
MANAGEMENT ISSUES

Dealing with the police

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The majority of accident and emergency (A&E) departments have a good working relationship with the police, based on a mutual understanding of the conflicts which arise from the need, on one hand, to treat patients with confidentiality and on the other hand, the role of the police in maintaining law and order.

In A&E work we need police help for many reasons, not least of which is staff and patient protection against violent crime and abusive behaviour. Although many trusts have internal security arrangements, back up from the police is essential. We also use the police to help trace relatives and break bad news, particularly when the next of kin live in a different part of the country. They are able to give information regarding accidents or injuries, which helps the resuscitation of patients with major or multiple injuries. They also facilitate interhospital transfer by measures such as traffic control and have a key role in disaster planning and implementation.

Police usage of the accident and emergency department

The police force need us primarily as a source of information, which may be of a non-clinical or a clinical nature.

NON-CLINICAL INFORMATION

In order to fulfil their duties the police will often approach A&E to request information about patients attending for treatment. This information will often be of a non-clinical nature (such as the Korner minimum dataset) which under certain circumstances may be released.

In 1991, following extensive discussion between the BAEM executive committee, the British Medical Association, and the Association of Chief Police Officers,¹ written guidance was produced for consultants and/or other doctors in charge of A&E departments regarding the release of non-clinical information to the police.¹ It is suggested that non-clinical information will only be released if a crime is committed which is included (in England and Wales) under the Police and Criminal Evidence Act, schedule 5, parts I and II (for example, treason, murder, manslaughter, rape, kidnapping, possession of firearms with intent to injure, carrying firearms with criminal intent, and so on); section 116 (serious harm or security of the state or public order, etc), or provisions under section 168 (2d) Road Traffic

Act 1971 (for example, non-clinical details which would identify a person involved in a road traffic accident such as name, address, etc).

Requests for non-clinical information should be made by a police officer of the rank of inspector or above to the consultant or doctor in charge of the A&E, and a form of inquiry must be completed and signed.

These guidelines only apply to non-clinical information and even then the final decision as to the release of any information should only be made by the doctor in charge of the A&E department.

CLINICAL INFORMATION

On occasion the police make requests for clinical information. Release of such information must only be given with the informed written consent of the patient involved. The only exception to this rule would be to release information when ordered by a judge (or similar) in a court of law, or very rarely, when the offence is so serious and the release of information involves only such a small number of patients that a breach of confidentiality could be justified on the grounds of public safety. The circumstances under which a breach of such confidentiality occurs must be considered exceptional. Under these conditions it would be extremely prudent to seek the advice of a defence organisation, the solicitors acting for the hospital or trust, and also to seek support from a senior clinician such as the medical director.

POLICE STATEMENTS

The police will often ask A&E departments to provide written statements regarding injuries sustained and treatment given to persons suffering assault. Under these circumstances, it is the requesting policeman's responsibility to provide written informed consent for the release of such information. I would recommend that these statements should be prepared by the doctor concerned in their own time when consideration and careful thought can be given to them. I would recommend that they be shown to an A&E consultant before release.

These statements should contain factual information prepared in a language which is readily understood by lay persons. It should not contain anything that the doctor would not wish to repeat under oath in a court of law.

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A copy of each statement should be retained for the doctor's own personal records.

If the police request an opinion, for example as to whether an injury is consistent with a particular mechanism of injury, then the medical practitioner concerned should ask themselves whether they are experienced or expert enough to give this opinion and whether they would be able to stand up and justify this opinion under cross examination.

Victims of assault

Consideration must be given not only to providing good medical care, protection, and social or psychiatric support for victims of assault, but also to the responsibility of the police to investigate crime and collect evidence which can be put before a court of law to achieve successful prosecution of the perpetrators. Although it is clear that the primary role of A&E is to provide treatment, the preservation and collection of evidence should also be borne in mind, particularly in the case of serious crime such as murder or rape. It is important to avoid accidental or deliberate obstruction of a criminal investigation by the destruction of evidence. If the victim dies then all evidential material becomes the property of the coroner.

Although the actual collection of evidence will normally be the responsibility of a police surgeon, it is important that evidence is not inadvertently destroyed (such as cutting through stab or bullet holes in clothing when removing garments during resuscitation) or inadvertently cross contaminated. (In forensic science there is a principle that every contact leaves a trace which may be in the form of debris, such as hairs, textiles, fibres from clothing, or gunshot residues, or body materials such as blood, semen, saliva, etc. If the victim and alleged perpetrators are treated by the same persons or seated in the same areas, or treated on the same examination trolleys, cross contamination may occur.)

In the case of serious sexual assaults, clothing should be removed carefully, preferably with the person standing on brown paper so that any shed evidence may be retained and collected. Time is of the essence. Approximately 60% of fibres will be shed during the first hour; it is therefore important to handle the patient and their clothing with as little movement as possible and to allow for early forensic examination. Each item of clothing should be kept separate and should be moved as little as possible while it is removed and stored (that is, clothes inside out during removal should be left inside out). Clothes should be placed where they can be left safe, secure, and undisturbed until the police are available to pack and seal these items. Other items such as blankets or draw sheets should be retained for police examination.

Although the collection of evidence is important it should not interfere with medical treatment of the victim.

Drivers and alcohol

Following road traffic accidents the police may request a driver to provide a specimen of breath or blood in order to measure the alcohol level. They must ask consent from the doctor responsible for looking after the patient. This consent can be refused if the patient is unable to give informed consent (unconscious, head injury, and so on) or if the provision of the specimen would be detrimental to the patient's health, or when giving the statutory warning would be detrimental to the person's health (for example, if there is a sub-arachnoid haemorrhage). If venepuncture is performed it should be done by the police surgeon and not by the doctor looking after the patient.

Patients in custody

Patients will often attend A&E in custody handcuffed to one or more police officers. Our own policy is to triage these patients according to their clinical needs but nevertheless to expedite treatment where possible in order to minimise the length of time such persons are in the department. Such patients should be treated as any other person, that is to say, with care, consideration, and kindness, and it must be remembered that their medical needs are paramount. Any pressures to treat such patients unnecessarily quickly should be resisted. Particular care must be taken when asked to assess fitness to return to the cells, particular in the case of head injury or alcohol intoxication.

General considerations

With the development of specialist units within the police service (such as non-accidental injury and rape support units), where police officers are trained specifically in the investigation of such cases, potential conflicts between the medical profession and the police force can be minimised by a good working knowledge of the law as it pertains to these issues, the duties of the police force to investigate crime, and the duties of the medical profession to treat patients with confidentiality.

In order to avoid conflict, liaison between doctors and the police should be at a senior level. I believe that all contacts with the police should be of a formal nature. Advice or information must not be given "off the record" and any information given to the police should be in accordance with statutory legal requirements or good clinical practice. No information should be given which the practitioner would not be prepared to repeat in a court of law under oath. It is the duty of A&E to ensure that all staff are aware of the needs of confidentiality. It is not acceptable for administrative or clerical staff to breach this duty of confidentiality and to give information to the police.

¹ Central Consultants and Specialists Committee (CCSC), November 1991.