

## **Forensic Healthcare Service – Metropolitan Police Service – Current Status**

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### **Introduction**

This analysis is written by Jason Payne-James and Peter Green, both specialists in Forensic and Legal Medicine and Honorary Senior Lecturers at Barts and the London School of Medicine and Dentistry, and who are practising Forensic Medical Examiners (the term used by the MPS to describe forensic physicians) within the Metropolitan Police Service. Both have previously been appointed by the MPS to the Commissioner's Advisory Panel (on forensic healthcare). Both have undertaken peer-reviewed and published research on all aspects of police custodial healthcare. This report reinforces and supplements the information provided in live evidence to the Police & Crime Committee of the London Assembly on 10<sup>th</sup> October 2013. Evidence sources are identified wherever possible.

### **Background**

Prior to January 2009 forensic medical services for the Metropolitan Police Service (MPS), as required predominantly by the Police & Criminal Evidence Act 1984 (which identifies when custody teams should ask for assessment by a healthcare professional), was provided by independent registered medical practitioners (doctors - Forensic Medical Examiners - FME) contracted by the Metropolitan Police Service. These doctors worked in small practice groups. These groups met regularly to discuss matters of mutual interest and concern: they were required to ensure 24/7 cover of the FME rota. Payment for assessment was by item of service and demand was dependent on requests to doctors by the custody teams.

Project Herald was established by the MPS to change the delivery of service to a multiprofessional nurse (Custody Nurse Practitioner – CNP) and FME service. A combined CNP/FME project had worked successfully at Charing Cross Police Station. Despite a history of successful working together for 5 years, the opinions of the CNP and FMEs who practiced in Charing Cross were not sought.

The stated aims and background of Project Herald are shown in part below [Project Herald – changes to MPS forensic medical provision – Report 8: Date 7 February 2008: By Assistant Commissioner Territorial Policing on behalf of the Commissioner]:

#### ***Summary***

*Project Herald proposes to introduce a new custody-staffing model, which aims to deliver a more efficient, safer custody environment. This report focuses on arrangements for forensic medical provision within police custody suites*

#### ***A: Recommendations***

*That: members support the proposed new arrangements for the forensic medical services provision within custody suites and agree the proposed financial arrangements*

#### ***B: Supporting information***

2....This new approach will provide 24/7 medical practitioner availability in custody suites, providing improved healthcare for all detainees

3....The drivers for change are threefold

4....First, the current situation relies upon a custody sergeant – untrained medically in the main – making an assessment of a detainees to determine whether an FME examination is required

5....Second, many custody process rely on an assessment of a detainee's fitness to be dealt with in the first instance. This is usually a judgement by the custody officer but often crucial medical evidence for disclosure to the defence team and for use in interviews is also required....Where it is deemed necessary for such forensic medical interventions, the current system (PACE) requires a (sic) FME...or some other healthcare professional to be called. All subsequent processes (eg solicitors attendance; appropriate adult, social worker, interpreter, police liaison nurse, drug worker; investigating officers assessment of evidence and interview planning are delayed pending the arrival of the FME...

Data analysis has demonstrated that, in 38% of cases, delays awaiting the arrival of the FME are between 1 and 1.5h.....A permanent team of healthcare professionals will significantly decrease this delay and will be potentially far safer

6....Third, the current system of payment for FMEs is based on a fee per case. The MPS has little control over the budget for forensic medical services, as it is entirely demand driven....The current system allows for multiple detainee examinations during a single visit to attract significant fees during a relatively short attendance in the custody suite....

7....The Herald model has been derived from an extensive MPS review and a custody medical needs workshop, encompassing external as well as internal stakeholders and subject matter experts

8....The involvement of the Commissioners Advisory Panel on forensic medical matters will also provide appropriate advice on medical and professional issues

9...The benefits and risks/challenges of the new approach are set out below:

#### Benefits

- Speedier medical assessment and forensic medical recovery
- Providing improved care for all detainees
- Reduction in overtime costs/detention times due to delays in waiting for FMEs to attend custody
- Improved processing times
- Improving services to victims and to witnesses
- ...
- Increasing cell availability due to timely processing of detainees

#### Risks and Challenges

- Recruitment of sufficient appropriately skilled staff to fulfil the functions of the Custody Nurse role
- Contingency plans to cover periods of long term absence as custody nurses are difficult to replace or cover

#### Conclusion

11....Through the development of the Custody Nurse and the enhancement to the existing MPS role, the standard of custody services within the MPS will be significantly improved

#### Financial implications

2....The table below shows the current and estimated costs of providing nurses in custody suites, together with savings identified to offset the increased staffing costs. It is based on a phased rollout, recognising the

*need to stage recruitment over a number of years, and assumed the employment of 50 nurses in 2008/09, 75 nurses in 2009/10 and 75 nurses in 2010/11*

**Table 1 Herald – estimated costs of deployment of nurses in custody suites**

	<b>2008/9 M</b>	<b>2009/10 M</b>	<b>2010/11 M</b>
Existing FME budget	13.577	13577	13577
<b>Additional Costs</b>			
Cost of Nurses	2.1	5.25	8.4
Recruitment and training/one off accommodation costs	0.2	0.2	0.1
Total additional costs	2.3	5.45	8.5
<b>Total Revised Budgeted Costs</b>	15.877	20.521	23.571
<b>Proposed savings in custody medical provision</b>			
FME new pay structure	-1	-2	-2
FME reduced demand		-4	-8
Sub-total FME savings	-1	-6	-10
<b>Net budgeted costs</b>	14.877	14.521	13.571
Impact on mtfp	1.3	-0.55	-1.5
Proposal to cover shortfall			
Contribution from TP	-0.2	-0.2	-0.1
Contribution from met modernisation fund	-1.1		
Impact on budget	0	-0.75	-1.6

The above aims and perceived benefits and risks and challenges of Project Herald are reviewed by the authors, comparing the situation in 2008 with the present arrangements.

The new system put in place from January 2009 was intended to have the majority of detainee assessments undertaken by nurses, with FMEs providing support for complex and statutory situations. In practice, it turned out that the CNPs were confined to their custody suites and FMEs provided cover for large areas of multiple custody suites, travelling between them when on call. There is very little contact between these two groups. At the same time that the FME areas have enlarged, there has been a concomitant and steady erosion of the numbers of doctors working as FMEs in the MPS. This has happened for two main reasons: a) financial (as remuneration for these posts are no longer competitive with, for example, GP sessions) and b) perceived lack of support from the MPS.

## **Nurse Recruitment**

It was intended that by 2011, 200 nurses would be in place providing 24 hour 7 day cover to a large range of custody suites. Currently a total of ~69 nurses are in post. Of a similar number in post 15 months ago 44% have left. It is not clear, despite the P & CCs best efforts to establish them, what the key reasons are for this high churn rates of nurses. The number now

employed represents approximately 1/3 of the numbers projected for 2011. As a result there have been multiple occasions when custody suites either a) have no cover (because of CNP absence or sickness), or b) have inadequate cover, as, in the absence of the rostered nurse this is provided by FMEs who are expected to cover the additional area whilst already covering an area that was deemed of an appropriate and safe size. Until this year, for reasons unknown to us, the CNP rota was apparently completely separate from the management of the FME rota, thus making rota management extremely difficult for the hard-pressed and extremely impressive rota management team.

## **Costs**

In 2008, a Freedom of Information Act (FOI) study was used by the authors to assess delivery of forensic medical services to all police services in England and Wales. The figures utilised in this study (Payne-James et al 2010) showed that in the MPS in 2007 there were 223,999 detainee assessments, with a total detainee throughput of 395,000. The total budget for forensic medical services in 2007 was GBP 12,627,128. The cost of each assessment to the MPS at that time was therefore GBP 56.4. This was the cheapest cost of service provision in England and Wales, compared with all other police services and including nurse only, mixed provision (including doctors, nurses and paramedics) and other doctor only services. This study also included comparison with all outsourced providers.

When the authors repeated the FOI national study in 2012, the MPS declined to disclose these data on s43 FOI grounds.

This year, recent figures for 1 4 2011 to 31 3 2012 showed 263,714 detainees passing through custody. 85,165 saw a healthcare professional with a total of 122,225 examinations as some detainees were seen more than once (Inspector Jacqui Nicholas, personal communication). Data presented by Commander Adrian Hanstock and Superintendent Annette Wightman to the P & CC on 10<sup>th</sup> October 2013, indicated a current total budget of ~ GBP13.4 M. Based on this figure and the total number of examinations, the cost per contact with an HCP for the MPS in 2013 has therefore almost doubled since the inception of the current service to ~ GBP 109.

## **Attendance Times**

One of the stated aims of Project Herald was to improve attendance times (ie the time from which a request for an assessment was made by the police to the time at which they were seen by a healthcare professional - HCP), whether CNP or FME. There was a belief that having 24 hour cover (two 12 hour shifts of nurses) would provide an immediacy of attendance when compared with FMEs travelling between stations. In practice this is not the case. This may be due to a whole variety of reason, for example, multiple prisoners to see at any one time, travel delays to work, administrative tasks to be carried out, toilet breaks, food breaks.

It is perhaps crucial to understand that attendance time does not allow any interpretation of a) quality of care or b) appropriateness of care. The problem with the emphasis on attendance times has been raised previously (Norfolk & Payne-James 2008). As yet no studies have been

undertaken of outcome of healthcare assessments of detainees, in relation to the background of the examining HCP, although such a study is urgently needed.

Despite this, while developing Project Herald, much reliance was placed by the MPS, on concerns about attendance times. Data have not previously been gathered on this aspect of the work, as we understand it has not been thought possible to interrogate the National Strategy for Police Information Systems (NSPIS) for this type of information.

In the light of the questions and requests of the Assembly Members present on the P & CC, research has since been undertaken by the authors that explored in detail, a) time to attendance, b) length of time of assessment of a random sample of health assessments within the MPS, in the current month of October 2013. This was undertaken in the course of day to day FME work, utilising NSPIS. All HCPs have access to the Detained Person’s Medical Form which provides the relevant information, including time of call-out by the custody team, time of start of assessment and time of completion of assessment.

Detailed analysis show the following from a sequential sample of 192 detainees, seen by CNPs (n = 104) or by FMEs (n = 88). The data was taken from 24/7 nurse custody suites, stations with mixed CNP/ME cover and stations with no nurse cover. Day and night and weekend and weekday sessions were sampled. When reviewing the detailed data, it was clear that the CNP data are less interpretable than FME data, because in a number of cases a) although a request is made, on a significant proportion of occasions the detainee never gets seen (29 of this sample had not been seen at the time data were collected) , and b) Detained Persons Medical Forms appear in many cases to be filled in retrospectively (ie after a detainee has been seen). The significance of why this happens is unclear. Unlike FMEs, HCPs have NSPIS privileges that allow them to complete referral forms themselves. As the purpose of referral should be to address issues of concern to the police regarding management, it seems inappropriate for the referral to be written by a Health Care Practitioner, notwithstanding that such a practice is not obviously compliant with the Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) standard of professional independence of health care provision in places of detention. It was also common to find that contact details (the time the HCP was called and response received), were not recorded).

The summary data presents averages in Table 2 below that compares a) time to start of assessment after initial request, between FME and CNPs, b) length of time of consultation, for FMEs and CNPs, c) the maximum and minimum wait times before assessment:

**Table 2 Mean FME and CNP Attendance and Examination Time Data in minutes – October 2013**

<b>Time (minutes)</b>	<b>FME</b>	<b>CNP</b>
<b>Mean – time to start of assessment from initial referral</b>	<b>87.3</b>	<b>86.2</b>
<b>Mean – time take for HCP assesment</b>	<b>12.4</b>	<b>14.1</b>

<b>Maximum delay before assessment</b>	<b>410</b>	<b>542</b>
<b>Minimum delay before assessment</b>	<b>0</b>	<b>0</b>

**[Raw data of this study are available for review]**

This sample shows that there are virtually no differences between mean times to assessment from initial request (FME 87.3 minutes vs CNP 86.2) for those detainees who have been examined. When taking ‘no examinations at time of data collection’ into account the mean time from request to assessment for CNPs rises to 117 minutes. Clearly the reasons for these substantial delays for detainees in police stations which have 24/7 nurse cover is a major concern and needs further research. However it is very clear that on-site CNPs do not result in any relevant access to quicker assessment, than using FMEs covering multiple stations.

If the assessment times for detainees are explored CNP assessment times are only ~ 2 minutes longer on average when compared with an FME, so cannot be the explanation for the delays in access.

The initial Project Herald data provided data on ‘response times as a percentage of total call-outs’. Those data are provided below in Table 3 and compared with current figures:

**Table 3 FME and CNP Attendance Times 2013 compared with 2008**

<b>Response Time from Request for Attendance to Start of Examination (minutes)</b>	<b>% of calls (2008)</b>	<b>% FME (2013)</b>	<b>% CNP (2013)</b>
<b>&lt;30</b>	<b>31.1</b>	<b>34.8</b>	<b>31.2</b>
<b>&lt;60</b>	<b>30.4</b>	<b>11.1</b>	<b>15.6</b>
<b>&lt;90</b>	<b>15.9</b>	<b>18.5</b>	<b>10.4</b>
<b>&lt;120</b>	<b>10.3</b>	<b>13.5</b>	<b>6.5</b>
<b>&lt;180</b>	<b>8.4</b>	<b>7.4</b>	<b>14.3</b>
<b>&gt; 180</b>	<b>3.7</b>	<b>14.8</b>	<b>22.1</b>

**[Raw data of this study are available for review]**

In 2013 77.9% of FME assessments are now started within 120 minutes of referral, compared with 63.7% of CNP referrals. This compares with a total of 87.7% in 2008 prior to introduction of the new system, a substantial deterioration.

### **Additional Issues**

Clearly by virtue of completely different training and working practices, doctors and nurses possess different skill sets and capabilities. With regard to custody healthcare the two most important competences relate a) to the ability to conduct mental health assessments and b)

the ability to prescribe medication. All doctors are trained (as part of basic medical training) to be able to undertake mental health assessments (and for example, any registered medical practitioner, can make one of the Recommendations for Section under the Mental Health Act, even if not s12 approved). Nurses are limited with respect to mental health assessment a) unless they have had specific mental health training and b) are limited in what they can prescribe which itself may be dependent on relatively limited indications under Patient Group Directions. It is also understood that at present, nurses can administer no medication to a detainee within 6 hours of their booking in time in a police custody suite.

These differences in skills and practice thus may have the potential for substantial clinical and procedural impact on the vulnerable detainee population who are over-represented in relation to the general population in terms of mental health issues, drug and alcohol use and physical health problems (Payne-James et al 2008). These are often complex patients with concomitant complex needs.

Thus within the MPS at present, any detainee is subject to a 'police station lottery' in terms of the skill-base and competencies and ability to assess and treat, that depends on where he or she is arrested and to which custody suite they are taken and whether a CNP or a FME provides healthcare. No data are available that allow a determination of how often CNPs clinically consult with FMEs.

It is unclear whether these changes adversely impact on other services in London (eg the London Ambulance Service, Emergency Departments), but despite a substantial reduction in throughput of detainees in the MPS custody suites between 2007 and 2012, ambulance service call-outs to MPS police stations have risen from 7516 to 8767 (as a percentage of overall detainees assessed from 1.9% to 3.32%), a substantial increase (London Ambulance Service, personal communication). In all but one of the seven 24/7 nurse cover stations, LAS callout numbers have increased.

## **HM Joint Inspectorate**

HMI make a number of regular announced and unannounced inspections. The layout and format of the reports is standardised with a 'cut and paste' element. There is normally a nurse on the inspection team. It is not made clear whether the nurse is in clinical practice and whether they have any experience in police custodial healthcare. Forensic physicians or other doctors are not part of the inspection team, although healthcare always has its own section within the reports. Many of the reports have Police Custody Surveys, with generally low numbers of respondents.

It is of interest to note that a common theme is the absence of choice of a female FME to assess female patients, while the paradox that most CNPs are female does not get mentioned. Clearly a male detainee's choice of gender of healthcare professional is very limited.

Praise is given for the development of a Peer Review and Audit Scheme for FMEs, but this initiative was not established by the MPS but by, and at, Barts and the London School of Medicine & Dentistry.

A number of issues have been identified in recent inspections, and relevant ones are reported below, taken as verbatim quotes and are consistent with current research findings [All reports referred to may be seen at the HMIC website - <http://www.hmic.gov.uk/publications>] :

***Unannounced inspection....Redbridge...30 January – 2 February 2012 [Police Custody Survey Sample – n=40]***

*‘clinical governance arrangements for FMEs were inadequate’*

*‘primary health services were adequate but there were sometimes delays in the arrival of forensic medical examiners when they were called’*

*‘we were told that the FME also covered three other boroughs’*

*‘longest wait...three hours 22 minutes’*

*‘no evidence that such delays were monitored or investigated’*

***Unannounced inspection ....Waltham Forest...30 January – 1 February 2012 [Police Custody Survey Sample – n = 17]***

*‘primary health services and clinical governance were good’*

*‘nurses based in the site 24 hours a day’*

*‘nurses we spoke to...had received a comprehensive induction and attended regular training events’*

*‘longest wait had been approximately 4 hours 19 minutes’*

*‘one detainee had requested to see a healthcare professional but this had not happened...there was little explanation of why this had been the case’*

*‘nurses used proformas...the records we looked at were comprehensive’*

*‘medications were usually not provided unless the detainee had been in custody for 6 hours, while we understood the reasons for this rule, we were concerned it was too stringent...given that there was evidence of long waits to be booked into custody’*

***Unannounced inspection.....Lewisham.....8-10 May 2012 [Police Custody Survey Sample – n = 17]***

*‘nurses employed by the MPS were permanently on site; doctors were on call, with reasonable response times’*

*‘only 17% of detainees seen...rated the quality of care as good or very good’*

*‘nurses...had no regular access to clinical supervision’*

***Unannounced inspection.....Bromley.....8-10 May 2012 [Police Custody Survey Sample – n = 44]***

*‘response times from forensic medical examiners was good....quality of service was high’*

*‘female doctors were not always available to detained women’*

*‘clinical governance arrangements were unclear’*

*‘50% of detainees...rated the quality of care as good or very good’*

***Unannounced inspection..Haringey....3-5 December 2012 [Police Custody Survey Sample – n = 14]***

*‘governance was developing with some evidence of progress’*

*‘the peer review initiative for forensic medical examiners was a positive move to assure safe up-to-date clinical practice’*



*'response times by FMEs was variable...as the FME covered more than one area'*

*'a formal peer review process for FMEs had been introduced'*

*'peer review by forensic medical examiners was an excellent initiative to assure and improve safe clinical practice and prepare for medical revalidation'*

*'detainees did not have a choice of male or female FME'*

**Unannounced inspection..Westminster....4-9 February 2013 [results of survey too small to be used]**

*'custody nurses were based in the suits 24 hours a day..supported by on –call forensic medical examiners'*

*'recent gaps in staffing had resulted in more frequent reliance on FMEs, with response times sometimes up to 4 hours'*

*'female detainees were not always able to see a female doctor'*

*'overall governance was reasonable'*

*'custody nurses had clear management supervision and the line managers offered annual appraisal with clinical supervision'*

*'we saw nurses leaving the door open while seeing detainees, even when no risk to their safety had been identified, which compromised confidentiality'*

## Summary

If the above evidenced data are compared with the Benefits and Risks & Challenges identified in Project Herald initially, an assessment can be made of whether the project has succeeded or failed. Naturally many other factors influence these issues, but with regard to the forensic medical services project, taking each in turn:

### Benefits

- *Speedier medical assessment and forensic medical recovery - **No evidence to support speedier assessment. It is slower, with CNP assessments being delayed longer than FME assessments. Frequent non-cover of custody suite. Data suggests slower and sometime no assessment***
- *Providing improved care for all detainees – **There is no researched evidence to support improvement***
- *Reduction in overtime costs/detention times due to delays in waiting for FMEs to attend custody – **If anything, delays have been increased by the introduction of the new system. There is no evidence to support reduction as there is no difference in assessment time delays between CNPs and FMEs***
- *Improved processing times- – **There is no evidence to support improved processing***
- *Improving services to victims and to witnesses – **There is no evidence to support improvement***

- *Increasing cell availability due to timely processing of detainees – **There is no evidence to support increased cell availability as a result of the changes to the healthcare service***

### **Risks and Challenges**

- *Recruitment of sufficient appropriately skilled staff to fulfil the functions of the Custody Nurse role – **The MPS has failed to recruit adequate numbers of CNPs. The reasons why are unclear***
- *Contingency plans to cover periods of long term absence as custody nurses are difficult to replace or cover – **Failure to recruit CNPs and erosion of FME numbers have meant that there is no resilience in the system***

### **Conclusions**

None of the intended three aims or the other intended benefits of Project Herald have been achieved. The forensic healthcare service available to detainees, although not failed has been degraded at considerable cost and with an absence of any measurable benefit. Concerns raised, or attempted to be raised, at early stages in the project which identified potential problems were ignored.

Perhaps most surprising is that plans were developed without anticipating or factoring in the possibility of a reduced service need, due to reduction in crime rates. Changes in the MPS build plan do not also appear to have been taken into account. The model designed prior to 2008 has not in any way been reviewed or adapted to take these factors into account.

This does not mean that a properly managed, high quality, effective forensic healthcare service for the MPS at an appropriate budget cannot be achieved. A full integrated professionally managed forensic healthcare service utilising the complementary, not competing, services of nurses and doctors, appropriately trained and qualified in clinical forensic medicine, in tandem with the skilled and professional custody staff would give the MPS the opportunity of providing **a world class forensic healthcare service** within tight financial constraints. However proper consideration should be given, rather than just lip service paid, to engaging with those with the clinical and current practical skills to properly advise on how this service should be delivered and training should be provided. Relevant professional advice would also demonstrate the benefits of a trained and motivated group of healthcare professionals to both detainees and the MPS.

Somewhat surprisingly, considering the MPS commitment to diversity and issues of vulnerability, no effort has hitherto been made to seek the views of detainees (the end users of the service) with regard to the healthcare provision available to them. A preliminary study is currently being developed working with the Independent Custody Visitors to provide data to address this issues.

On a final note, based on the current throughput of detainees and number of assessments, it is of interest that were the previous system, prior to 2009 still to be in place, the overall cost

to the MPS of the entire forensic healthcare service budget would be approximately GBP 6,893,490 for a service entirely staffed by FMEs (approximately half the current spend), giving the same (or probably better) attendance times to those that are currently enjoyed in the MPS area.

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**25<sup>th</sup> October**