police station, the eight detention cells are full. Among those detained are two drunken men arrested after fighting broke out in a nearby pub; one of the area’s most persistent burglars, who is a registered drug addict, has been charged with attempting to break into a chemist’s shop; a woman driver has been breathalysed at the roadside and is suspected to be over the legal limit for alcohol; and patrol officers have brought in a man whom they believe to be suffering from a mental disorder and requires detention for his own safety. He is placed in a special observation cell near the custody desk which is equipped with an intercom and a camera activated by movement.

An experienced casualty nurse, who is employed by the Forensic Medicine Consortium which serves the whole force, is on duty for his usual Saturday night session. He attends to the minor cuts suffered by the drunken brawlers and keeps them under close observation in the ‘drying out’ cells until they are sober enough to be interviewed. The nurse also carries out the blood test on the suspected drunk driver. Liaising with the custody officer, he speaks on the telephone to the experienced police surgeon who is on call for the town that evening; after describing the symptoms of the burgling addict, it is agreed that the doctor will attend within 30 minutes to prescribe medication to alleviate withdrawal symptoms. While at the station he will conduct the mental health assessment of the disordered offender, in conjunction with a psychiatric social worker who is also employed by the Consortium.
The Doctor’s Bill

For the Home Office

1. Undertake research or peer review into the content of police surgeon examinations with a view to identifying the extent to which other health practitioners such as nurses could be involved in service provision.

2. Review the PACE provisions on the definition of ‘medical practitioner’ to ensure that the existing definition is not constraining the achievement of a quality service and value for money.

3. Consider introducing a standardised approach to the recording of police surgeons’ advice/instructions, with appropriate guidance for custody officers.

4. Allow forces to enter into local agreements on remuneration for forensic medical services.

5. Conduct research into the feasibility of detoxification centres for detainees who are intoxicated or are drug abusers.

For police authorities

6. Ensure that a review of forensic medical services is undertaken at appropriate intervals, covering contractual arrangements, budget and quality assurance.

7. Ensure that all police surgeons are engaged on a proper contractual basis.

8. Consider the pros and cons of entering into a block or cost-and-volume contract for the provision of forensic (and other) medical services.

For police forces

9. Collect and analyse management and performance information to identify patterns of demand and workload, and highlight variations that may reflect underlying problems in service delivery or value for money.

10. Ensure that custody officers receive appropriate training before taking up their post, or as soon as practicable afterwards.

11. Ensure that custody officer training includes appropriate coverage of forensic medical issues.

12. Bring together custody officers and police surgeons once or twice a year for joint training/awareness sessions.
The Doctor’s Bill

For police forces (cont.)

13 Review tenure arrangements to ensure that an appropriate balance is struck between developing expertise in the role and addressing welfare issues.

14 Ensure that custody officers benefit from effective supervision and support from managers, reflecting the stressful and demanding nature of the role.

15 Review procedures for dealing with mentally ill detainees, with a view to increasing the rate of diversion at the point of arrest.

16 Seek to improve custody suite facilities; in particular, consider:
   - the appointment of civilian detention staff;
   - provision of observation cells for vulnerable prisoners;
   - provision of a suitable number of low-level bunks; and
   - extension of CCTV into at least one cell per suite.

17 Introduce a management infrastructure for police surgeons.

18 Nominate a police officer or civilian to co-ordinate police surgeon issues such as budget control, rotas, quality assurance and training.

19 Introduce formal, structured recruitment procedures for police surgeons.

20 Develop a force-wide training policy for police surgeons and ensure that this is adequately resourced.

21 Review procedures in respect of statements from police surgeons to ensure that they are not being provided unnecessarily.

22 Consider whether local circumstances merit departure from the national terms and conditions on police surgeon remuneration.

23 Standardise police surgeon contracts, incorporating the best features of various contracts currently in use.

24 Explore the possibility of moving from individual contracts to some form of outsourced block contract.
Appendix

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The Commission gratefully acknowledges the contribution of these individuals, other commentators from HM Inspectorate of Constabulary, the Police Superintendents’ Association and the Police Federation, and those in the fieldwork forces. The responsibility for the contents of the report rests with the Commission alone.

Fieldwork Forces

Cheshire Constabulary
South Yorkshire Police
West Midlands Police
North Yorkshire Police
Hampshire Constabulary
North Wales Police

Visits were also made to Merseyside Police and West Yorkshire Police
References

1. Home Office, Police and Criminal Evidence Act 1984 (s60(1)(a) and s66) Codes of Practice, HMSO, April 1995.
10. Dr Debbi Rogers, Head Injury Warning – Advice to Custody Officers, Association of Police Surgeons, October 1997.
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Since its beginnings in the 1830s, the police’s forensic medical service has changed dramatically. Once primarily physicians to police officers and their families, the role of police surgeons has diversified and their work today is a vital element in the criminal justice system.

The provision of forensic medical services is currently under scrutiny for a number of reasons. Demand for police surgeons to attend police stations and crime scenes has risen steadily and this trend looks set to continue, particularly with the growth in alcohol and drug abuse among prisoners. But some forces are struggling to recruit enough police surgeons to meet this demand; all forces are concerned about the quality of the service that they receive, as well as its rising cost.

This report examines the current arrangements for providing forensic medical services and makes recommendations that are aimed at police officers responsible for managing these services, the Home Office, police surgeons, GPs and other medical practitioners, custody officers and officers who are responsible for training and strategy. Areas highlighted for improvement include the need to develop a system of national standards and a more structured framework for organising and monitoring the service as a whole, to provide better training for custody officers and better custody suite facilities. The report also calls upon the Home Office to review the statutory basis for police surgeons' work to allow police forces greater flexibility in purchasing and managing forensic medical services.