NATIONAL GUIDANCE ON THE DELIVERY OF POLICE CUSTODY HEALTHCARE AND FORENSIC MEDICAL SERVICES

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National Guidance on the delivery of Police Care Healthcare and Forensic Medical Services

Introduction

This document provides the national guidance to support the delivery of Police Care Healthcare and Forensic Medical Services through a partnership approach between individual geographic NHS Health Boards and Police Scotland. This national guidance also provides NHS Health Boards / Partnerships with a template (Appendix 1) for service delivery, designed to inform local operating procedures.

This document is underpinned by the national Memorandum of Understanding for the Delivery of Police Custody Healthcare and Forensic Medical Services, which has been developed between the Police Service in Scotland and NHS Scotland, based on a clear common purpose and set of values.

Background

In 2008, following publication of the HM Inspectorate of Constabulary for Scotland Thematic Inspection: Medical services for people in police custody the Police and the NHS in Scotland acknowledged that they have a joint responsibility to address the health and wellbeing of communities and to look at ways of improving the services to people in police custody.

In July 2011 the Director General of the National Health Service (NHS) in Scotland, NHS Board Chief Executives and representatives of Association of Chief Police Officers Scotland (ACPOS) agreed to move towards a partnership arrangement for Custody Healthcare and Forensic Medical Services whereby the services provided by Police Forces under the Scottish Home Department Circular 7362 dated March 1950 should be delivered by territorial NHS Health Boards.

In this context Ministers have now agreed the general approach being taken towards a transfer of funding and responsibility for the provision of healthcare and forensic services in police custody, based on the following proposals:

- Responsibility for the delivery of healthcare in police custody which is a function of Health Boards, under the terms of the NHS (Scotland) Act 1978 should remain the function and responsibility of Health Boards

- Forensic medical services should be delivered by the Health Boards but remain a function and responsibility (with effect from 1 April 2013) of the Scottish Police Authority (SPA) under section 31 of the Police and Fire Reform (Scotland) Act 2012

- Reflecting those responsibilities, healthcare and forensic medical services should be delivered as part of a combined service
Funding for healthcare in custody and forensic medical services should transfer from the police to Health Boards

Current figures indicate there are around 200,000 custodies per year with an estimated 35% requiring medical intervention i.e. around 70,000. This provides 70,000 opportunities to tackle health inequalities through a common purpose and common value approach. Of these it was estimated that 45-50% had drug or alcohol related problems and some 7% had mental disorders.

Common Purpose

- To preserve life and reduce harm.
- To provide detainees with access to an appropriate range and quality of NHS health care services according to their needs.
- To deliver high standards of care, consistent with services provided throughout NHS Scotland
- To reduce health inequalities
- To provide a safe, secure environment for the health assessment and treatment of persons in police custody.
- To ensure that all relevant information and evidence is gathered consistently, preserved, analysed and exchanged appropriately and within both the law and applicable judicial protocols.
- To ensure that all forensic examinations undertaken provide the highest level of support to victims and evidence.
- To work with other agencies to maintain this common purpose.

Common Values

- To provide open, consistent, high quality and accountable public services.
- To encourage mutual respect for stakeholders and parties, encompassing health care and staff governance.
- To ensure openness in disclosure of necessary information, and reasonable notice of change.
- To encourage partnership in strategy and business planning.
- The provision of best value, joint approaches to common problems, and best use of available resources.
- To promote continuous service improvement.
Custody healthcare and forensic medical tasks requiring to be provided:

**General healthcare**
- Clinical assessment of persons in police custody
- Assessment of drug & alcohol intoxication and withdrawal
- Mental health assessment of persons in police custody
- Clinical treatment of illness or injury in custody
- Medications management and prescribing
- Care planning in custody
- Interventions, signposting referrals and follow up arrangements
- Advice to partner agencies and individuals relevant to the continued health and well being of individuals on their transfer or release from police custody

**Custody healthcare**
- Fitness to be detained assessment
- Fitness to be charged assessment
- Fitness for transfer assessment
- Fitness to be released safely
- Appropriate adult recommendations

**Forensic healthcare**
- Fitness for interview or further interview
- Documentation and interpretation of injuries
- Road Traffic Act 1988 and other drink/drug assessments
- Forensic sampling and retrieval
- Intimate searches
- Sudden and suspicious death verification
- Sexual Offences examination
- Appropriate involvement in Paediatric Forensic medical examination
- Provision of reports, statements and court attendance
Legislative framework

In addition to the NHS (Scotland) Act 1978 and Acts referred to above the principle legislative framework within which the service will be delivered includes:

- The Human Rights Act 1998
- The Criminal Procedure (Scotland) Act 1995
  - Section 13 – Suspects & Witnesses
  - Section 14 – Detention at Police Stations
  - Section 15 – Rights on Arrest & Detention
  - Sections 18 to 19B Powers for obtaining samples
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Adults with Incapacity (Scotland) Act 2000
- The Vulnerable Witnesses (Scotland) Act 2004
- Protecting Vulnerable Groups (Scotland) Act 2007
- Children (Scotland) Act 1995
- The Road Traffic Act 1988
- Police and Fire Reform (Scotland) Act 2012
- Fatal Accidents and Sudden deaths Inquiry (Scotland) Act 1976
- Terrorism Act 2000
- Immigration and Asylum Act 1999
- The Data Protection Act 1998
- The Common Law of Scotland
- Scottish Home Department Circular 7362, March 1950

Further to the above, the following professional guidance should also be considered applicable and informs this Guidance document:

- NHS Scotland Guidance and Standards
- Faculty of Forensic and Legal Medicine Guidance
- Royal College of Nursing: Health and nursing care in the criminal justice service
- General Medical Council (GMC) and Nursing and Midwifery Council (NMC) Guidance
- BMA & FFLM: Health care of detainees in police stations (2009)
- Care and Welfare of Prisoners SOP Police Scotland
Governance and Administration

The entire ethos of the service is based on an accessible multidisciplinary approach fully integrated into local NHS Health Board governance arrangements and NHS service provision, delivered in partnership with Police Scotland. There should be clear corporate management, accountability and clinical governance arrangements.

The aim is to provide a safe, clinically effective, cost effective and timely service addressing any inequalities in custody healthcare and ensuring provision of suitably trained medical and nursing staff to meet the specific healthcare needs of persons in police custody and achieve highest standards of forensic medical provision.

Any model of delivery must promote equity of access, patient centred delivery and patient dignity and respect not compromised by physical, language, cultural, social, economic and other barriers. As stated above a template for service delivery is included at Appendix 1.

A Knowledge Network has been established by NHS Education Scotland (NES) to provide consistent training and development tools for NHS (and partners) staff helping deliver these services.

This guidance will be reviewed on an annual basis and any documents referred to will be updated at this time. This will be a function delegated from the National Coordinating Network.

The National Co-ordinating Network (NCN)

A National Co-ordinating Network for Healthcare and Forensic Medical Services for people in police care has been developed as a collaboration of agencies to work towards this joint purpose of improving health and forensic medical services to people in police care. The Terms of Reference details the workings of the Network.

The partners are NHS Scotland, Police Scotland, Crown Office and Procurator Fiscal Service, Local Authorities and Scottish Government working in partnership to achieve the aims of the Network as laid down in the Terms of Reference.
Structure of the National Co-ordinating Network NCN

NATIONAL COORDINATING NETWORK

Scottish Government Health and Social Care, and Justice
NHS Boards Regional Planning Groups
Scottish Police Authority (SPA) / Police Scotland
Local Authority Social Work, Crown Office / Procurator Fiscal

National Coordinating Network Board (NHS Boards/Police/Social Work / COPFS)
Strategic direction and oversight

National Coordinating Network Support Group
(Chairs of subgroups, regional leads)
Operational Management of Network

Healthcare Services for people in police care
Forensic Clinical Services for people in police care
East, West and North regional collaborations

Mental health, addictions
Alcohol SAS / Police MoJ
Specialist Forensic services (Adult sexual assault)
Specialist Forensic services (Child protection / serious abuse)
Specialist Forensic services (other)

Standing DELIVERY SUPPORT for local partnerships and regional collaboratives

Training, development competencies subgroup
National Guidelines / subgroup
IM&T / Telehealth subgroup
Medicines management subgroup
Finance subgroup
Estates subgroup
Temporary PLANNING AND POLICY groups
APPENDIX 1

TEMPLATE FOR SERVICE DELIVERY

1. SERVICE OUTLINE

1.1 Overview

Each Health Board, through a partnership approach with Police Scotland, should have an agreed and clear model of service delivery for the provision of police custody healthcare and forensic medical services in their Health Board area.

1.2 Delivery model

It is recognised that delivery models will vary between Health Boards but nevertheless the aims and objectives for a safe, accessible and comprehensive service are the same across Scotland. This template is designed for use by NHS Health Boards/partnerships to offer consistency and flexibility to meet local variations and need.

As part of a co-ordinated service Health Boards are expected to provide suitably qualified and trained Healthcare Professionals (HCPs) to:

- See and examine any person whose detention is being contemplated by the relevant custody officer, in order to ascertain and give a written opinion regarding their fitness for detention, transfer and/or interview, and to examine any person and give a written opinion on their fitness for release.

- Where appropriate provide advice by telephone or telemedicine link on the above.

- Provide a suitable Care Plan for the person to remain in custody.

- Take appropriate action to ensure the medical wellbeing of any person the HCP considers unfit to be detained or interviewed.

- If required to provide a Mental Health Assessment for persons in custody, or others who have come to the attention of the Police. If not suitably qualified have access to qualified Healthcare Professionals for that purpose.

- To provide risk assessment checks in partnership with custody staff.
Prescribe and where required by legal or clinical governance framework oversee the management of medication to custodies.

To obtain forensic evidence from, and to examine and render medical assistance to, complainers, alleged perpetrators, suspects and offenders, including any persons suspected of drink/drug driving and other traffic offences when requested to do so by Police Scotland.

To examine alleged child victims of neglect, physical or sexual abuse where this role has been agreed by local partnerships.

To examine alleged victims of Sexual Offences, through a Sexual Assault Referral Centre (SARC) or Sexual Assault Referral Network (SARN) where available, or using other accepted locations and arrangements when not.

To provide medical support where multiple arrests are undertaken, which may require, by arrangement, a number of individual HCPs to carry out examinations, to avoid any cross-contamination (or allegation) between victim and suspect(s).

To attend, if required by the Senior Investigating Officer (SIO) the scenes or suspected scenes of crime, traffic or other incidents in keeping with agreed protocols, and to examine/confirm the death of any person, pronounce life extinct.

To examine any remains that are believed to be human remains and give an opinion (if possible), as to whether they are that.

To see and examine Police Officers and support staff and complainers, where an allegation of assault has been made by one of the parties.

To conduct intimate searches of persons (with the person’s consent), who are believed to be secreting drugs or other evidence under proper authorisation and clinical and ethical guidance for such examinations.

To provide a full written report or statement concerning the exercise of duties for the performance of his/her duty where required.

To attend any Court of law or tribunal when required to do so, in order to give evidence in connection with any matters with which the HCP has been involved in the course of their duties. For these purposes, any disciplinary tribunal under the Police Misconduct Regulation is to be regarded as a tribunal under this paragraph.

To see and examine and, if necessary and appropriate, render immediate medical assistance as first aid to any Police Officer or Police staff, injured in the course of their duty, recording any relevant detail.

Relevant healthcare interventions, screenings, health promotion and onward referrals or signposting to mental health, drug and alcohol services and other services should be initiated in line with clinical need and local delivery plans. The service would link into any regional or national managed clinical networks and be responsive to developing national standards.
2. ADMINISTRATION

2.1 Qualifications and vetting
All persons engaged as a Health Care Professional (HCP) undertaking custody healthcare and/or forensic medical roles, should meet the following minimum qualifications and standards:

- Must have undertaken pre-employment screening required by the Health Board
- Vetting through the Non Police Personnel Vetting level 2 process
- Must have Protecting Vulnerable Groups Scheme (PVG) Disclosure
- Should hold a full UK driving licence (if using own car for work purposes)
- Should have demonstrable skills in listening, reading, writing and speaking English that enables effective communication in clinical practice with patients and colleagues

2.1.1 Doctors
- Must be registered with the General Medical Council (GMC), undertake revalidation and hold a licence to practise
- Should have achieved recognised competency in a relevant specialty
- It is also desirable that Doctors should have and/or work towards relevant postgraduate qualifications
- Forensic Medical Examiners (FMEs) also known as Forensic Physicians (FPs) provide medical care and, when required, forensic assessment of detainees/suspects in police custody, complainants/complainers (alleged victims) of crime, police officers injured while on duty, and attend scenes of death. They provide interpretation of their findings to the police, solicitors, and courts verbally and in writing. Statements for court and presentation of evidence in court are required in a proportion of these cases (FFLM 2010).

2.1.2 Nurses
- Must be registered with the Nursing and Midwifery Council (NMC) educated to degree level (or working towards)
• Evidence further education/CPD in relevant areas e.g. Minor Injury/Minor Illness/ Advanced clinical examination / Nurse Prescribing/Mental Health/Substance Misuse

Where Custody Nurses provide healthcare services within police custody suites their work is focused on conducting clinical assessments, identifying and implementing appropriate interventions, collecting forensic samples, providing advice and guidance, and maintaining detailed and accurate records to ensure the health, safety and welfare of people held in police custody (RCN 2009).

Nurses will at all times and in all matters work in accordance with the Nursing and Midwifery Council Code of conduct.

2.1.3 Other Health Professionals (e.g. Addiction Workers etc.)

• Current and continuing registration with the appropriate body
• Have necessary training, qualifications, experience and current competency

2.1.4 Probity

All HCPs will be required to advise the Health Board organisational lead in writing, if he/she:

• Ceases for any reason to be registered with the relevant professional body
• Becomes subject to any disciplinary, health or performance proceedings before their professional body, whether or not arising out of, or pursuant to, the HCP’s performance or his/her duties under the Police/Health Board agreement
• Is arrested, charged, summonsed or reported for any criminal offence (other than a fixed penalty Road Traffic) or he/she is the subject of a criminal investigation
• Is prevented by illness or incapacity from fully discharging his/her duties, in particular, where any period of illness or incapacity has lasted, or is expected to last, for more than 3 months
• Becomes pregnant, to enable a risk assessment to be carried out
• Accepts an appointment as Justice of the Peace or other civil post
• Undertakes activities (professional or otherwise) out with the scope of the Police/Health Board agreement, which might lead to a conflict of interest with his/her duties

2.1.5 Appraisal

All HCPs performing a Custody healthcare or forensic medical or nursing role, will include this aspect of their role in annual appraisal and undertake relevant CPD.
2.2 Training

All HCPs are expected to undertake NHS mandatory training as advised nationally in conjunction with NHS Education Scotland (NES). Each Health Board will oversee training requirements as deemed appropriate. NHS Education Scotland has developed a Knowledge Network for use by NHS and partner staff in the delivery of this service to aid training and development.

The following is indicative of the content of training:

- The Scottish legal system
- The Police Service in Scotland
- Criminal Procedures
- Consent, confidentiality and ethics
- Personal Safety
- Record Keeping and Information Sharing
- Custodial medicine and duty of care
- Assessment and diagnosis of physical and mental health status of individuals
- Assessment of alcohol / drug intoxication and withdrawal
- Forensic and medical implications of conditions
- Care plans, interventions and onward referral
- Fitness for Detention
- Fitness for Interview
- Appropriate Adults
- Place of Safety requirements
- Management of people detained under the Terrorism Act 2000
- Road Traffic Legislation
- Drink/Drug Driving theory and practical procedure
- Injury documentation, classification and interpretation
- Restraint
- Doctor at Scene of Death
- Law relating to Sexual Offences – adults and children
- Examination in Sexual Assault – adults and children
- Domestic Violence
- Protection of Vulnerable Groups
- Child Protection, Adult Protection and Public Protection
- Disclosure
- Court Room Skills
- Report writing and statements
2.3 Governance

2.3.1 NHS

2.3.1.1 Organisational Lead

In addition to the Chair of the Network (NHS Chief Executive) each Health Board will have a clear organisational lead (or similar) who will have overall strategic responsibility that ensures key processes are in place to provide quality of care, support for those within the service and a framework for clinical governance within the structure of the Health Board. The Organisational Lead will be first point of contact within the Health service for Police and is responsible for the clinical governance and risk management of the service. They will ensure that systems, processes and procedures are in place to assure the delivery of safe and effective care and maintain a link for regional solutions where services are shared between Health Board areas.

2.3.1.2 Clinical Lead

A Lead Clinician (or as agreed in each Health Board) will provide advice, supervision and support to HCPs performing Custody and forensic medical roles, lead on updating guidance, and SOPs and will manage the audit process for health. The Lead Clinician will preferably have attained or be working towards Membership of the Faculty of Forensic and Legal Medicine (FFLM) or have equivalent postgraduate qualification or experience.

2.3.2 Police Scotland

2.3.2.1 Strategic Lead

An officer of the rank of Assistant Chief Constable (ACC) will have the strategic lead for Police Scotland and will have responsibility for ensuring processes are regularly reviewed and updated in line with National guidance.

2.3.2.2 Tactical Lead

A Tactical Lead will be appointed who will be accountable to the aforementioned ACC. This lead officer will be responsible for liaising with the management of Custody Division for related matters, including updating of Standard Operating Procedures (SOPs), training requirements and acting as initial point of contact with the Health Board as well as linking with forensic services where issues may be raised in relation to the quality of samples provided. The Tactical Lead will conduct regular auditing of all processes and provide management information for the Strategic Lead on a monthly basis and will coordinate the Police Scotland local contacts with Health Boards established through the Local Partnership Models.

A key responsibility will be to provide a conduit to the National Co-ordinating Network Board for Forensic medical & Healthcare Services for People in Police Care.
2.3.3 Partnership Working

The NHS Board and Police Scotland locally will jointly consider all on going issues including, but not restricted to, sharing of management information from both partners, review of service delivery, significant case reviews, events planning and contribute to the National Co-ordinating Network as well as national managed clinical networks, any regional arrangements and national police custody forums.

2.4 Incident Reporting and Review

NHS and Police Scotland Incident Management Policy and Procedures will be used and all incidents will be reported using local NHS and Police procedures.

Within this policy an incident is defined as “any event or circumstance arising during NHS care or service provision that could have or did lead to unintended or unexpected harm, loss or damage. Harm is defined as “injury (physical or psychological), disease, suffering, disability or death”. In most instances harm can be considered to be unexpected if it is not related to the natural cause of an illness or underlying condition.

A death in custody is where any of the following circumstances apply:

- The death occurs in a Police Station or Custody Centre (including such temporary Police accommodation at, for example football stadia);
- The death occurs in hospital, the deceased having been taken there from a Police Station because of apparent injury or illness;
- The deceased was taken direct to hospital, after being arrested or detained in the street, because of apparent injury or illness;
- The deceased was in Police custody at Court;
- In any other case where at the time of death the deceased as in the care of the Police, for example, death occurring in a Police vehicle.

In Police terms an adverse incident is any incident, which, if allowed to continue to its ultimate conclusion, would have resulted in the death, serious injury or harm to any person.

Quarterly NHS/Police liaison meetings will be used to both monitor and review all such adverse incidents reported, to ascertain any learning or system changes that may be required to improve quality of care.

Such liaison will feed into the National Co-ordinating Network, to enable sharing of best practice and lessons learned.

2.4.1 Police Investigations Review Commissioner (PIRC)

Scotland has a single police service and therefore, where an independent investigation is required, the Crown can direct the PIRC as an independent body to undertake and report on its behalf. Similarly the Chief Constable or the Scottish Police Authority can ask PIRC to investigate.
For example, the death of any person who had direct or indirect contact with the police would usually be referred to COPFS. COPFS will then decide whether to instruct PIRC to carry out an investigation.

The Chief Constable must refer to the commissioner

- Any death or serious injury of a person who had direct or indirect contact with the police at or before his or her death where there is an indication the contact may have caused, or contributed to, the death.

- The use by police of a firearm, Taser or CS spray must be referred.

The Scottish Police Authority (SPA) must refer

- Any circumstance in which there has been a serious incident involving the police

- Potential misconduct by a senior officer that the SPA feels needs investigated

Other matters may include where the Commissioner considers it in the public interest to investigate.

Health Boards have a statutory duty to co-operate with PIRC and employees and contractors involved in the delivery of police custody healthcare and forensic medical services must be aware of this and that they may be contacted by PIRC in investigation of such circumstances.

2.5 Medication

All processes and procedures related to the safe and secure handling of medicines and to the prescribing and administration of medicines to custodies in Police Custody Centres will follow the relevant Health Board and NHS Directors of Pharmacy national policies, procedures, formularies and guidelines.

In addition, reference should be made to the FFLM Safe and Secure Administration of Medication in Police Custody and Operational procedures and equipment for medical rooms in police stations guidance documents.

2.5.1 Ordering Medicines

The ordering of medicines will be in accordance with individual Health Board policies and procedures as agreed with Police Scotland.

2.5.2 Receipt of Medicines

The receipt of medicines will be in accordance with individual Health Board policies and procedures as agreed with Police Scotland.
2.5.3 Storage and Security

The storage and security of medicines in Police Stations will follow the principles of the individual Health Boards as agreed with Police Scotland. All HCPs should be familiar with the content of this policy.

In general:

Each Police Station will have a secure locked cabinet for the storage of medicines. These cabinets will be located in the Medical Room. Only medicines must be stored in these cabinets.

- Access to these cabinets must be restricted to registered HCPs. Within each Police Office procedures must be in place regarding the security of keys. These procedures must be agreed locally between HCPs and Police staff.

- When not being administered to patients, all medicines must be locked away.

- All medicines must be kept in their original container. Medicines must not be decanted or transferred from one container to another by HCPs.

- In each Police Office procedures will be in place for the routine date checking of all medicines. All medicines should be date checked on a monthly basis.

- Expired medicines should be returned, in a sealed pharmacy bag, to the supplying hospital pharmacy for destruction.

- Any medicines being disposed of within the Police Office must be discarded in blue-lidded waste containers specific for pharmaceutical waste.

2.5.4 Patient Group Directions (PGDs)

A PGD is defined as a written instruction for the supply and/or administration of a licensed medicine in an identified clinical situation. It applies to groups of patients who may not be individually identified prior to requiring treatment.

Before a PGD is implemented in Police Custody the relevant Health Board must approve the use of that PGD. Only NHS Scotland approved PGDs will be implemented. Only fully competent and trained nurses may use the PGD. The Senior Custody Charge Nurse and all staff working under the authority of the PGD must sign the PGD.

It is the responsibility of the Senior Charge Nurse (Police Custody) to ensure that the list of staff using any PGD is up to date, that audit of the PGD is carried out, that only valid PGDs within their review date are being used and that medical staff are informed of the implementation of PGDs. The Senior Custody Charge Nurse (Police Custody) must also provide the Lead Nurse with details of PGDs being implemented.

2.5.5 Administration and Self-Administration Under Supervision of Medication

All Medication to be administered or self-administered under supervision will be in accordance with individual Health Board policies and procedures as agreed with Police Scotland.
Administration of medication in police custody may be carried out by the forensic medical examiner (FME); other HCP, or by self-administration by the detainee, either kept in their own possession or supervised by a HCP or police custodian.

The most appropriate means of administration will be dependent on a range of factors, which may include: the medication; the method of authorisation of the medication and relevant regulatory restraints; the clinical condition of the Custody; and the availability of appropriate staff.

When non-clinical police custodians are required to supervise the detainee’s self-administration of medication it is essential to ensure that:

- Instructions for the medications are clearly communicated to and understood by the custody staff.
- The correct medication is offered to the intended person at the appropriate time.
- Accurate records of prescribing and consumption are kept to include the date and time of consumption.
- Any documentation used by Police Scotland to assist with self-medication should, in common with the Care Plan be stored in a suitable place and retained for the standard time years in accordance with Police Procedures.

2.5.6 Patients Own Medicines in Custody

Medicines that have previously been dispensed for a patient e.g. by a community pharmacy that have been brought into police custody with the patient, must be assessed for suitability before being administered/self-administered under supervision.

These medicines remain the patient’s own property and, where at all possible, consent should be obtained before they can be used or destroyed.

A HCP should assess patients’ own medicines and comply with locally agreed procedures.

In general, the following criteria should to be used to assess these medicines:

The container

- The medication must be in the original (dispensing or manufacturer’s) container
- Actual quantity in container must be less than or equal to that stated on the dispensing label i.e. there must have been nothing added to the container since dispensing
- Bottles containing tablets, capsules or liquids, despite being labelled correctly, are not suitable for use unless they are unopened
- Must be clearly labelled as below
The label
- Must be legible
- Must be in English
- Must have the name of the patient to whom the medicine will be administered
- Must have the name and strength of the medication
- Must have the appropriate directions
- Must have an in-date expiry date
- Must have the dispensing pharmacist or dispensing doctor’s name and address and the dispensing date displayed
- Must have the quantity of medication dispensed

The medication
- Must be of acceptable appearance; tablets/capsules are clean, whole and without signs of deterioration
- Must be no doubt over identity
- The patient must confirm that storage has been appropriate

2.6 Record Keeping

All medical and nursing records must be compliant with guidance and standards set out by professional bodies such as General Medical Council and Nursing and Midwifery Council and NHS Scotland standards.

There should be regular audits of record keeping with all staff expected to adhere to guidance and standards set out by Health Boards and professional bodies. Information Sharing Protocols should be in place to allow the safe sharing or personal information between the respective bodies to ensure effective care of people in custody (see 2.14).

Any Information Management (IM) systems will comply with statutory obligations for the management and operations of IM & T within the NHS, including, but not exclusively:
- Common Law duty of confidence
- Data Protection Act, 1998
- Freedom of Information Act, 2000
- Computer Misuse Act 1990
- Caldicott Principles and Guidance

2.6.1 Custody Care Plan

While each Health Board will have an auditable method of recording healthcare examinations, the principal record to convey directives to Police Scotland for the care of a person will be the Custody Care Plan.
This record will contain

- Confirmation (or otherwise) of fitness to be detained (by Tick box)
- Police Observation frequency/reason
- Medication requirements
- Medication administering arrangements
- Health review frequency
- Name and designation of HCP
- Signature with date & time

2.6.2 Reports and Statements

In the event that an Investigating Officer requires an HCP to submit a report or statement, the HCP must ensure that the record is typed, prior to submission, so as to reduce the risk of information being misread due to poor quality handwriting detail.

All reports or statements requested must be completed and submitted in full, within 14 days of the initial request or sooner if required by the case. In the event that a HCP is to move on or have a leave period within that time period, the report/statement must be completed prior to going away.

Quality of reports and statements will be reviewed at the quarterly partnership meetings.

2.7 Court Attendance

As part of the HCPs duties, there is an expectation that they will at times be required to attend Court to give evidence.

On receipt of citation or request to attend, it will be the responsibility of the individual HCP to make himself/herself available for attendance. Whilst arrangement can be made with the Crown Office and Procurator Fiscal Service (COPFS) to have a HCP on standby for Court, this arrangement is far from ideal for those having to travel considerable distances. For this reason, it would be advantageous for the HCP to contact the Procurator Fiscal’s Office dealing with the case, to reduce the likelihood of valuable time being wasted.

Court skills and witness training should be provided, to help ensure effective presentation of evidence, familiarity with Court and legal processes, as well as and to provide the HCP with a mechanism of support and confidence in this area.

Where the HCP is required to provide a witness statement concerning any examination undertaken in the course of their duty, the statement should be provided in typed format within 14 days of that request or other timescale as agreed or dictated by requirements of the case.
2.8 Interpreting Services

Police Scotland will be responsible for the provision of qualified Interpreters and blind/deaf interpreting services.

If for any reason or conflict of interest it becomes apparent use of Police interpreting services is not appropriate the NHS Board will be responsible for the provision of qualified interpreters and blind/deaf interpreting services for use in general healthcare examinations.

Any conflict of interest or cultural issues should be discussed beforehand with the Interpreters, Custody staff or HCPs.

2.9 Appropriate Adults

The Criminal Procedure (Scotland) Act 1995 and the Mental Health (Care and Treatment) (Scotland) Act 2003, are the primary legislations regarding any need for the services of an Appropriate Adult and consideration will be given to all vulnerable groups, including children and persons with mental health problems, or considered mentally vulnerable, accessing this.

The Mental Health (Care and Treatment)(Scotland) Act 2003 defines mental disorder as “any mental illness, personality disorder, or learning disability however caused or manifested”. For the purposes of Appropriate Adults this should include people with acquired brain injury, autistic spectrum disorder and people suffering from dementia.

The Vulnerable Witnesses (Scotland) Act 2004 defines as vulnerable witnesses as being adult witnesses whose quality of evidence may be affected.

The Investigating Officer can consider a medical examination of interviewee to ascertain fitness for interview (fitness for interview will not delete need for Appropriate Adult).

Identifying when an Appropriate Adult is required

The following indicators are listed for guidance but this is not a definitive list of criteria:

- Unusual and excessive anxiety
- Incoherence (not solely drug or alcohol induced)
- Inability to understand or answer questions
- Unusual behaviour traits
- Information from interviewee in respect of mental health, hearing disability or other communication need
- If during course of an interview an Investigating Officer has cause to suspect a mental disorder, he/she will be required to contact an Appropriate Adult and postpone commencing their interview until their arrival.
- Information from persons who know the interviewee
Alert Cards/Advocacy Cards carried by the interviewee

Information from Social Work services, as to whether the interviewee is known to them for support services

Where a Standard Police Report is submitted in respect of any case where an Appropriate Adult has been used, the Remarks Section must make reference to the person’s physical or mental health. The report must also contain full contact details of the Appropriate Adult, any statement made by the Appropriate Adult about the interview and any notes taken by the Appropriate Adult will be submitted as a Production.

Where the HCP or Custody staff through risk assessment has assessed a person to be in need of the Appropriate Adult services, the Investigating Officer will be advised of this opinion and thereafter, Police will call out an Appropriate Adult in line with local instructions and the supporting Guidance on Appropriate Adult Services in Scotland.

2.10 Response Times

Arrangements should be in place to allow immediacy of telephone advice and the overall workforce provided should be sufficient to provide a timely response as agreed for a particular case to reflect the clinical and forensic needs of patients and people in custody. This may also be remotely (video conference) where established.

A sooner response may be preferable in certain road traffic assessments, similarly victim examination may need to be delayed for clinical reasons or until the individual is ready to be examined.

2.11 Complaints Procedure

All Police related complaints will be dealt with through the Complaints about the Police procedure. Leaflets explaining the process are available at all Police Offices.

Similarly, complaints against HCP will be dealt with within the NHS complaints procedures.

Where there is a complaint spanning both Health and Police services, both complaints should be cross-referred and if necessary, jointly investigated.

Informing the Police staff member and/or HCP regarding any allegation against them, should be made in line with present procedures and in the event of a joint complaint, made after consultation between Police and Health Leads.

The Police Investigations Review Commissioner (PIRC) may also have a role in investigating complaints in certain circumstances (see 2.4 above).
2.12 Management Information

Management Information should be reviewed at quarterly NHS Police liaison meetings. Such information may also be required for national monitoring and management purposes. Data to be considered may include:

- Number and location of requests
- Types of request
- Response times
- Referrals to hospital
- Referrals to other organisations/departments
- Complaints and Quality issues
- Training requirements
- Critical incident reviews and lessons learned
- Cost and resources information
- Estates and environment information

2.13 Improvement and Development

Health Boards and Police Partnerships are expected to undertake a continuous cycle of self-assessment, audit and improvement working with the National Co-ordinating Network in implementing best practice developments.

2.14 Information Sharing

An Information Sharing Protocol (ISP) should exist between each Health Board and Police Scotland (at Divisional level) and other partnership organisations, as appropriate (local authorities and third sector organisations). Details of the relevant procedures should be available to employees of the Board and Police Scotland via their Intranets. Where such information is provided, however, clear and unambiguous instructions should be given. All other information should be recorded in healthcare notes. An Information Sharing Protocol template (the Scottish Accord on the sharing of personal information) is attached as Appendix 2 of this document.

2.14.1 Sharing information with the police

Where information needs to be passed to the police, concerning the individual’s health and his or her need to be given medication or kept under observation while in custody, only the information necessary to safely fulfill this requirement should be disclosed. Custody officers should be provided with clear and detailed instructions about any medical supervision required, including the frequency of visits needed. In providing this information, they should bear in mind that police officers are not medically qualified and cannot be expected to interpret complicated medical terminology.
Due account should also be taken of confidentiality and specific information about detainees’ health should only be provided when it is necessary to protect their health or that of others who come into contact with them.

Where there is a forensic or evidential potential or intent to information gathered the purpose and use of this should be made clear to the individual being examined with appropriate consent obtained early and any duty to disclose or provide a report for COPFS made clear.

2.14.2 Sharing information with other health care providers

As with other areas of medical practice, it is important to share information with other providers of health care involved in the clinical care of the individual. This includes ensuring that a confidential record of any medical treatment provided, or requested, by the forensic medical examiner while the individual is in police custody, accompanies the individual when transferred elsewhere.

Where another doctor, such as a psychiatrist, has been consulted about, or has seen, the patient, this should be included in the notes. This should include information about suspected mental disorders, physical illness, substance misuse or suicidal tendencies.

2.14.3 NHS Information Technology

Secure NHS IT systems should be available at the locations as agreed with Police Scotland. All terminals should be password protected and secured within a lock fast medical room (or similar) where access is restricted to healthcare professionals and Police custody supervisors only. Relevant information will be accessed wherever possible and exchanged within the appropriate information sharing protocols and professional standards.

Local Standard Operating Procedures should identify the processes and contact points for obtaining support and resolving technical difficulties.

2.15 Business continuity

Arrangements for service business continuity for both custody healthcare and forensic medical services must be incorporated into Health Board business continuity arrangements with contingency plans, whether through local services or regional support, clear. Details of each partner’s responsibility in any contingency plans should be clearly identified.
3. FACILITIES

3.1 Custody Medical Room

Police will provide suitable facilities for use by HCPs aiming to meet the following specifications:

NHS Health Facilities Scotland guidance and FFLM Operational procedures and equipment for Medical Rooms should be adopted to provide suitable facilities. These will be provided by Police Scotland to NHS Scotland standards and requirements with equipment provided by local Health Boards. Local Models will outline locations and specifications.

Terminals for relevant NHS IT (including video conference facilities, where appropriate) will be provided within each Medical Room. Access to the medical room is restricted to HCP’s and Police staff access only on instruction. Access to NHS IT equipment must be restricted to NHS Staff.

Custody Medical Rooms will remain locked when not in use, to prevent unauthorised access and potential for cross-contamination. Custody staff can hold keys for entry to the Medical Room but secure arrangements should exist so that only HCPs have access to medical records and drugs cabinets.

Healthcare records shall at all times be treated as medical-in-confidence i.e. restricted information and must be stored securely within the Medical Room. Access to healthcare records will only be available to the HCP.

All medical rooms should be equipped with adequate safety features e.g. panic strips

The standard of medical rooms will be monitored as part of the monthly custody area audit and any issues identified will be raised with the Lead Officer in the first instance.

3.2 Victim Examination Facilities

In general, it is accepted that Police premises are not a suitable venue for victim examination. However, it is also accepted that currently there are a number of reasons why these may still require to be used until other premises are available and have been agreed.

Examination facilities should provide the opportunity for the victim to relax and prepare for the examination; afford the victim adequate privacy; and provide the victim with time and facilities to wash and change their clothing at the completion of the examination.

Agreement may be reached between individual Health Boards and Police Scotland on suitable locations, which, dependent on the nature of examination, may be healthcare premises such as a hospital, GP Surgery or Health Centre or, where forensic integrity is required, a suitable jointly agreed and maintained facility.
3.3 Cleaning Specification

3.3.1 Custody Medical Examination Rooms
Specifications for the enhanced cleaning and maintenance of rooms used for medical purposes should be put in place and regularly reviewed, in accordance with NHS and Health Board guidelines and as agreed with Police Scotland. Such contracts will be the responsibility of facility provider.

However, it should be emphasised that owing to the potential for cross-contamination, a basic control should be that cleaning equipment/materials used to clean cells, cell corridors or cell shower/wash areas should not be used to clean Custody Medical Examination Rooms.

Guidance on the required cleanliness and hygiene minimum standards are set out in the NHS Scotland National Cleaning Services Specification.

3.3.2 Rooms or Suites used for Forensic Medical Examination
The room or suite needs to be cleaned after each use to prevent DNA contamination.

This should be done as agreed by each Health Board and Police Scotland, but should take into account nationally agreed procedures and standards along with any recommendations from the Scottish Police Authority (SPA) Forensic Service.

As a general guide, cleaning is to a greater enhanced standard and should include the forensic waiting room, the medical examination room, the bathroom and toilet within the facility. Within the medical examination room the floor, couch (even if covered with a protector at the time of the medical), worktop, writing desk, sink and taps need to be cleaned each time the room is used using designated equipment and disinfectant solutions and wipes following locally agreed procedures based on national recommendations.

NHS Scotland National Cleaning Services Specification

FFLM Operational procedures and equipment for medical facilities in victim examination suites or Sexual Assault referral centres (SARCs)

3.4 Medical Equipment
Each Health Board will supply and maintain equipment for therapeutic purposes and maintain and monitor stock levels. Calibration and maintenance of the equipment is the responsibility of the Health Board.

Police Scotland will supply any forensic kits/equipment and a supervisor will be responsible for maintaining and monitoring of stock levels. All equipment will be secured within the Medical Room or other approved location.

The FFLM Operational Procedures Equipment for Medical Rooms in Police Stations and Victim Examination Suites specifies a recommended list of contents.
3.6 Healthcare environment

Police and Health Boards should work together to ensure any delivery of healthcare on their premises is from a clean environment that meets Health Facilities Scotland recommended standards including adoption by Police Scotland of NHS Scotland National Cleaning Services Specification and work towards HAI Scribe compliance for healthcare facilities such as medical rooms on their premises.

Police and Health Boards should work together in order to undertake regular audits of the environment and where appropriate raise any non-compliance issues immediately with Police Scotland.

3.5 Waste management

Clear arrangements for management and disposal of healthcare (including clinical) waste to equivalent standards, as Health Facilities Scotland Waste Management Guidance should exist. Responsibility for this provision must be clearly documented within the partnership including where in some areas Police have discharged this to the local NHS Board.

3.7 Infection control

NHS National Infection Prevention and Control Guidance including use of Standard Infection Control Procedures (SICPs) should apply for all healthcare delivery with transmission-based precautions (TBPs) instituted where and when appropriate.

HCPs should have access to appropriate Personal Protective Equipment (PPE) and body fluid cleaning kits in the medical room.

3.8 Health and safety

Partnerships at a local level must have a comprehensive health and safety policy that complies with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1992).
4. CUSTODY HEALTHCARE

4.1 General Healthcare

Where individuals are detained in police custody it is important their specific healthcare needs continue to be met and any new or additional needs assessed.

On instruction the duty HCP will undertake to attend the specified location and conduct relevant medical examination. In general, the standard of care provided will be at least equal to that provided by the NHS with specific assessment and management of risk for the custody environment. Telephone advice may be appropriate in some cases but this must be clearly documented.

Any immediate or emergency situation will be dealt with through current arrangements with the ambulance service or direct transfer to an Accident and Emergency department.

The duty HCP will be expected to work within competencies, referring on where required and have the necessary knowledge, skills and experience to:

- Assess and/or treat illness
- Assess and/or treat injuries sustained
- Give advice to the Custody Officer on general care of the detainee when in custody
- Ensure appropriate arrangements are in place for any medication requirements
- Assess and manage risk related to healthcare in a custodial setting
- Provide a Care Plan for any healthcare interventions or on going care required

Where appropriate, specialist clinical resources may be involved in the care of the detainee.

In addition, opportunity should be taken to provide health promotion advice and interventions with follow up arrangements or signposting for further care.

4.1.1 Initial examinations

Initial examinations where required and where possible should include as a minimum:

- Background information from custody staff on reason individual is in police custody
- Information from custody staff from the Custody Vulnerability Assessment
Any risks, concerns or warnings custody staff are aware of

Past medical and psychiatric history

Previous self harm

Current medication
  - Prescribed
  - Over the counter
  - Illicit

Allergies

Gender requirements, special dietary requirements, diversity or disability needs

Social history

Educational background and understanding

Time last ate & slept

Basic observations including general demeanour and behaviour, level of consciousness, pulse, blood pressure, respiratory rate, pupil size and reactivity

Signs or symptoms of drug or alcohol intoxication or withdrawal

Access to the NHS Emergency Care Summary, or electronic Key Information Summary (eKIS) if this exists, should be made available under pre-existing consent models for NHS workers. This will assist, as one of at least two sources of information for safe medicines reconciliation and allow any special notes, alerts or healthcare considerations that are recorded to be taken account of while in custody.

A care plan for that individual while in custody should be formulated with clear written and verbal instructions relevant to care while in police custody given to custody staff.

The following are not fit for care in custody and should be transferred to hospital by ambulance:

- An intoxicated person who is unable to walk and talk
- An intoxicated person who has a head injury
- Any reduction in level of consciousness
- A suspected overdose of drugs or drugs & alcohol
- Seizures while in custody
4.1.2 Privacy for healthcare assessments and medical examinations

The duty to respect the individual’s privacy to the greatest extent possible is not only a professional obligation but is also a requirement of the Human Rights Act. Any infringement of that right must be legitimate and proportionate.

The purpose of the examination and the risks involved will determine the need for accompaniment for healthcare assessments. This may be for reasons of chaperone or safety after risk assessment. Additionally, corroboration may be required in certain cases for the forensic element of any examination or sampling.

A Police Officer or second HCP may be required with the appropriateness for each case decided on an individual basis and the decision recorded within the risk assessment portion of the Custody Record. The COPFS/Police Scotland guidelines for recovery of forensic material/conduct of forensic medical examinations will be referred to where necessary.

At all times the duty to respect an individual’s privacy as far as possible, will still apply.

4.1.3 Assessment of Post Incident Conditions

As part of the initial medical examination of prisoners, HCPs may be required to give a consideration of health conditions as a consequence of the arrest and where necessary, give treatment of injury effects.

Such injuries, or complaints of alleged injuries, could be as a result of the use of

- Handcuffs
- Baton
- CS Spray
- Taser
- Restraint Belts or
- Use of Force

Training in awareness of the effects of Personal Protective Equipment used by Police Officers, in order to give an assessment and treatment of any injuries caused by the use of this equipment and techniques, should be included in induction courses.

HCPs may be required to give an opinion of any injuries possibly for criminal or internal discipline matters should a complaint be made and, similarly, report any adverse incidents.

To assist in preservation of evidence, the on-duty Scene of Crime Officer will be made available to take photographs of any injuries. It will be the responsibility of the police-investigating officer tasked with the investigation of the allegation to make all necessary arrangements in line with Complaints about the Police procedures.
4.2 Assessment in Relation to Substance Misuse (Intoxication)

Where an individual in the community is intoxicated and in need of medical assistance the Management of people in the community who are drunk and incapable Memorandum of Understanding between Police and Scottish Ambulance Service applies.

Police Custody Staff will monitor all detainees at risk of intoxication and raise any concerns with a Healthcare Professional or if indicated arrange for ambulance transfer to hospital.

A Healthcare Professional must medically assess all detainees who are felt to be intoxicated as a result of substance misuse. This assessment must take place within a clinically appropriate timescale.

The clinical assessment will take place within a designated healthcare area unless the patient is physically incapable of being brought to this location.

This assessment will include a minimum documentation of Glasgow Coma Scale assessment, pulse, blood pressure, respiratory rate and pupillary size documentation.

Examination will also exclude other causes of a decreased conscious level including head injury, hypoglycaemia, stroke, postictal etc.

The use of an intoximeter for non-evidential blood alcohol measurement can be a useful tool to aid diagnosis and management in those where alcohol excess is suspected as a possible cause of a decreased conscious state.

Alcohol or drugs may mask other conditions. A person who is drowsy and smells of alcohol or intoxicants may be suffering from:

- Diabetes
- Epilepsy
- Head injury
- Drug intoxication or overdose
- Stroke

4.3 Assessment in Relation to Substance Misuse (Withdrawal)

Police custody staff will contact a Healthcare Professional to discuss detainees at risk of drug or alcohol withdrawal. Following this discussion a clinical assessment will be carried out if deemed appropriate within the agreed contractual timescales or within a mutually agreed period.

The clinical assessment will take place within a designated healthcare area unless the patient is physically incapable of being brought to this location.
This assessment will include a documented history of the reported quantities of substances used and objective parameters including a minimum of pulse, BP and pupillary size. For those reporting an active history of intravenous drug misuse clinical examination should include a “site check” to confirm the detainees’s history and also look for abscesses, cellulitis, etc. A urine sample for drug estimation should also be collected to support clinical findings, particularly for individuals who report non-intravenous illicit use or who are prescribed unsupervised methadone.

4.3.1 Management of Specific Drugs

Alcohol

Alcohol-dependent detainees may develop withdrawals as early as 6-8 hours after their last consumption of alcohol and before blood alcohol reaches zero. Common clinical features include tachycardia, sweating, tremor and agitation. Severe alcohol withdrawal can lead to delirium tremens and seizures.

Benzodiazepines

The acute cessation of benzodiazepines can lead to a clinical picture of withdrawals similar to that seen with alcohol. The development of withdrawal symptoms is slower than that seen with alcohol, typically developing within two days, and the risk of withdrawal seizures within police custody is low.

Opioids

Many detainees will use multiple opioids with differing half-lives resulting in a variation as to when withdrawal symptoms will develop. Typically withdrawals from heroin will commence approximately eight hours after last use. Clinical features include tachycardia, rhinorrhea, pupillary dilation, sweating and gooseflesh.

Opioid withdrawals are influenced by psychological factors and subjectively detainees may complain of numerous symptoms including tremors, nausea, feeling “hot and cold”, myalgia, anxiety and agitation. Greater weight should be given to objective clinical findings when assessing for opioid withdrawal.

Psychostimulants

Withdrawal from psychostimulant drugs such as cocaine, ecstasy and amphetamine does not produce major physical withdrawals. Psychological dependency is common in habitual users with insomnia and depression being precipitated on withdrawal.

Hallucinogens

Hallucinogenic drugs such as LSD have a relatively quick onset of symptoms (10-60 minutes) with recovery seen usually within twelve hours. No physical withdrawal syndrome is typical although anxiety may be precipitated.
Volatile substances

Solvent abuse leads to intoxication that can develop within one minute and persist for up to 45 minutes. Presentation can be similar to alcohol intoxication although perceptual disturbances and hallucinations are more common. There is no physical withdrawal syndrome and no specific management is required.

Cannabis

Withdrawal from cannabis in detainees may precipitate mild symptoms including insomnia, agitation and irritability. No specific treatment is required.

Methadone and Buprenorphine (Suboxone/Subutex) Treatment

Prisoners in receipt of a community substitute prescription of Methadone or Buprenorphine will have the prescription confirmed by telephone contact with the dispensing chemist following detention. Police staff should collect this medication if possible. The Healthcare Professional will administer the substitute treatment on a supervised basis following clinical assessment if deemed appropriate.

4.4 Pregnancy

Prisoners who are detained and report themselves to be pregnant should be discussed with the Healthcare Professional. Pregnancy itself is not a medical condition that would preclude the detention of females in police custody. It may be undesirable to keep a female in the latter stages of pregnancy, or in whom complications have already been encountered, within the police office environment.

4.5 Management of Diabetes

Following detention in custody any patient reporting a diagnosis of Insulin Dependent Diabetes Mellitus should be discussed with the Healthcare Professional. Prior to contacting the Healthcare Professional, police custody staff should have established the insulin regime usually taken by the patient, the time of last insulin administration and ideally the result of a blood glucose ('BM') test. It should also be ascertained whether the patient’s insulin medication is in the police office or whether it can be collected from the prisoner’s home.

Following discussion the Healthcare Professional will advise with regards to future insulin administration times and doses. If felt clinically necessary, the Healthcare Professional may attend to assess the prisoner prior to further insulin administration.

Diabetes is a self-managed condition and prisoners would usually administer their own insulin under supervision of the police custody staff unless there are specific reasons to believe this to be unsafe. In the custody environment insulin will be administered after a prisoner has eaten to prevent the possibility of manipulation of treatment resulting in hypoglycaemic episodes that may necessitate hospital admission.
4.6 Monitoring and Observation

In general there are 4 levels of observations on a prisoner while in Custody:

- **General Observations**: Checked every hour
- **Frequent Observations**: Checked more frequently e.g. 30 minutes
- **Intermediate Observations**: Visited and roused every 30 minutes
- **Constant Observation**: Supervised constantly (CCTV may be used)

For constant observation CCTV technology providing constantly monitored CCTV images to a remote monitoring room can be used on a ratio up to four-to-one otherwise constant observation is on a one to one observation cell or face to face basis.

- **Constant (Close Proximity) Observation**

  In exceptional circumstances should the risk assessment so dictate e.g. if a restraint belt is in use, or under medical advice, constant close physical supervision may be required and prisoners can be placed under Constant Close Proximity Observation. This requires a one-to-one, face-to-face ratio of prisoner to attendant (gender specific). This must not be used as a substitute for Mental Health Place of Safety arrangements (see 4.8.1).

  As a standard all custodies detained in cells are to be visited at least once per hour by custody staff. It is good practice to conduct visits at both regular and irregular intervals, reducing the opportunities for custodies to commit acts that would put their safety at risk. **At each visit, all custodies are to be roused and spoken to and are to give a distinct verbal response.** The only exception will be when a HCP has given a direction that continued hourly rousing will have a detrimental effect on a custody for a specific condition.

  In some areas CCTV ‘Casual Observation’ may also be available where staff performing other duties monitor CCTV but not on a constant basis.

  The level of observation on a prisoner will be dependent on the circumstances of the individual and level of risk – Standard, Raised or High Risk with decision made in accordance with national police policy, HCP advice where indicated and Care and Welfare of Prisoners SOP Scotland.

  Under normal circumstances, only General Observations are made on Custodies held that pose no special risks, on the hourly basis. More frequent observations should be conducted for individuals under the influence of drugs or alcohol, or those where medical circumstances dictate.

  **CCTV is not an alternative for checking and rousing, but may be used in addition.**

  In addition to Police Service Policy, the HCP will detail any level of observations recommended by them in person to the Custody Officer and in writing to be included in the custody record and contribute to the custody care plan.
4.7 Fitness Assessments

These will be as agreed by each Health Board and Police Scotland, taking into account any external advice or standards deemed appropriate (such as FFLM and COPFS guidelines).

A Custody Health & Forensic Medical Examination proforma may provide a framework to aid and note these assessments. Proforma used should be agreed by NHS locally and communications between HCP's and custody staff will be as agreed.

4.7.1 Fitness to be detained

Where there is doubt or concern about an individual’s fitness to be detained in police custody the duty HCP will undertake assessment for Fitness to be Detained at the request of a Police Officer.

Examination will take place in the Custody Medical Room of the Police Office, occasionally in the Police Cell, if indicated by safety or security, or rarely in another appropriate location e.g. hospital, depending on the circumstances.

During the assessment, the duty HCP will undertake to be particularly considerate of:

- Alcohol or drug intoxication and withdrawal
- Mental health
- Self harm risk
- Diabetes
- Epilepsy
- People with head injuries
- Detainees with special healthcare needs and diversity, disability or special dietary needs.

At the end of the examination, the HCP will inform the Custody Officer verbally and in writing of the outcome of the assessment and any special instructions. He/she will advise of arrangements and timings of any reviews required.

Where the Custody requires hospital treatment, the duty HCP will undertake to liaise with hospital staff and/or ambulance services, to arrange admission or A & E attendance and provide the relevant documentation for transfer.

Where the Custody is to remain in hospital, Police Scotland custody procedures will be followed.

On returning to the Police office Police Scotland custody procedures will be followed and HCP advice sought on fitness to be detained and on going care plan.

Where any person detained in Police Custody is unfit to be detained, the HCP will advise the Custody Officer of steps considered necessary from medical expertise for the well-being of that person.
4.7.2 Fitness for interview

In the majority of cases a police officer is able to assess whether an individual is fit for police interview. However where there may be concerns or fitness is unclear further assessment is indicated.

In general this assessment will be undertaken by the duty FME or other suitably trained and experienced HCP. In certain cases it may be appropriate that this is a psychiatrist or forensic psychologist.

Examination aims to protect both the individual and the justice process and as such should:

- Determine that the individual has capacity to understand and follow the interview identifying any suggestibility and/or vulnerability to forced or false confession
- Identify whether interview may have an unacceptable detrimental effect on health including mental health of that individual
- Identify any precautions or safeguards required to assist the person during police interview

Examination would therefore generally include assessment of:

- Personality characteristics
- Mental & Physical Health
- Substance Misuse, intoxication or withdrawal states
- Cognitive and functional capacity
- Consideration of interview demands and characteristics
- Totality of circumstances

Informed consent should be obtained and detailed contemporaneous notes taken. The examining HCP should inform the Police of the outcome of his/her assessment verbally and in writing.

Specific outcomes will be:

- **Unfit at any stage** e.g. severe dementia, severe learning difficulties
- **Unfit at present** e.g. intoxication, withdrawal state, illness amenable to treatment
- **Precautions are advised** e.g. Appropriate Adult or further advice
- **Fit for interview**

It will then be a matter for the Police whether to proceed or not to interview.

Where any reassessment or further treatment is indicated before interview, this will be arranged by the HCP at the time of initial examination.
4.7.3 Fitness to be charged
These will be as agreed by each Health Board and Police Scotland, taking into account any external advice or standards deemed appropriate (such as COPFS guidelines for forensic examinations).

On instruction this assessment will be undertaken by the duty HCP.

Assessment will include:

- Age and Maturity
- Physical State
- Mental State
- Intellectual capacity
- Language
- Understanding of the nature of the charges
- Need for further information
- Need for Appropriate Adult

Information on the outcome of the assessment will be directly relayed to the requesting Police Officer by the HCP at the end of the examination and details attached to the Custody Record accordingly.

4.7.4 Fitness for transfer
These will be as agreed by each Health Board and Police Scotland, taking into account any external advice or standards deemed appropriate (such as COPFS guidelines for forensic examinations).

Where there are concerns by the Custody Officer, the duty HCP will attend on instruction and assess fitness to transfer to another location, including:

- From one Custody Suite to another
- From Police Office to Court
- To hospital

Taking into account the Custody's:

- Physical State
- Mental State
- Any Infectious Disease or Infestation
- Mode of transfer (air/ferry/road/van/car/ambulance)
Where indicated, the duty HCP will advise accompanying personnel (Police or security firm) of any information relevant to the care of the Custody during transfer, and complete documentation on any relevant medical condition or on-going healthcare needs for healthcare professionals at the receiving end.

Custody staff must ensure the Prisoner Escort Record (PER) is fully completed to reflect the findings/decision from the HCP.

Reference to the Care and Custody handbook for guidance on transportation of Custodies should be made.

4.7.5 Fitness to be released safely

These will be as agreed by each Health Board and Police Scotland, taking into account any external advice or standards deemed appropriate (such as COPFS guidelines for forensic examinations).

In general, and where requested by the Custody officer, the duty HCP will examine a Custody’s fitness to be released assessing this with due concern for both the released safety of the individual and his/her continuing physical or mental health needs, impact of seriousness of any charges against the person – for instance persons who have been arrested for sexual offences, particular offences involving children or child pornography may be at an increased risk of self-harm, following release from Custody.

This will take place either:

- At the time of initial examination of Fitness to be Detained
- At later review and reassessment if indicated
- At the request of a Police Officer

The Custody Officer will be informed of the outcome of this assessment, which will be recorded on the Custody Risk Assessment and Care Plan.

Where there is concern that a Custody is not fit to be released safely, the duty HCP will inform the Custody Officer and advise either on timing of reassessment, alternative arrangements needed or undertake to reassess before discharge at the request of the Custody Officer.

4.8 Mental Health Assessment in Custody

These will be as agreed by each Health Board and Police Scotland, taking into account any external advice or standards deemed appropriate (such as COPFS guidelines for forensic examinations).

HCP’s should be trained in delivery of appropriate mental health assessment as relates to custody and also be cognisant in assessment of any forensic implications, factors relevant to detention in police custody or affecting fitness plead or to appear in court. Where appropriate, referrals will be made to specialist services including support services or for further psychiatric assessment if indicated.
There should be provision on the Custody healthcare and forensic medical examination form for details of examination relevant to mental state.

The duty HCP will, at all times, be mindful of the vulnerable nature of many Custodies and advise accordingly on any aspects of mental state or learning disability which may impact on care in Custody, or decision to prosecute, including any risk of self-harm, acute or active psychiatric illness.

The HCP, where appropriate, will contribute to multi-agency planning geared at meeting the needs of mentally disordered offenders and diversion from the Criminal Justice System.

4.8.1 Place of Safety

The Mental Health (Care and Treatment) (Scotland) Act 2003, Section 300 defines a Place of Safety (POS) as:

- A Hospital

- Premises which are used for the purpose of providing a care home service (as defined in Section 2(3) of the Regulation of Care (Scotland) Act 2001); or

- Any other suitable place (other than a Police Station) the occupier of which is willing temporarily to receive mentally disordered persons.

A Police Station (or Police Office) may only be construed as a Place Of Safety if no Place Of Safety is immediately available – Section 297(5) of this Act. The Police power to remove a person from a public place is bestowed by Section 297 in Part 19 of the Act.

Police cells are not suitable places for holding people who are unwell with mental health conditions given potential for the police cell environment to exacerbate a person’s condition.

Police, Health Boards and Local Authorities must work together to ensure suitable arrangements for Place of Safety are available and included in local Psychiatric Emergency Plans.
5. FORENSIC SERVICES

5.1 Sudden Deaths

A ‘sudden or suspicious death’ in forensic terms is regarded as a death resulting from violence, suicide and unknown or suspicious cause. The Police must investigate all deaths of this nature and a detailed report of the circumstances be submitted to the Procurator Fiscal.

Upon receiving a report of a sudden death, Police Officers attending will approach the enquiry from the perspective that a crime has, or may have been, committed. This will ensure that the Police fulfil the obligation placed upon them by the Police (Scotland) Act 1967 Section 17.

Police attendance at Sudden Deaths are categorised into the following:

- No suspicious circumstances
- Suspicious Death
- Fatal Accident
- Sudden Infant Death Syndrome
- Drugs related death
- Suicide
- Murder
- Death in Police Custody

In the event of a sudden death, a duty HCP may be called to attend when requested to assess vital signs of any body and pronounce life extinct.

The vast majority of cases of sudden death however are not considered suspicious or unexplained and in these circumstances, death verification from suitably trained attending ambulance crew, GP, hospital doctor or other HCP may be accepted.

Similarly in these circumstances, after discussion with the Procurator Fiscal service, the person’s GP or hospital doctor may be prepared to issue a death certificate.

Certifying cause of death will be provided by relevant medical professional only where he/she is in a position to do this. This may depend on:

- Involvement in the medical care of the deceased
- Whether a post mortem is required
Discussion with the Procurator Fiscal

Access to background medical information sufficient for a ‘view and grant’

Where there are circumstances, which give rise to suspicion or unexplained circumstances a forensic pathologist or FME may be required to verify death in preference. This could include deaths by suicide, sudden unexplained deaths in infancy and drug related deaths.

### 5.2 Assaults – Prisoners, Suspects, Complainers and Police Officers

Where a HCP is required to examine a complainant or suspect of assault for evidential purposes, they will:

- Ensure immediate therapeutic needs are met
- Accurately classify and document any injuries
- Ensure aftercare requirements are met

They will be expected to provide evidence or evidence of opinion within their competence and professional level of expertise in relation to marks, scars or injuries found on any examinee.

Provision should allow for second opinion and joint examination for complex cases if required.

The duty Scene of Crime Officer will undertake any requirements for non-intimate photographic evidence.

### 5.3 Forensic sampling

Where there is a requirement for forensic sampling for evidential purposes Health Boards will provide a suitably trained HCP to work with the investigating officer in obtaining any evidential samples. Procedures undertaken will depend on:

- Circumstances of the incident
- Investigative or legal requirements i.e. the points to prove
- Preservation and recovery of best evidence
- Persistence data
- Wellbeing and consent of the person concerned

At all times close attention to maintaining integrity and continuity of evidence must be applied with correct sampling techniques e.g. specific swabbing techniques or venepuncture requirements, documentation, labelling and storage of specimens, maintaining chain of evidence and any requirement for corroboration strictly adhered to.
Recommendations from the Scottish Police Authority (SPA) Forensic Service should be applied. In addition, Recommendations for the Collection of Forensic Specimens from Complainants and Suspects are provided and regularly updated by the FFLM.

Where there is potential for cross contamination in certain cases consideration must be given to arrangements for examination at different locations and by different HCPs.

### 5.3.1 Intimate samples

Section 18 of the Criminal Procedure (Scotland) Act 1995 provides that where a person has been arrested and is in custody a constable may, with the authority of an officer of the rank of inspector or above, take the following samples:

- Hair of an external part of the body other than pubic hair
- From a fingernail or toenail
- From an external part of the body, by means of swabbing or rubbing, a sample of blood or other body fluid, of body tissue or of other material
- Mouth or saliva swab (can also be taken by a police custody and security officer)

It is only a suitably qualified medical practitioner or registered healthcare professional, however, who may take intimate samples.

Intimate samples in Scotland are defined in the Immigration and Asylum Act 1999 as:

- Sample of blood, semen or any other tissue fluid, urine or pubic hair
- Dental impression (by e.g. a dental practitioner)
- Swab taken from a person’s body orifice other than the mouth

Intimate samples may lawfully be taken, without the individual’s consent, under the authority of a sheriff’s warrant. Healthcare professionals however must be aware of their ethical and professional obligations regarding consent in such circumstances.

### 5.4 Sexual Offences Examinations

Examination in sexual offence cases consists of both a therapeutic and forensic element.

Only experienced and appropriately trained HCPs, generally specially trained forensic medical examiners assisted by forensic nurse examiners are utilised for this role.

Reference should be made to the guidelines being developed by the working group for sexual assaults.

Each Health Board will:

- Have HCPs qualified to examine adult complainants
- Have HCPs qualified to examine alleged suspects
Have arrangements to prevent HCP cross-contamination

Have a system to document injuries

Obtain samples under sound governance procedures

Assist with blood and pregnancy tests

Arrange aftercare and testing for sexually transmitted infection

Consideration should be given, where possible, to the need to have arrangements for gender specific examination (male and female) for examination in cases of sexual offences and domestic violence.

Health Boards and Police should work together towards provision of colposcopy and suitable joint facilities for examination.

Examination should be timed appropriately to meet both evidential and therapeutic requirements

In these cases evidence from the medical examination may be required to prove an essential fact and to minimise potential for dispute, the examination should be carried out by a forensic medical examiner (FME) trained in sexual offences examination with either forensic nurse, second FME and/or video colposcopy corroboration. A police officer should be present to receive samples taken, but does not require to witness the forensic examination which should be corroborated as above.

The DVD recording from video colposcopy enables the Crown to obtain, where necessary, the opinion of a medical expert not present at the examination. It also affords any defence medical experts an opportunity to view the recording and prevents need for repeated examinations.

Sexual offences examination kits are provided by Police and contain sampling material in modular form along with full instructions on use. This is detailed on the guidance notes, which are provided with each kit.

### 5.5 Child Protection Examinations

A thorough assessment of the child’s health needs is an essential element during child protection joint investigations. Although it may not provide evidence that a child has or has not been abused, a comprehensive assessment of the child and family’s medical history and the child’s health can assist the planning and management of any investigation and inform risk assessment.

Where it is clear that a forensic opinion will be required, for example, when there is reported or suspected serious physical assault or injury or sexual abuse, the forensic examination should also include a comprehensive medical assessment.

As such Health Boards must have arrangements in place to provide suitably trained Forensic Medical Examiners for Joint Paediatric/Forensic examinations.

The decision on whether an actual medical examination is appropriate and the type of medical examination, i.e. whether a joint paediatric/forensic examination or specialist paediatric
Agreement should be reached in relation to:

- Need for a medical examination
- Type of medical examination
- Who should conduct the examination
- The purpose of the examination
- Where it should take place
- When it should take place

5.5.1 Need for child protection examination

A specialist paediatric or joint paediatric/forensic examination may need to be carried out under the following circumstances:

- The child urgently requires more specialist assessment or treatment at a paediatric department (for example, if they have a head injury or suspected fractures)
- The account of the injuries provided by the carer does not provide an acceptable explanation of the child's condition
- The result of the initial assessment is inconclusive and a specialist's opinion is needed to establish the diagnosis
- Lack of corroboration of the allegation, such as a clear statement from another child or adult witness, indicates that forensic examination, including the taking of photographs, may be necessary to support criminal proceedings against a perpetrator and legal remedies to protect the child
- The child's condition (for example, repeated episodes of unexplained bruising) requires further investigation
- In cases of reported or suspected child sexual abuse, as the medical examination has to be carried out by medical practitioners with specialist skills using specialist equipment

5.5.2 Specialist paediatric examination

This provides a comprehensive assessment of the child, establishing the need for immediate treatment and ongoing health care as well as providing a high standard of forensic evidence to sustain any criminal or care proceedings and offering reassurance and advice to the child and carers.

The examination is intended to encompass both the child's need for medical care and the legal requirement for evidence in a single examination.
5.5.3 Joint examination including joint paediatric forensic examination

Requirement for joint examination may be influenced by a number of factors including:

- Requirement for complimentary skills (forensic or clinical)
- Requirement for corroboration

Usually such examinations involve a paediatrician and a forensic medical examiner. However, it may be necessary to involve another complimentary medical professional such as a genitourinary physician, orthopaedic surgeon, or family planning doctor, if the case demands it.

If two professionals are involved they need to determine in advance of the assessment what skills they bring to the examination and who will undertake which component of the examination.

Health Boards should have in place clear arrangements for joint examination and these should be outlined in local interagency child protection procedures.

Police will make available provision for non-intimate photo-documentation e.g. imaging bruising.

During a paediatric/forensic medical examination of a child when sexual abuse is reported or suspected a colposcope must be used to record the medical findings of the examination. Such photo documentation of the examination can be made available for a second opinion on behalf of the Crown or defence.
5.6 Road Traffic Act 1988 Procedures


Taking blood specimens, Medical assessment and/or medical observations maybe required for the above legislation, which deals with persons

- Exceeding the prescribed limit for Drink
- Unfit through Drink and/or Drugs

whilst driving a motor vehicle (Road Traffic Act 1988), working on railways or trams (Transport and Works Act 1992), working as a professional seaman (Railways and Transport Safety Act 2003) or performing an aviation function (Railways and Transport Safety Act 2003)

In pursuance of forensic evidence for the above, kits will be available for drink/drug procedures at all Police Offices and are provided by Police Scotland. Additional kits are held with regards separate hospital procedures.

All blood samples will be taken by a registered medical practitioner (generally an FME) or registered healthcare professional (generally a custody or forensic nurse) trained in drink/drug procedure.

Where the individual is a hospital patient then as legislation stands at the moment it should be a medical practitioner engaged in services to the police who takes the blood sample i.e. usually the FME in accordance with relevant legal and ethical consents from the patient and the medical practitioner in charge of their clinical care.

The attending HCP must obtain appropriate consents for any procedures. He/she will also assess any medical reasons why a sample of blood may not be provided. The HCP taking the blood sample will complete all relevant labels and documentation with due regard for continuity of evidence.

The DVLA provides guidance for doctors on medical fitness to drive which all the duty FMEs must be familiar with.

Medical assessment for the purposes of Section 4 Road Traffic Act 1988 must currently be undertaken by a medical practitioner, usually an FME, and may be aided by use of a proforma. This assessment includes the examinee’s past medical history, physical, neurological and psychiatric examination, as well as divided attention testing to assess if the individual’s condition might be due to a drug.

In particular this will include assessment for conditions that may affect impairment testing or may themselves result in impairment or rendering unfit to drive including:

- Drug intoxication (prescribed, over the counter and illicit)
- Withdrawal states
- Metabolic disorders including blood sugar abnormalities
- Head injury
- Other physical injury
- Neurological disorders
- Current physical illness including fever, ENT conditions
- Fatigue
- Mental illness

At the end of the assessment, the medical practitioner will advise the Custody Officer of findings and if there is a condition present that might be due to drugs.

Where consent to assessment is not obtained then observations only without examination will be made.

### 5.7 Intimate Body Searches

For more detailed guidance please see the FFLM/BMA document [Recommendations for Healthcare Professionals asked to perform intimate body searches](#).

**An intimate search constitutes a search of any body orifice other than the mouth.**

Where an intimate search is considered necessary in Scotland this may lawfully be carried out under the authority of a Sheriff’s Warrant by a suitably qualified person.

The request may be made to search for:

- A concealed weapon or something that could and might be used to cause physical injury
- Class A drugs

Where a medical practitioner or registered nurse is requested to perform such a search on a person detained in police custody they should address issues of consent (legal and ethical) with the Custody and the Police ensuring proper authorisation and documentation has been obtained and also where appropriate warn the individual of potential complications of certain drugs.

Where requested and when possible, arrangements for a HCP of the same sex should be considered to perform the search.

Any such search for drugs must take place in suitable medical premises with **full resuscitation facilities available.**

Therefore, agreement must be reached at a local level any intimate body search for drugs will only take place within an NHS establishment, and preferably one with an A&E department.
5.8 Persons Detained Under Terrorism Legislation

Training and additional vetting will be required for HCPs likely to have a role in the healthcare of persons detained under the Terrorism Act 2000.

Where such a facility exists in a Health Board area Police Scotland should undertake to make suitable arrangements for this additional expectation.
Scottish Accord on the Sharing of Personal Information

Information Sharing Protocol for

[Insert details here]
Content
### Part A – Introduction to this ISP

1. Scope and purpose of this ISP
2. High level functions of this ISP
3. Service Users included in this ISP
4. Benefits to Service Users
5. Details of personal information being shared
6. Key identifying information
7. The information sharing partner organisations

### Part B – Justification for sharing personal information

8. Legislative/statutory powers
9. Consent

### Part C – Operational procedures for this ISP

10. Summary
11. Fair processing information
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13. Refused and withdrawn consent
14. Recording consent
15. Sharing information without consent
16. Action to be taken where subject lacks mental capacity
17. Temporary impairment of capacity
18. Information collection
19. Frequency of information sharing
20. Retention Schedules
21. Subject Access Requests
22. Information security
23. Complaints
24. Review of this ISP
Part D – Methods and controls for the sharing of personal information to support this ISP

25 Information flow reference table

26 Details of information to be shared
Part A – Introduction to this ISP

1 Scope and purpose of this ISP

1.1 This Information Sharing Protocol (ISP) is supplementary to the Scottish Accord on the Sharing of Personal Information (SASPI), and has been agreed between the participating partner organisations. Partners have given consideration to its contents when drawing up this document.

1.2 This ISP has been prepared to support the regular sharing of personal information for [insert details here].

1.3 It supports the information sharing partner organisations involved and the groups of Service Users it impacts upon. It details the specific purposes for sharing and the personal information being shared, the required operational procedures, consent processes, and legal justification.

1.4 [Insert the aims of the information sharing here, if appropriate in bullet point form].

1.5 This Information Sharing Protocol covers the exchange of information between [Insert a brief description of the partner organisations and the specific purposes of the information sharing here, if appropriate in bullet point form].

1.6 This information may also be shared to support the effective administration, audit, monitoring, inspection of services and reporting requirements. Partners may only use the information disclosed to them under this ISP for the specific purpose(s) set out in this document.

2 High level functions of this ISP

2.1 The functions which this information sharing protocol community are seeking to support involve:

• [Insert details of the functions in bullet point form here].

2.2 Personal information shared to support functions other than those detailed above are not supported by this ISP.

3 Service Users included in this ISP

3.1 The Service Users which this ISP relates to include:

• [Insert details of the Service Users in bullet point form here].

4 Benefits to Service Users

4.1 Benefits to the Service Users include:

• [Insert details here in bullet point form of how the ISP will benefit the Service Users].

5 Details of personal information being shared

5.1 Personal information shared for the purpose of this ISP includes a range of information regarding the Service Users needs.

5.2 The information shared might therefore include:

• [Insert details here to describe the type of information to be shared, these should be listed in bullet point form. Any identifiers used should also be included].
Full details of the information which is covered by the ISP is included in Annex A.

5.3 The information is used to [insert details of how the information described above will be used here].

5.4 Only the minimum necessary personal information consistent with the purposes set out in this document must be shared.

6 Key identifying information

6.1 When sharing information, the following identifiers will be used where available, to ensure that all partner organisations are referring to the same Service User:

- [Insert personal identifiers here, these should be listed in bullet point form]

7 The information sharing partner organisations

7.1 This ISP covers the exchange of information between staff of the following organisations that are engaged in delivering the service outlined in this document:

<table>
<thead>
<tr>
<th>Information Sharing Partner Organisations</th>
<th>Responsible Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Insert organisation details here]</td>
<td>[Insert managers job title here]</td>
</tr>
<tr>
<td>[Insert organisation details here]</td>
<td>[Insert managers job title here]</td>
</tr>
</tbody>
</table>

Insert rows below as necessary

7.2 The responsible managers detailed above have overall responsibility for this ISP within their own organisations, and must therefore ensure the ISP is disseminated, understood and acted upon by relevant staff.

7.3 Staff of these partner organisations who work directly with Service Users in order to carry out the functions described in this ISP, are bound by this document.

7.4 The term ‘staff’ encompasses paid workers, volunteers, students and other temporary workers approved by the employing / hosting organisation, whose duties include those relating to the functions outlined in this ISP.

7.5 Partner organisations will ensure that all current and newly-appointed staff receive appropriate training in the application of this ISP and the requirements of the SASPI framework.

Part B – Justification for sharing personal information

Please note: Staff should not hesitate to share personal information in order to prevent abuse or serious harm, in an emergency or in life-or-death situations. If there are concerns relating to child or adult protection issues, the relevant organisational procedures must be followed.
8 Legislative / statutory powers

8.1 Disclosure of information will be conducted within the legal framework of the Data Protection Act 1998 (DPA), the Human Rights Act 1998 and in compliance with the common law duty of confidence.

8.2 [Insert details here of any additional provisions of power provided to any partner organisations undertaking statutory duties in the sharing of information. If no additional powers are appropriate then remove this point].

9 Consent

9.1 Consent is normally required to share information between different partner organisations. To provide valid informed consent the Service Users or their lawful representatives, must be provided with appropriate information to enable them to make an informed decision.

9.2 Implied consent is given when a Service User takes some action, including making a judgement, in the knowledge that in doing so he or she has incidentally agreed to a particular use or disclosure of information.

9.3 Explicit consent is given by a Service User agreeing actively, either verbally or in writing, to a particular use or disclosure of information. It can be expressed either verbally or in writing, although written consent is preferable since that reduces the scope for subsequent dispute.

9.4 Consent must not be secured through coercion or inferred from a lack of response to a request for explicit consent. The Practitioner must be satisfied that the Service User has understood the information sharing arrangements and the consequences of providing or withholding consent.

9.5 Consent should not be regarded as a permanent state. Opportunities to review the Service User’s continuing consent to information sharing should arise during the course of the service provision. The Practitioners should exercise professional judgement in determining whether it would be appropriate to re-visit a Service User’s continued consent at any given juncture. Ideally it should take place in the context of a review or re-assessment.

Part C – Operational procedures for this ISP

10 Summary

10.1 Only the minimum necessary personal information will be shared on a need-to-know basis and only when it supports the delivery of the purposes and functions set out in this ISP.

10.2 Personal information will only be collected using the approved collection methods, ensuring the required information is complete and up-to-date.

10.3 All reasonable steps must be taken to ensure that anyone who has received information is notified of any relevant changes and if any inaccuracies are found the necessary amendments will be made.

10.4 Decisions about Service Users should never be made by referring to inaccurate, incomplete or out-of-date information.

10.5 Information provided by partner organisations will not be released to any third party without the permission of the owning partner organisation.

10.6 Staff must also follow their own organisation’s procedures relating to the handling of personal information.
Please note: Staff should not hesitate to share personal information in order to prevent abuse or serious harm, in an emergency or in life-or-death situations. If there are concerns relating to child or adult protection issues, the relevant organisational procedures must be followed.

11 Fair processing information

11.1 It is necessary to communicate with the Service User or their lawful representatives about the need for information sharing at the earliest appropriate opportunity, preferably at first contact.

11.2 Being clear and open with Service Users about how their personal information will be used, will allow them to make an informed decision regarding consent for the sharing of their information.

11.3 Partner organisations will clearly inform the Service Users about what personal information is to be shared, who the information will be shared between, why it needs to be shared and for what purposes it will be used for.

11.4 Agreed methods of providing this information are:

- [Insert details here, names of the leaflets etc. should be listed in bullet point form]

12 Obtaining consent

12.1 The approach to obtaining consent should be transparent and respect the Service User.

12.2 For the purposes of this ISP, [insert – ‘implied’, ‘explicit’ or ‘no’ - here] consent will be required from Service Users.

12.3 [If it is determined that no consent is required from Service Users, justification must be described here, if not then remove this point].

12.4 Partner organisations should be prepared to be open with their Service Users about the role that their consent plays in the information sharing process and indeed be clear about the type of circumstances in which they may share personal information without their knowledge or consent.

12.5 If there is a significant change in the use to which the information will be used compared to that which had previously been explained, or a change in the relationship between a partner organisation and the Service User, then consent will be sought again.

12.6 Consent obtained from Service User’s for the purposes of this ISP will only be used to support the delivery of the purposes and functions set out in this document. Once the service provision of this specific ISP concludes, then consent obtained will also end. In the event of a similar or subsequent service provision undertaken in the future, new consent will be obtained.

12.7 Staff should use opportunities such as reviews or assessments to reaffirm the Service User’s consent to the sharing of information outlined in this ISP.

13 Refused and withdrawn consent

13.1 A Service User has the right to refuse their consent to have information about them shared. They also have the right to withdraw previously granted consent at any point, to the sharing of their information. Further personal information should not then be shared.

13.2 Where the Service User has refused or withdrawn consent, the implications of withholding consent will be clearly explained to them and this dialogue will be recorded in [insert agreed]
National Guidance on the Delivery of Police Care Healthcare and Forensic Medical Services

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documentation here]. If a Service User withdraws consent to share personal information it will also be explained that information already shared cannot be recalled. See section 15 below, for further information.

13.3 Personal information can be lawfully shared without consent where there is a legal requirement or where an appropriate professional of sufficient seniority within the partner organisation has taken the view that the duty of confidentiality can be breached in exceptional circumstances, and where there is a substantial over-riding ‘public interest’. Such situations where information might be shared without consent include:

- ‘Life and death’ situations, for example where information is shared in an emergency in order to preserve life;
- Where a person’s condition indicates they may be a risk to the public or may inflict self harm;
- In order to prevent abuse or serious harm to others
- On a case-by-case basis, to prevent serious crime and support detection, investigation and punishment of serious crime;
- Within the healthcare setting, the appropriate professional is the Caldicott Guardian whose prior approval must be sought to share personal information without consent in the exceptional circumstances as outlined above.

This is not an exhaustive list

14 Recording consent

14.1 Decisions regarding Service Users’ consent of how and when it was obtained and whether it was provided in verbal or in written form, must be recorded in [insert agreed documentation here. It should be clear exactly what the Service User has provided consent for].

14.2 Details of refused or withdrawn consent should also be recorded together with any subsequent reviews of consent.

15 Sharing information without consent

15.1 Staff are permitted to disclose personal information without consent in order to prevent abuse or serious harm to others. If there are concerns relating to child or adult protection issues, staff must follow the relevant local procedures of their partner organisation.

15.2 Personal information can be lawfully shared without consent in exceptional circumstances; where there is a legal requirement and where there is a substantial over-riding ‘public interest’. For example there can be a public interest in disclosing information to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime. Within a healthcare setting the prior approval of the Caldicott Guardian must be sought to share personal information without consent in the exceptional circumstances outlined above.

15.3 If a claim of substantial public interest is made, justification will be clearly stated and any decision to share information with another party without the consent of the Service User will be fully documented in Service User’s file by appropriate organisation. This note will include details of the legal requirement used and details of the member of staff who authorised the sharing.

15.4 The Service User will usually be informed of this decision and of the information which has been shared; unless by doing so it would risk harm to others or hinder any investigation or legal proceedings.
16 Actions to be taken where a Service User lacks capacity

16.1 Whenever dealing with issues of capacity to consent, local rules and procedures should be followed and these must be compatible with the Adults with Incapacity (Scotland) Act 2000 and its associated guidance.

17 Temporary impairment of capacity

17.1 Where a person has a temporary loss of capacity, consent will be deferred, if appropriate, until such time as consent can be obtained. Consent to share information will be sought when capacity is regained.

17.2 Where it is not appropriate to defer the sharing of information, then it will not be appropriate to defer consent, as consent cannot be obtained retrospectively. Therefore, only where deemed necessary, may information be shared without consent, see section 16 above for further information.

18 Information collection

18.1 The approved collection tools for partner organisations to gather the personal information detailed in this ISP are:

- [Insert details of the collection tools / methods here, these should be listed in bullet point form]

19 Frequency of information sharing

19.1 The personal information outlined within Section 5, Part D and Annex A, will only be shared on a need-to-know basis to support the functions of this ISP.

19.2 Partner organisations will share relevant personal information [Insert details here or state as detailed in Annex A].

19.3 Should changes be made to a record, all reasonable efforts must be taken to ensure that anyone who has received a copy of the record is also alerted to the change.

20 Retention Schedules

20.1 Personal data will be held, processed and then destroyed securely in accordance with the retention schedule of each partner organisation.

21 Subject Access Requests

21.1 Requests for personal information will be processed and responded to using the standard SAR procedure within each partner organisation.

22 Information Security

22.1 Breaches of security, confidentiality and other violations of this ISP must be reported in line with each partner organisations’ incident reporting procedures.

22.2 Significant data breaches involving personal information provided by partners under this ISP should be notified to the partner that originally provided the information.
23 Complaints

23.1 Each partner organisation has a formal procedure by which Service Users can direct, their complaints regarding the application of this ISP.

24 Review of this ISP

24.1 This ISP will be reviewed [Insert agreed date for review here] or sooner if appropriate.
Scottish Accord on the Sharing of Personal Information

ISP Declaration of Approval

Formal approval of each Information Sharing Protocol (ISP) must be undertaken separately by each partner organisation. Signing of this declaration must be by a senior responsible manager who has authority to sign on behalf of the organisation. This approval is not required to be circulated with partner organisations however; a copy of this declaration must be passed to the ISP Co-ordinator who is responsible for ensuring that each of the partner organisations involved in this specific ISP have approved the protocol.

Part D – Methods and controls for the sharing of personal information to support this ISP

25.1 The [Insert the agreed format of information]

25.2 The information flow reference table will be reviewed and updated as necessary, to reflect any changes in the processing of personal information detailed in this ISP.

Information flow reference table

ISP Name: ____________________________________________________________
Version: ____________________________
Date: ____________________________
Review Date: ____________________________

Organisation: ____________________________________________________________

Signed by: ____________________________________________________________
Name: ____________________________________________________________
Position: ____________________________________________________________
HQ Address: ____________________________________________________________
Tel No: ____________________________
E-Mail: ____________________________________________________________
Date: ____________________________
### Annex A – Information which can be shared under this ISP

<table>
<thead>
<tr>
<th>26</th>
<th>Details of information to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.1</td>
<td>[Insert full details of the information which will / can be shared here]</td>
</tr>
<tr>
<td>Description</td>
<td>Information Exchange 1</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>1</strong> Information Flow Reference</td>
<td></td>
</tr>
<tr>
<td>a Reference number allocated to any information flow processes to which each set of information relates.</td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> High Level Function(s)</td>
<td></td>
</tr>
<tr>
<td>a General description of the function(s) or service(s) to which the information relates.</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> What information will be shared</td>
<td></td>
</tr>
<tr>
<td>a Description of the information to be provided.</td>
<td></td>
</tr>
<tr>
<td><strong>4</strong> Personal Identifiers included in the above</td>
<td>Surname</td>
</tr>
<tr>
<td>Main identifiers being used to identify the Service User.</td>
<td>Date of Birth</td>
</tr>
<tr>
<td></td>
<td>Service Reference No</td>
</tr>
<tr>
<td><strong>5</strong> Provider organisation(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>a</strong></td>
<td>Provider organisation(s).</td>
</tr>
<tr>
<td><strong>b</strong></td>
<td>Directorate(s) or department(s) responsible for providing the information.</td>
</tr>
<tr>
<td><strong>c</strong></td>
<td>Roles of staff responsible for providing the information.</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Destination organisation(s) (Who to)</td>
</tr>
<tr>
<td><strong>a</strong></td>
<td>Recipient organisation(s) with whom this information will be shared.</td>
</tr>
<tr>
<td><strong>b</strong></td>
<td>Directorate(s) or department(s) responsible for receiving the information.</td>
</tr>
<tr>
<td><strong>c</strong></td>
<td>Roles of staff receiving the information.</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>Reason(s) for use of the information (Why / Purpose)</td>
</tr>
<tr>
<td><strong>a</strong></td>
<td>Description of why the information is required e.g. law, SG directive, care of individual (more than one reason may apply).</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>Source of data (What system)</td>
</tr>
<tr>
<td></td>
<td>Description of the information system(s), from which the information to be exchanged, is obtained.</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>b</td>
<td>Description of the module or fields accessed when using another organisations IT system to shared data. Details of other non-relevant data which is also available, including any necessary risk assessment undertaken.</td>
</tr>
<tr>
<td>9</td>
<td>Form title and reference number</td>
</tr>
<tr>
<td>a</td>
<td>The title and reference number of any form or letter used to convey and / or collect the information.</td>
</tr>
<tr>
<td>10</td>
<td>Destination records(s) / system(s) (Where to)</td>
</tr>
<tr>
<td>a</td>
<td>The information record(s), system(s) or other destination of the information shared.</td>
</tr>
<tr>
<td>11</td>
<td>When exchanged / shared (When)</td>
</tr>
<tr>
<td>a</td>
<td>Details of when the information needs to be exchanged or shared e.g. daily, weekly, monthly, yearly, as and when.</td>
</tr>
<tr>
<td>12</td>
<td>Communication media (How)</td>
</tr>
<tr>
<td>a</td>
<td>Details all formats in which the information is to be transferred to the recipient e.g. fax, direct feed from system, verbal transfer at</td>
</tr>
<tr>
<td></td>
<td>Communication media controls (How)</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>a</td>
<td>Details how all security controls are applied, e.g. password protected files, encryption of files, and encryption of media, including any risks assessments undertaken.</td>
</tr>
</tbody>
</table>

| 14 | Issues or comments not included in the above |