# Contents

**POLICE CARE NETWORK**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>1.1 Background</td>
<td>4</td>
</tr>
<tr>
<td>2. Role, Remit and Objectives</td>
<td>5</td>
</tr>
<tr>
<td>2.1 Rapid Review of the Network</td>
<td>5</td>
</tr>
<tr>
<td>2.2 Revised Aims and Objectives</td>
<td>6</td>
</tr>
<tr>
<td>2.3 Revised Scope</td>
<td>6</td>
</tr>
<tr>
<td>2.4 Revised Role</td>
<td>7</td>
</tr>
<tr>
<td>3. Strategic Leadership and Governance</td>
<td>9</td>
</tr>
<tr>
<td>3.1 Operational Support</td>
<td>9</td>
</tr>
<tr>
<td>3.2 Strategic Links with Policy and Strategy</td>
<td>9</td>
</tr>
<tr>
<td>4. Healthcare and Forensic Medical Services for Victims of Rape and Sexual Assault People in Police Custody</td>
<td>10</td>
</tr>
<tr>
<td>4.1 Design and Delivery of Services</td>
<td>10</td>
</tr>
<tr>
<td>4.2 Clinical Pathways</td>
<td>11</td>
</tr>
<tr>
<td>4.3 National Colposcope Specification</td>
<td>11</td>
</tr>
<tr>
<td>4.4 Forensic Kits</td>
<td>11</td>
</tr>
<tr>
<td>4.5 National Cleaning Regimes</td>
<td>12</td>
</tr>
<tr>
<td>4.6 Forensic Medical Examination Feedback</td>
<td>12</td>
</tr>
<tr>
<td>5. Healthcare Services for People in Police Custody</td>
<td>13</td>
</tr>
<tr>
<td>5.1 Numbers of people in police custody</td>
<td>13</td>
</tr>
<tr>
<td>5.2 Ensuring access to Healthcare</td>
<td>14</td>
</tr>
<tr>
<td>5.3 Mental Health</td>
<td>15</td>
</tr>
<tr>
<td>5.4 Substance Misuse</td>
<td>15</td>
</tr>
<tr>
<td>6. Quality Improvement</td>
<td>18</td>
</tr>
<tr>
<td>7. Forensic Medical Services for People in Police Custody</td>
<td>21</td>
</tr>
<tr>
<td>7.1 Guidance for Healthcare Professionals Undertaking Intimate Search Examinations for People who are in Police Custody</td>
<td>21</td>
</tr>
<tr>
<td>7.2 Guidance for Forensic Physicians in cases of Sudden Unexpected Death in Infancy that involve a medical examination of the infant’s parents or primary carers</td>
<td>21</td>
</tr>
<tr>
<td>8. Education, Training and Competencies</td>
<td>22</td>
</tr>
<tr>
<td>8.1 Training for Police Officers</td>
<td>22</td>
</tr>
<tr>
<td>8.2 Child and Adolescent Forensic Medical Examination Course</td>
<td>22</td>
</tr>
<tr>
<td>8.3 NES Training Courses</td>
<td>22</td>
</tr>
<tr>
<td>9. Adastra</td>
<td>23</td>
</tr>
<tr>
<td>10. Communications</td>
<td>23</td>
</tr>
<tr>
<td>Bibliography</td>
<td>24</td>
</tr>
<tr>
<td>Annexes</td>
<td>25</td>
</tr>
<tr>
<td>Annex A - Health Foundation Maturity Model and Scores</td>
<td>25</td>
</tr>
<tr>
<td>Annex B - HM Inspectorate of Constabulary for Scotland (HMICS) Recommendations</td>
<td>29</td>
</tr>
<tr>
<td>Annex C - CMO Taskforce Workplan</td>
<td>30</td>
</tr>
<tr>
<td>Annex D - Rape Crises Scotland Feedback</td>
<td>31</td>
</tr>
<tr>
<td>Annex E - Quality Indicators</td>
<td>34</td>
</tr>
<tr>
<td>Annex F - Child and Adolescent Forensic Medical Examination Course</td>
<td>37</td>
</tr>
</tbody>
</table>
Executive Summary

Welcome to the fifth Annual Report from the National Co-ordinating Network for Healthcare and Forensic Medical Services for People in Police Care (Police Care Network). The Network continues to work in partnership, across traditional organisational and geographical boundaries, to realise a programme of work that supports the delivery of healthcare and forensic medical services for people in police care.

We are pleased to welcome Mr James Crichton, Chief Executive of the State Hospital Board for Scotland who was nominated to chair the Police Care Network Board on behalf of the NHS Board Chief Executives Group. James has significant experience across NHS Scotland, working in a number of territorial NHS Boards, primarily in the mental health field and we look forward to working with him to take the Network forward over the coming years.

If you would like to find out more about the work of the Network, please contact Hannah Cornish, Programme Manager by email: hannah.cornish@nhs.net or telephone: 0131 275 7400.

Further information can be found on our website http://www.policecare.scot.nhs.uk/

Network Team
Dr George Fernie, Clinical Advisor to the Network
Dr Louise Scott, Clinical Advisor to the Network
Hannah Cornish, Programme Manager, Police Care Network
Graham Milne, Programme Manager, Victims of Rape and Sexual Assault
Laura McDonnell, Programme Support Officer (until November 2017)
Pauline Mullen, Programme Support Officer (from December 2017)
1. Introduction

The aim of the Annual Report Police Care Network is to provide partners with an update on the work of the Network, focusing on key achievements during the financial year 2017-18.

The work of the Network would not be possible without the input of a range of professionals involved. The Network Support Team would like to take this opportunity to thank all of those involved for their commitment and contribution to the Network this past year.

1.1 Background

In July 2011, the Director General and Chief Executive of the 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 delivery of healthcare and forensic medical services whereby the services provided by Police Forces should be delivered by territorial NHS Boards.

In this context, Ministers agreed the responsibility for the provision of healthcare and forensic services in police care, based on the following proposals:

- Responsibility for the delivery of healthcare in police care, which is a function of NHS Boards under the terms of the NHS (Scotland) Act 1978, should remain the function and responsibility of NHS Boards.
- Forensic medical services should be delivered by NHS Boards but remain a function and responsibility of the Scottish Police Authority (SPA) under section 31 of the Police and Fire Reform (Scotland) Act 2012.

In practice, a clear separation of the provision of healthcare and forensic medical services is often difficult and impractical. The Scottish Government therefore decided that NHS Scotland should provide appropriate forensic medical services, on behalf of Police Scotland within joint local/regional NHS and Police Scotland partnerships.

Responsibility for forensic medical services remained with the SPA / Police Scotland, although delivery is a matter for the NHS. Roles and responsibilities are articulated in a Memorandum of Understanding between Police Scotland and NHS Boards\(^1\).

Responsibility for healthcare and forensic medical service delivery transferred from Police Scotland to NHS Boards in April 2014. The Network was established in May 2013 to support and facilitate these transfer arrangements.

\(^1\) Although it is recognised that greater clarity is required around this and this is currently being worked through by Scottish Government as part of the CMO Taskforce for the Improvement of Services to Victims of Rape and Sexual Assault (HMICS 2017).
2. Role, Remit and Objectives

2.1 Rapid Review of the Network

On 1st April 2018 it will be 4 years since the NHS took over the responsibility for the delivery of healthcare and forensic medical services for people in police care. In this time there has been considerable change locally, with the increasing role of both IJBs and Regional structures, as well as nationally with the establishment of the CMO Taskforce for the Improvement of Services for Victims of Sexual Assault and the Health and Justice Collaboration Improvement Board.

The Police Care Network Board agreed that this was an apt time to:
- reflect on the work of the Network over the past five years
- take stock of where the Network is now
- plan ahead for the next 3-5 years to ensure that the Network adds value and meets the needs of all of its stakeholders
- ensure that there is clarity around roles, responsibilities and governance.

The Network held a Strategic Planning Day on Monday 19th February where members of the Network Board and Operational Support Group heard the views of partners within the Network. Some successes included:
- improved partnership working
- clinical governance arrangements for safe administration of medication in Police Custody settings
- involvement in joint training with Police Scotland
- provision of health improvement initiatives
- joint guidance around intimate searches and standardised procedures for sudden.

Areas that had proved more challenging include:
- the limitations of Adastra
- the limitations around the enhanced role of forensic nurses
- responding to emerging trends such as New Psychoactive Substances
- responding to service user feedback.

Using the Health Foundation Maturity Model, a validated tool to assess the effectiveness of Networks, was used to gauge the effectiveness and impact of the Police Care Network. An analysis of the Maturity Model scores is included in Annex A. The afternoon focused on the importance of clinical leadership within the Network and ensuring that partnership decisions were clinically assured and evidence based.

The key findings from the day were:
- There is a pressing need to refresh and clearly articulate the aims and objectives (purpose and direction) of the Network, ensuring that there is a structure and governance arrangements that allow the Network to deliver on the aims and objectives.
- Appropriate membership needs to be considered in the context of a new structure – this should consider the role of IJBs and the Regional Planning Groups.
- It was suggested on the day that a short life working group should be formed to take this forward.
- There is a need to better understand how the Taskforce sits in relation to the Network and better articulate who is responsible for what.
- Once the aims, objectives and governance are articulated, the Network should have a workplan which aligns with this. This will potentially involve the creation of SLWG and long standing to develop some of the outputs required.
To respond to the findings, further work was done to undertake to refresh the role, remit and governance arrangements, with a more streamlined structure and renewed focus on quality improvement. The proposals were taken to the NHS Board Chief Executives who have endorsed the aims, objectives and approach. Work will take place over early 2018-19 to refine the workplan and the role of specific short life working groups.

2.2 Revised Aims and Objectives

The Network aims to support consistency in service quality and healthcare outcomes for individuals who receive services across Scotland, recognising that different NHS Boards will have differing service models in place which meet the needs of their population and geography.

This includes facilitating and supporting the delivery of:

- **Person centred healthcare and forensic medical services for people in police custody in Scotland.** This should include a clinical needs assessment which meets the person’s immediate healthcare needs, as well as seeking opportunities for health improvement and / or referral to other health and social services where appropriate.
- **Accessible, person centred, trauma informed health care and forensic medical services and access to recovery, for anyone who has experienced rape or sexual assault in Scotland.** This should include a clinical needs assessment which meets the person’s immediate healthcare needs, provides ongoing support and safety planning and referral to specialist services where appropriate.
- **High quality forensic medical services,** undertaken in an appropriate environment, using up to date kit and sampling techniques.

2.3 Revised Scope

This includes the provision of healthcare and forensic medical services for people detained by Police Scotland under terrorism defences and people detained by the British Transport Police where people are taken to a Police Scotland custody suite. Other areas, including services for people detained by Border Force, will be scoped and, if deemed appropriate will fall in scope of the Network.

With regards to child sexual assault and non-accidental injury, it is recognised that there are well established regional Child Protection Managed Clinical Networks (MCNs) that work together to progress national pieces of work. The Police Care Network will not take on work explicitly in this area, rather the Network will work collaboratively with the three CP MCNs where necessary on areas where there is a national remit or where guidance covers a number of areas, including paediatric services – eg decontamination guidance for forensic medical suites.

With regards adult services for victims of rape and sexual assault: in 2017 Scottish Government established a Chief Medical Officer’s Taskforce for the improvement of services to victims of rape and sexual assault. Given the interdependencies of this area of work, the Network will not take on additional pieces of work in this area until some of the key deliverables of the Taskforce are more developed. The Network may assume responsibility for supporting implementation although this remains to be confirmed.
The scope does not extend to people who Police Scotland come into contact with who are not taken into police custody, e.g., those who are drunk and incapable, or those in mental health crises who are taken to a health or social care place of safety or who access community triage/diversion services. There may be a need for Network to engage with these areas due to the interfaces with police custody.

2.4 Revised Role

The Network does this by:

- Providing national strategic leadership and advice to NHS Boards, IJBs and Police Scotland in relation to the delivery of healthcare and forensic medical services.
- Providing a forum for partnership working and resolve issues requiring national agreement between partners through consensual collaboration.
- Engaging with NHS Board Chief Executives if significant operational issues with service delivery are raised through the Network by Police Scotland, the Crown Office and Procurator Fiscal Service or NHS Boards.
- Developing clinically assured, evidence informed guidance to support service delivery and help ensure the delivery of consistently high quality services.
- Collaborating with relevant scrutiny bodies to inform the development of clinical and service standards where appropriate.
- Facilitating data analysis and review to support continuous improvement and quality assurance in the quality of care (CQI).
- Providing a forum to support peer review of services against nationally agreed guidance and standards where available. This will:
  - include the development of reports to NHS Boards to support the development of action plans for continuous improvement.
  - involve developing aggregate national reports to provide a national picture and facilitate benchmarking where feasible.
  - This is separate and distinct to clinical peer review where clinicians may discuss individual cases.
- Providing a forum for peer support for healthcare professionals to support continuous professional development and to work with NES to support the development of training courses or resources where training needs are identified.
- Engaging with organisations to advocate for service users and services and influence policy and strategy.

The Network will achieve its remit through the establishment, co-ordination and support of a network structure which allocates specific areas of responsibility to a range of topic specific short life working groups, while providing overall strategic leadership and advice through a National Advisory Board.
The governance structure is outlined below.

Figure 1: Network structure
3. Strategic Leadership and Governance

The Network Board provides national strategic direction to the Network and advice to the services the Network supports. For 2017-18 it had three primary functions:

- monitoring service delivery to ensure that it meets needs and is delivered efficiently, effectively and equitably across Scotland.
- overseeing progress against the Network’s objectives and directing action to ensure they are met.
- reviewing the role, remit, governance and objectives of the Network, as highlighted in section 2.

3.1 Operational Support

The Operational Support Group co-ordinates and oversees the work of the Network subgroups to implement the decisions of the Network Board and the achievement of the Network’s objectives. It also provides a forum for interchange and linking between the Network subgroups and Regional Collaboratives and assists in the design and continuing delivery of services.

3.2 Strategic Links with Policy and Strategy

Over the course of the year members of the Network have engaged with key policy and legislative agendas.

Refreshing the Justice Strategy

Scottish Government’s Justice Directorate worked to refresh the Justice Strategy. Network members have worked with Justice Directorate’s Analytical Services Team to develop the evidence base of the healthcare needs of people in contact with the justice system in order to inform the Strategy. One of the 7 priorities for the Justice Strategy will be to ‘work with others to improve health and wellbeing in justice settings, focusing on mental health and addictions’. The Justice in Scotland: Vision and Priorities and associated Delivery Plan, 2017-2018 were published in July 2017.

Mental Health Strategy: 2017-2027

In 2016-17 Network members contributed to the Scottish Government’s consultation on its Mental Health Strategy. The strategy was published in 2017 and recognises the high prevalence of mental health problems among those in contact with the justice system and notes that there are many opportunities to develop and improve actions that promote good mental health for people who come into contact with the justice system as a result of their offending behaviour, or who contact the police in distress.

The Strategy commits to increasing the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to prisons. Over the next five years Scottish Government has committed to increasing additional investment to £35 million for 800 additional mental health workers in those key settings. The Network has been working with the Mental Health Policy Team in Scottish Government to progress this action.
4. Healthcare and Forensic Medical Services for Victims of Rape and Sexual Assault People in Police Custody

In March 2017, HM Inspectorate of Constabulary for Scotland (HMICS) published their Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime. The aim of the report was to provide a strategic overview of the forensic medical services provided to adult and child victims of sexual crime, and to give a high-level assessment of these services in terms of their current delivery against national policies and standards. It also highlights strategic issues for consideration by key stakeholders, and is intended to inform future scrutiny of this area. The report made a number of recommendations and these are outlined in Annex B.

In April 2017 the Scottish Government established a Chief Medical Officer led Taskforce for the Improvement of Services for victims of rape and sexual assault. The Taskforce provides the necessary leadership so that NHS Boards are supported to provide services to better meet the needs of victims.

Specifically, the Taskforce’s role is to provide leadership and support for the:

- The services being developed to be trauma informed and centred around the individual
- Appropriate infrastructure is available to support these services
- Inclusion of those individuals who are adversely affected by the experience of the individuals e.g. children, in the health and social care and support services
- Consideration of the feedback from groups such as Rape Crisis Scotland and the relevant recommendations of the HMICS report – HMICS Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime 2017
- Preparation by NHS Boards to meet the National Standards being developed by Healthcare Improvement Scotland
- Recording and collecting consistent data to inform continuous quality improvement
- Accessibility of education and training by healthcare staff, particularly to deliver forensic medical services
- Provision of clarity is provided about the roles, responsibilities and governance of the services.

A number of different workstreams have been established to progress different elements of work. The CMO Taskforce workplan is included in Annex C. The Network Team have supported a number of these workstreams.

4.1 Design and Delivery of Services
The Network has supported the Design and Delivery of Services subgroup which has developed options for a trauma informed person centred service for victims of rape and sexual assault available across Scotland 24 hours a day 365 days a year. This has included progressing a national helpline number to support access into the service.

4.2 Quality Improvement
The Network supports the Quality Improvement workstream of the CMO Taskforce. This has four main strands:

- Developing mechanisms for national reporting of activity and against national quality indicators this work was led by Information Services Division (ISD). ISD, in partnership with the Network, produced estimates of demand, and potentially additional need, for forensic medical services for victims of rape and sexual assault. This has informed the work of the CMO Taskforce and its subgroups with regard to current and future service provision.
- **Developing standards and quality indicators to support improvement in services.** This work is being led by Healthcare Improvement Scotland. In December, *Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: Children, young people and adults standards* were published. An Action Review meeting for the Standards to learn from the development process has been held and work is underway to develop quality indicators and this will be a priority for 2017-18.

- **Develop an agreed national dataset** which services can implement to consistently collect information about people affected by rape and sexual assault and the workforce who deliver relevant care in this area. This information will be then used to monitor and improve outcomes. This work is being led by ISD and is currently in development.

- **National IT system** - NSS IT is working with a wide range of stakeholders to outline the key business and technical requirements for an ideal IT clinical system to support forensic medical examinations for victims of rape, which facilitates ongoing healthcare support and, where required, the chain of evidence for the criminal justice system. The ability to provide data for local management purposes as well as national reporting is also included.

### 4.3 Clinical Pathways

The Network supports the Clinical Pathways workstream of the CMO Taskforce. This has involved developing *Sexual Assault Response and Review Arrangements Guidance* which sets out an evidence informed model of care for adults (age 16+) who present following sexual assault in Scotland. The model of care has been developed using the best available evidence and expert clinical views. It outlines best practice for supporting the immediate healthcare needs of individuals as well as forensic evidence capture if required. It also provides advice for healthcare professionals in relation to the provision of ongoing support and follow up.

The guidance can be used by NHS Boards to inform the way in which services are delivered and structured locally. It in no way constrains NHS, Police Scotland or associated partnerships should they wish to enhance the model with innovative elements of service delivery.

Consultation on the guidance will take place over the course of 2018-19 with a view to publishing the resource towards the end of the calendar year.

### 4.4 National Colposcope Specification

A national specification for colposcopes used specifically in the examination of victims of rape and sexual assault has been developed. Clinicians from across Scotland provided the requirements for this design, which were developed into a specification by National Procurement. A procurement process has now been established, with the first two colposcopes being ordered for NHS Shetland and NHS Orkney.

### 4.5 Forensic Kits

Work was undertaken last year within the Network to define best practice with regards to forensic evidence capture and collection, and the most appropriate sampling kits to use for this purpose. The aim is to standardise and improve the quality of the kits available across Scotland in line with the FFLM and Scottish Police Authority recommendations and make the procurement of forensic sampling equipment more cost efficient. The kits have now been agreed and a national procurement framework is in place. This has supported the standardisation of quality of forensic sampling across Scotland.
4.6 National Cleaning Regimes
To support Recommendation 9 of the HMICS Overview Police Scotland should work with the Scottish Police Authority and NHS Scotland to introduce standard operating procedures for the forensic cleaning of police premises which continue to be used for medical examinations. These should comply with current guidance. The Network is developing a specification for a decontamination protocol which will be applicable within Police, NHS and multi-agency premises, during the transition out of Police premises.

4.7 Forensic Medical Examination Feedback
In 2014-15 two questions in relation to the forensic medical examinations were included in the feedback process for victims of sexual assault undertaken by Rape Crisis Scotland for Police Scotland. Data relating to these two questions is extracted and reviewed by the Network on a quarterly basis to look at themes and key learning points. This data is also cascaded to NHS Board Managers and Service Leads responsible for service delivery. A collated summary for 2017-18 is included in Annex D.
5. Healthcare Services for People in Police Custody

5.1 Numbers of people in police custody

The number of people coming into police custody in Scotland has fallen over time. The data below represents police custody episodes – i.e., the same person could be in police custody several times over the course of the year.

![Graph showing the number of people coming into police custody 2008-09 to 2017-18](source: Police Scotland)

**Figure 2: Police custody episodes data 2008-09 to 2017-18**

The [Criminal Justice (Scotland) Act 2016](source: Police Scotland) came into effect half way through week 4 of 2018. The Act removes the separate concepts of arrest and detention, replacing them with a power of arrest without warrant, where there is reasonable grounds for suspecting a person has committed, or is committing, an offence. The Act states that the police have a duty not to deprive people of their liberty unnecessarily.

There is an upper 12 hour limit when a person can remain in custody as a suspect. If a person is held in custody for a continuous period of 12 hours and has not been charged with an offence, they can only continue to be held in police custody if they are charged or the crime is an indictable offence and an application has made by the investigating officer for an extension can extended for a further 12 hours. The 12 hour period does not include any time period during which the person is at hospital or being taken to or forth from hospital for the purposes of receiving medical treatment.

When a person is cautioned and charged they become ‘officially accused’ and their custody disposal decision will be taken in a similar way as the current position. The Act introduces Investigative Liberation as a new investigatory tool available to police that facilitates a suspect’s release from custody with conditions that are necessary and proportionate for the purpose of ensuring the proper conduct of the investigation. The Act extends the rights of those held in police custody, including widened access to legal advice.
The graph below shows the national custody throughput from week 3 in 2017, week beginning 15th January 2017, when everyone was live using the new National Custody System, up to and including week 20 (14th - 20th May 2018).

**Figure 3: Police custody episodes data by reason for detention January 2017-May 2018**

A number of different workstreams have contributed to the enhancement of healthcare delivery in police custody. The groups and workstreams provide strategic direction and practical support to the delivery of healthcare in police custody services across Scotland, in line with the principle of continuous improvement.

### 5.2 Ensuring access to Healthcare

A short life working group with colleagues from Police Scotland and NHS Boards was established to enhance the process for identifying health and social risk and vulnerability. The aim was to improve referrals from Police Scotland to NHS services. The Risk Assessment had been adapted to suit a Scottish context from a version created by Dr Ian McKinnon currently being used in Custody Suites in Northumberland.

The Risk Assessment is an interactive tool with direct questions and supplementary prompts for further questions or suggested action based on the answer given e.g. referral to access specific healthcare services. Split in to twelve sections, the form notes details of physical health, pregnancy, mental health, learning disability, substance use (alcohol and drugs) and self harm amongst others. On completion, a short summary is presented which flagged areas of risk and further action as appropriate. It was envisaged that for high risk patients, action for referral would have already been highlighted during the process of completing the form to expedite referrals or transfer to Emergency Departments where necessary.

Over 2018-19 the Network will work with Police Scotland to embed the Risk Assessment into the National Custody IT System and to ensure it works operationally.
5.3 Mental Health

NHS Greater Glasgow and Clyde has worked in partnership with Breathing Space and Police Scotland to develop a pilot to improve access to services. From the 14 May 2018, to coincide with the start of the National Mental Health Awareness week, Clydebank Police Office Custody Suite has been chosen to run a Test Of Change for the NHS 24 service, Breathing Space. This initiative will allow people in custody to speak to a Breathing Space counsellor over the phone from within the Solicitor Access Room. This service is already available to the general public but this will be the first time the service can be accessed from a police custody suite. There is various reasons a person might want to speak to Breathing Space counsellor, however, below is a list of some of the more common reasons for calling including stress and anxiety, low mood, relationships, isolation and loneliness and thoughts of suicide.

Not everyone who asks to be referred to Breathing Space will be suitable, therefore, it will be up to the custody healthcare professional to act as the gatekeeper to the service and decide if a person could benefit from the contact. The recommended time period for the consultation will be 20 minutes, however, this is at the discretion of the custody supervisor who may need to review this during the more demanding periods on custody staff or if the Breathing Space counsellor informs them that they would like to extend the conversation. The learning from this Test of Change will be shared with Network to inform future service developments.

5.4 Substance Misuse

Smoke Free Prisons
In 2013 the Scottish Government published their tobacco control strategy, ‘Creating a Tobacco-free Generation’, in which it was recognised that creating a smoke-free Prison Service was a key step in achieving a smoke free generation. In July 2017 the Scottish Prison Service (SPS) announced its intention for all prisons in Scotland to be smoke free by the end of 2018. In order to support an improved patient journey from police custody to prison, the Network is working with NHS Health Scotland to develop resources for use along the criminal justice pathway.
Impact of Minimum Unit Pricing on Crime, Safety and Public Nuisance Evaluation Advisory Group

The Alcohol (Minimum Pricing) (Scotland) Act was passed in June 2012 and the Scottish Government implemented MUP on the 1st of May 2018. The Act includes a requirement to evaluate the operation and effect of Minimum Unit Pricing (MUP). Network members sit on the Crime, Safety and Public Nuisance Evaluation Advisory Group and work is underway to explore any potential impact of MUP on people attending police custody.

Screening People in Police Custody for Hepatitis C

People in police custody are known to present with increased prevalence of injecting drug use and are therefore a high risk group for blood borne viruses. Given the prevalence of injecting drug use amongst people in police custody and that injecting drug use is the primary route of transmission of Hepatitis C in Scotland, a team of police custody nurses engaged with the NHS Board Blood Borne Virus Managed Clinical Network to pilot a screening programme for Hepatitis C as a test of change.

People in police custody referred to a healthcare professional were screened to ascertain their risk of Hepatitis C and consent was obtained to screen at risk individuals for Hepatitis C as well as other blood borne viruses (Hepatitis B and HIV). Those who were currently, or had ever, injected drugs were targeted for screening. In addition to a verbal explanation as to the screening process, a consent form was also signed by service users which included consent for information to be collated in order to monitor and evaluate the screening programme.

Screening was undertaken using the Dried Blood Spot (DBS) testing process. Those who consented to screening were either given an appointment in 4 weeks time to discuss results with the local NHS Board Hepatology clinic, or given the option of results being passed to a community key worker or general practitioner. Where screening detected a blood borne virus, and the donor did not attend for follow up, assertive contact tracing was undertaken to inform service users of their screening results.

Information from completed consent forms was collated over an 18 month period (July 2016 to April 2018) to evaluate the screening of people in police care who were identified as being at risk of Hepatitis C infection. Between 1st July 2016 and 1st April 2018, 5,517 referrals were made to the NHS service. Referrals for drug problems accounted for 9% of all referrals. During the 18 month audit period, 59 people in police custody consented to DBS screening for blood borne viruses.
Figure 5: Number of referrals and number of DBS screenings undertaken

Of those screened using the DBS process, the Hepatitis C antibody was detected in 26 individuals indicating infection in the past but the presence of these antibodies did not indicate current infection. Of those 26 individuals whose screening detected the Hepatitis C antibody, 16 individuals were found to have the Hepatitis C antigen detected and were therefore currently infected with the Hepatitis C virus. Of those screened, none tested positive for either Hepatitis B or HIV.

Service users were given the choice of how they were informed of their DBS screening results. Service users could either have a follow up appointment with the specialist hepatology clinic, or their results could be communicated to their General Practitioner or community keyworker. For further information contact Barry Muirhead, Clinical Nurse Manager, Barry.Muirhead@nhslothian.scot.nhs.uk or Susan Millar, Clinical Forensic Nurse. susan.millar1@nhs.net
6. Quality Improvement

Quality and Outcome Framework for the Healthcare in Police Custody
The Quality Improvement and Outcome Framework provides logic models and a set of evidence informed indicators that can assess outcomes of healthcare delivery within police custody healthcare services and support service planning and quality improvement. The indicators were developed using NHS standards and clinical guidelines (where these exist), national outcomes frameworks, peer reviewed academic journal articles and agreed best practice, including discussion at national meetings. The Framework is available on the website.

The Network has also collected data on a number of the nationally available indicators which are reported below. The data for a number of the indicators is provided through national ISD reports which will be published in 2018-19. Data from previous years is included in Annex E.

Take Home Naloxone Kits
With support from Police Scotland Custody Division, THN Kits are being issued by healthcare professionals to those at risk of opiate overdose in order to prevent overdose deaths. The graph below shows the number of kits provided by NHS Board (where Boards provided data).

![Take Home Naloxone Kits provided by NHS Board 2015-16 to 2017-18](image)

**Figure 6: Number of Take Home Naloxone Kits provided by NHS Boards 2015-16 to 2016-17**
Alcohol Brief Interventions

Indicator A2: % of episodes where people identified as having an Alcohol Use Disorder (AUD) with hazardous or harmful patterns of alcohol consumption receive an Alcohol Brief Intervention (ABI). ABIs are practices that aim to identify a real or potential alcohol problem and provide motivation an individual to do something about it. The rationale behind this indicator is to ensure that appropriate people receive a short, evidence-based, structured conversation about alcohol consumption that seeks, in a non-confrontational way, to motivate and support the individual to think about and/or plan a change in their drinking behaviour, in order to reduce their consumption and/or their risk of harm. ABI delivery is an NHS Board Local Delivery Plan (LDP) standard, with NHS Boards expected to deliver 20% of ABIs in ‘wider settings’ which includes police custody.

NHS Boards are increasingly delivering ABI to people in police custody. The graph below shows the number of ABIs delivered in police custody by NHS Board (where Boards provided data) though not explicitly those who were identified as having an AUD with hazardous and harmful patterns of alcohol consumption (as defined as FAST +ve (score of 3 or more) or an AUDIT score between 8-19).

![Number of ABIs delivered by NHS Board 2014-15 to 2017-18](image)

Figure 7: Number of ABIs delivered by NHS Board 2014-15 2014/15 to 2016/17

As per Delivering Quality Alcohol, Drugs and Tobacco Healthcare Services to People in Police Custody in Scotland – Guidance for Police Scotland and Healthcare Professionals figure 9 contains data for ABIs delivered by healthcare professionals only (Police Care Network).
Mental Health

Indicator MH1: **% of episodes where people are detained in police custody premises as a ‘Place of Safety’ as defined by section 297 of the Mental Health Care and Treatment (Scotland) Act**

The rationale behind this indicator is to help ensure that people are treated in the most appropriate location. This data is not recorded consistently across services however Police Scotland has a duty to report use of ‘place of safety orders’ to the Mental Welfare Commission. In 2017 the Mental Welfare Commission for Scotland published data relating to use of place of safety orders in their report *Place of Safety Monitoring Report 2016* (Mental Welfare Commission for Scotland 2017). Over the last 10 years the Mental Welfare Commission has been notified of increasing numbers of place of safety orders, which they believe is due to better reporting by the police. In 2016/07 there were 130 notifications, rising to 795 in 2015/15. Since 2011/12 the percentage where a police station is used has fallen from 18% to 1%, as demonstrated in the graph below.

![Graph showing the use of Place of Safety Orders over the years](image)

*Figure 8: Use of Place of Safety Orders (Mental Welfare Commission for Scotland 2017)*

Complaints

Indicator GH5: **% of complaints that are made by people in police custody relating to the delivery of healthcare and forensic medical services** and Indicator GH6 **% of complaints that are made by people in police custody relating to the delivery of healthcare and forensic medical services that are upheld**.

Previous Annual reports have reported this data; however there are a low number of complaints within this service. Over the coming year the Network will work with NHS Boards to develop mechanisms for qualitative patient feedback.
7. Forensic Medical Services for People in Police Custody

7.1 Guidance for Healthcare Professionals Undertaking Intimate Search Examinations for People who are in Police Custody

The Network has developed guidance to describe the process for undertaking intimate search examinations for people who are in police custody in Scotland. The guidance aims to help protect patients’ interests, making them feel safe and re-assured when undergoing an examination. It should also serve to protect doctors from allegations of inappropriate behaviour that might lead to criminal, civil and GMC proceedings as well as adverse professional and reputational risk. The Network is working with services to implement the guidance locally, particularly around the area of chaperone availability.

7.2 Guidance for Forensic Physicians in cases of Sudden Unexpected Death in Infancy that involve a medical examination of the infant’s parents or primary carers

The Network has developed guidance for Forensic Physicians when undertaking a medical examination of the infant’s parents or primary carers in cases of Sudden Unexpected Death in Infancy.

Both Guidance documents are available on request from Hannah Cornish – hannah.cornish@nhs.net
8. Education, Training and Competencies

8.1 Training for Police Officers

In partnership with NHS colleagues and Police Scotland have co-produced a standardised training package for Police Officers working in Police custody to support education and training on health conditions and healthcare delivery. The presentations had been split into General Health and a standalone presentation on Mental Health. A cadre of NHS Professionals are now able to deliver this training package on courses across Scotland.

8.2 Child and Adolescent Forensic Medical Examination Course

The Child and Adolescent Forensic Medical Examination Course was organised by the West of Scotland Child Protection Network, the Healthcare and Forensic Medical Service in NHS Greater Glasgow and Clyde and the Police Care Network and took place in October 2017 in Glasgow.

The aims of the course were to provide a refresher to the medical, psychological, social and legal aspects of child sexual abuse and non accidental injury.

The day was attended by 18 Forensic Physicians, 4 from the South East (NHS Borders, Fife, Forth Valley and Lothian), 2 from NHS Highland and 12 from West of Scotland (NHS Ayrshire and Arran, Lanarkshire and Greater Glasgow and Clyde). Participants were asked to complete an evaluation of the day. Ten (56%) responses were received and the results are presented below.

The course was very positively evaluated. The programme for the day can be found in Annex F.

8.3 NES Training Courses

NES has refreshed the Essentials in Sexual Offences Examination and Clinical Management (Adults & Adolescents) - Best Practice for Scotland which ran in 2017-18.

Below is a summary of the number attendees at each of the training courses.
<table>
<thead>
<tr>
<th>Attendees</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>Total No. trained in individual courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>New to Forensic Medicine – A Teaching Programme</td>
<td>course in development</td>
<td>11</td>
<td>22</td>
<td>6</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Essentials in Sexual Offences Examination and Clinical Management (Adults &amp; Adolescents) - Best Practice for Scotland</td>
<td>22</td>
<td>21</td>
<td>18</td>
<td>36</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Scottish Conference for Professionals Working in Forensic Medicine</td>
<td>100</td>
<td></td>
<td>41</td>
<td></td>
<td>141</td>
<td></td>
</tr>
<tr>
<td>Introduction to the role of the Forensic Medical Examiner Course</td>
<td>2 courses: 37 and 45</td>
<td>41</td>
<td>32</td>
<td></td>
<td>155</td>
<td></td>
</tr>
<tr>
<td><strong>Total No. receiving training by year</strong></td>
<td>82</td>
<td>163</td>
<td>64</td>
<td>79</td>
<td>36</td>
<td>432</td>
</tr>
</tbody>
</table>

Figure 10: Training course attendees between 2013-14 and 2017-18

9. Adastra
A Sharepoint site has been developed as a resource to share key documents relating to Adastra.

The Adastra User Group has worked with NHS Boards to support implementation in areas where the system was not being used.

10. Communications
In line with the Network’s Communications and Engagement Strategy, the Network has developed the following communications:

- Quarterly newsletters communicate key decisions and actions arising from the Network Board meetings, as well as other work going on within the Network and related fields.
- Quarterly Highlight Reports provide the Network Board with an update on the work of the Network and service provision within the Regional Collaboratives.
- Quarterly Network Board minutes communicate key decisions and actions arising from the meetings.

Website
The website provides a repository for Network documents, information on each of the subgroups and key network activities - [http://www.policecare.scot.nhs.uk/](http://www.policecare.scot.nhs.uk/)
Bibliography

Healthcare Improvement Scotland (2017) *Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: Children, young people and adults standards*, Edinburgh: Healthcare Improvement Scotland


*Criminal Justice (Scotland) Act 2016*


Scottish Government (2017) *Chief Medical Officer led Taskforce for the Improvement of Services for victims of rape and sexual assault*


## Annexes

### Annex A - Health Foundation Maturity Model and Scores

<table>
<thead>
<tr>
<th>Purpose and Direction</th>
<th>Governance and Structure</th>
<th>Leadership and Facilitation</th>
<th>Knowledge Capture and Reuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Membership coverage is complete, providing well-balanced representation. Diversity and cultural/organisational differences are well handled. Governance is fully effective, demonstrating a genuine strategic interest in the success of the network. Sponsors are proactive advocates who champion the cause and promote successes externally.</td>
<td>Leadership is shared seamlessly between several members, who have time and support to carry out the role effectively. There is good understanding of dynamic social processes (e.g. bridges and brokers, connectors and mavens) and how to facilitate the network to get the best from them. There is a virtuous circle of credibility and confidence in the network to respond and deliver.</td>
<td>Members bring new insights, analysis and content for inclusion as a matter of course. Discussions are regularly distilled into valuable knowledge assets. They become essential reading for all members, and may spawn other products, guides and checklists for wider use. Mechanisms for capturing and sharing are well established, including live and virtual events.</td>
</tr>
<tr>
<td>4</td>
<td>All members are clear about the purpose of the network and its role in convening, ameliorating, and advising or building community. Deliverables for the community are well known and plans to achieve them are underway. The network “starter” is accessible to all, and used to induct new members.</td>
<td>Network membership is well rounded, with actions in place to fill any gaps. Relationships with other networks are clear. They work to share and learn beyond the boundaries and with external stakeholders whenever appropriate. Governance is fully effective and is valued. Healthy membership turnover – few “passengers”.</td>
<td>A dedicated portal provides a gateway to well-managed information resources. The network has tangible products which go beyond FAQ to include, for example, top tips, examples, case studies, expertise, tools and templates. Examples of analyses and research knowledge are easily found, and members regularly provide new material.</td>
</tr>
<tr>
<td>3</td>
<td>The network has an agreed charter, clearly stating the purpose, scope, and ways of working. Most members have a good understanding of the purpose of the network and could articulate it to others. There is an agreed plan for developing the network for the next year.</td>
<td>Good coverage of potential membership and awareness of any gaps in representation. Sponsor is in place, understands what is required of them and is regularly active in the network. Governance has been considered and is in place at the appropriate level. Subgroups may evolve around specialist subjects.</td>
<td>The network has a credible leader/facilitator in place, with dedicated time available for the role. Other members of the network support the leader informally. The network responds positively when the leader requests participation in an event or response to a challenge/question.</td>
</tr>
<tr>
<td>2</td>
<td>Network scope is loosely defined. Ways of working are emerging. The community is still forming and establishing ground rules. More time is required to converge on a shared agenda for all members. Short-term plans for the network may exist, but are not widely shared.</td>
<td>Network has reasonable coverage but there are still notable absences. Governance is not really on the agenda. A named sponsor may exist, but their commitment is not really visible through action. No distinct roles and responsibilities in the network beyond the leader.</td>
<td>A leader or facilitator for the network has emerged or been appointed, but with little or no dedicated time. Responses to events and requests is mixed, usually coming from a small sub-set of the network. There is still a sense of untapped potential.</td>
</tr>
<tr>
<td>1</td>
<td>No sense of goals or plans – it’s all about the here-and-now. Focus not yet clear, exchanges often stray off-topic. Members learn about how the network works via osmosis and personal experience!</td>
<td>No real perception of gaps in networks, or effort to fill them. Leadership is ad-hoc and stagnating: some people are tooing the will to other actively participate or leave the network. Sponsorship and governance not present.</td>
<td>The network continues to bump along without clear leadership, operating on the best endeavours of a few. Participation a spare-time activity and responsiveness is somewhat hit and miss.</td>
</tr>
</tbody>
</table>

---

25 | Police Care Network
<table>
<thead>
<tr>
<th>Integrity and Vitality</th>
<th>Learning and Improvement</th>
<th>Impact and Value</th>
<th>Sustainability and Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td>High levels of trust and mutual respect enable passionate discussions. People are able to discuss their feelings. Conflict is handled professionally, openly and positively. People honour commitments to participate and deliver. Good range of contributions and unsolicited offers. Members regularly interact on a peer-to-peer basis as well as with the network as a whole. Where appropriate, interaction extends well beyond the boundaries (e.g. suppliers, partners, other networks).</td>
<td>The network regularly engages in formal and informal learning, (e.g. guest speakers, internal and external benchmarking, project reviews and visits) with strong participation. The network models reflective practice and seeks ways to improve its effectiveness through evaluation and feedback. Members openly share their learning from failures as well as successes.</td>
<td>The network is acknowledged by members and stakeholders alike for its impact. Members are proud of their accomplishments together, and tell stories of measurable impact and innovation. The network reviews the impact it is having in order to understand and repeat its successes. Specific external stakeholders and influencers are targeted with impact stories.</td>
<td>The network is not reliant on a specific individual to maintain momentum. Multiple channels (e.g. voice, data, email, webinar) are used innovatively. Dialogue is rich and varied, incorporating personal exchanges and business focus. There is an agreed strategy for growth, funding and recruitment of new members.</td>
</tr>
<tr>
<td>Leaders ensure regular, effective, animated virtual meetings and events. People make this a priority and participation levels are high. Contributions come from the full of members. Members know about each other’s expertise and experience. Diversity and cultural differences are well utilised. Leaders ensure that interactions stay focussed and forward thinking.</td>
<td>Network members regularly share their insights and lessons learned without the prompting of the facilitator. Members make full use of the network to ensure that their projects learn from others, e.g. via Peer Assists. Plagiarism (with accreditation) is seen as a positive - “steal with pride”. Curiosity levels are high: “Not invented here” is not observed here.</td>
<td>The network tracks, captures and shares success stories, with evidence of benefits and impact. These stories are celebrated and communicated to an external stakeholders and audiences. Stakeholders understand the impact the network is having, and actively promote this.</td>
<td>Newcomers rapidly feel welcome and involved and bring new energy to the group. Dialogue is stimulating and there is a sense of dynamism and interest. Fresh thinking is regularly brought into the network through external input. Sources of funding and support are understood.</td>
</tr>
<tr>
<td>The network makes use of voice, data-sharing and social media tools where possible. Contributions come from a wide range of members and people’s expertise is appreciated. Most questions receive response, but some go unanswered. Leaders sometimes work “behind the scenes” to find responses to unanswered questions.</td>
<td>The network leader encourages members to reflect and share lessons. Members demonstrate an interest in learning from their peers and are willing to ask for help.</td>
<td>The network members have a shared understanding of the value they add. Some senior stakeholders visibly acknowledge this. Examples exist which clearly demonstrate clear impact, for example, on patient outcomes.</td>
<td>Membership grows organically at expected levels. Funding and support are discussed. Members talk about the future of the network and are ambitious for growth.</td>
</tr>
<tr>
<td>Network leaders work hard to stimulate interaction between members, but responses usually come from the usual suspects whilst others remain silent. Occasional divisions and differences surface within the community, which can divert time and resources away from more valuable discussions.</td>
<td>Members “talk the talk” about learning and improving, but don’t always walk the walk. Learning is thought of in terms of personal development and training, rather than collective improvement. Lessons are sometimes shared, but rarely applied because of a sense of “oh, but we’re different”.</td>
<td>Some members can point to examples of value and impact, but nobody has the big picture. Some success stories may be captured, but in an ad-hoc manner. Senior stakeholders are aware of the impact, but lack passion to really promote this.</td>
<td>The network is visible, but membership is static. No plans to recruit new members or pursue additional sources of funding. Opportunities to merge with overlapping communities are not discussed. Dialogue is predictable and not varied.</td>
</tr>
<tr>
<td>Communities interact via e-mail only. Most members have never met face-to-face, and rarely interact verbally. Trust levels are low.</td>
<td>A few people use the community to voice their opinions or advance their own agenda, but there is little interest in learning from the experience of others. People don’t talk about failure or share the lessons. Whores are reinvented, mistakes repeated.</td>
<td>Impact is not really discussed. Members are comfortable just to “belong to the club”. Nobody takes responsibility for capturing and sharing successes or prompting the “Are we making a difference?” conversation.</td>
<td>The network is taking-over on the basis of goodwill but competition for members’ time leads to periods of drought. It’s all about survival rather than sustainability.</td>
</tr>
</tbody>
</table>
Summary of scoring rationale

1. Purpose and Direction - Rating = 2
   - In previous years this would have scored higher, in 2014 when the transition from Police Scotland to NHS was planned and implemented. Need now to focus on taking forward and a new purpose. Is there need for a review?
   - Accountability – who is the Board accountable to and who is accountable to the Board?
   - MoU is well articulated in general but is out of date and needs refreshed.

2. Governance & Structure - Rating = 3
   - Good at point of transfer but now time to refresh.
   - Need to look at role of IJBs and role of Regions
   - Good structure through regions but doesn’t take account of differences between regions and areas where NHS Boards work less regionally.
   - What structure is needed to support, a review is needed for workforce capacity.
   - The CMO Taskforce has raised awareness of this area of work but it is important to promote Custody Healthcare also.

3. Leadership & Facilitation - Rating = 3
   - There is credible facilitation with good willingness to be part of the process, time and effort.
   - Expectation that questions raised will be considered and positive engagement. Questions raised, is there is an environment of authorising processes.
   - Network needs to go to 14 HB’s CEO’s for approval and not 1 single person.
   - Is there the right level of people / leadership across the Network?
   - There is not enough efficient dedicated time to the Network.

4. Knowledge and Capture Review - Rating = 3
   - Variations depending on which part of the network you are in.
   - It would be a desirable but shouldn’t repeat what the FFLM do, it’s not necessary to reinvent the wheel for the sake of it.
   - It would be good to have a clinically useable portal.

5. Integrity & Vitality - Rating = 3
   - This was vital; there were common goals and high energy early on in the timeframe.
   - There is a difference between national and local provision.
   - The ability of the network to influence was questioned and debated around the table.
   - The Structure of the Network Board – Ops Board, Quality of the Ops Support group – they are at different levels.
   - Governance and Accountability – what is the role of the Network, can we lobby and advocate? Going forward, we should possibly strengthen this role of the network.

6. Impact and Value - Rating 2
   - Lack of senior stakeholders, lack of ministerial support.
   - What is the role of the IJB’s? - There seems to be a layer missing.
   - In previous years the grade given may have been as high as a 4 or high 3 but it is now less, a 2 is fair.
   - Recommendations on subjects such as substance misuse would be good.
   - Locations and responses to ambulance call outs to police custody can vary according to postcodes.
   - Relationship between Board and the CMO Taskforce – the Role of the Board is now difficult to understand, who is responsible for delivering success.
• The Big Picture may have changed in time. It may be an idea to look at what exactly the big Picture is going forward.
• How do we bring together the work the different Taskforce and groups do to share and implement?
• There are areas that overlap. We need a clear idea of relationships between the Board and the Taskforce.
• Feedback from table 5: On reflection of previous years it would have been a 3 or a 4.
• Different oversight and governance, what is the role and purpose moving forward?
• The network has had an impact but it is difficult to evidence that.
• Communicating more externally is important and to be improved.

6. Learning and Improvement - Rating = 3
• There have been times when other areas work has been plagiarised so learning has been stolen with pride!
• Continuous improvement teams’ presentation – do we need an end to end continuous improvement review? Identify resources was difficult, feeling that we never quite got there.
• Subgroups have produced good work.
• Important that issues brought to the table are shared with others.

8. Sustainability and Renewal - Rating = 4
• Members share outputs, bring up issues, dialogue has changed over time.
• Need to be more focused and be clear once an output has been completed
• Funding support also has not changed.

What are your top priorities going forward?
1. Purpose and direction
2. Governance and Structure
3. Learning and Improvement
4. Impact and Value
The Scottish Government should review the legal basis for the current agreement between Police Scotland, the Scottish Police Authority and NHS Scotland to deliver healthcare and forensic medical services. This review should inform the nature and need for any refreshed national Memorandum of Understanding between the parties.

Police Scotland should work with the partners responsible for delivering the Archway service in Glasgow and the West of Scotland and strengthen its current governance arrangements to ensure the service is adequately resourced and meets the needs of the communities it serves.

The Scottish Government should engage with relevant agencies and stakeholders and bring forward proposals for establishing dedicated healthcare facilities across Scotland to meet both the healthcare needs of victims of sexual crime and the necessary forensic requirements. This should be informed by research and current best practice.

The Scottish Government should consider formally issuing the newly proposed national standards for the delivery of forensic medical examination for victims of sexual violence to all NHS Boards. These standards should be supported by a framework of publicly reported quality indicators and monitored through an effective audit and inspection regime.

Police Scotland should work with NHS Boards to urgently identify appropriate healthcare facilities for the forensic medical examination of victims of sexual crime. The use of police premises for the examination of victims should be phased out in favour of healthcare facilities as soon as is practicable.

The Scottish Government should work with relevant stakeholders and professional bodies including NHS Scotland, Police Scotland and the Crown Office and Procurator Fiscal Service to develop the role of forensic nurses in Scotland.

The Scottish Government should work with relevant stakeholders and professional bodies, including NHS Scotland, Police Scotland and the Crown Office and Procurator Fiscal Service to develop self-referral services for the victims of sexual crime. This should clarify the legal position for obtaining and retaining forensic samples in the absence of a report to the police and support formal guidance for NHS Boards and Police Scotland.

The Scottish Government should work with NHS Scotland to ensure that the existing healthcare ICT system (ADASTRA) is being used consistently for collating information on the volume and nature of forensic medical examinations across Scotland. This will inform future policy and decision making, including resourcing.

Police Scotland should work with the Scottish Police Authority and NHS Scotland to introduce standard operating procedures for the forensic cleaning of police premises which continue to be used for medical examinations. These should comply with current guidance.

Police Scotland should work with NHS Scotland to ensure suspected perpetrators of sexual abuse who are under 16 years old are not forensically examined within police custody facilities. The Criminal Justice (Scotland) Act 2016 defines a child as being a person under the age of 18 and consideration should be given to how this affects the treatment of child suspects in the context of forensic medical examinations.
Forensic Referral Report
Collated NHS Board responses
April 2017 – March 2018 by month

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Engaged with Support</th>
<th>Gave feedback</th>
<th>Forensic exam undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>752</td>
<td>540</td>
<td>331</td>
<td>80</td>
</tr>
</tbody>
</table>

**April 2017**
- They did it step by step & let me know why they were doing stuff
- SOLO officer works nights and so do I - feel like options are that he'll ring me either before work, during it or after and none are ideal. Additional: the doctor who gave me medical examination was a man and he made it a much nicer/more bearable experience than it might have been. He was friendly and warm and talked to me, joked. He was lovely.
- I would have preferred a female Dr but I'd already been there for hours and I just wanted to get it done and get it over with. I just wanted to go home.
- This is scheduled for a later date as it's to gather evidence of internal damage rather than forensics due to historic nature of reporting. Caller is naturally very anxious about this but unsure how to make this less traumatic.
- Caller said she has not had any problems and felt the Police did what they can for her. She had a good experience with the police and they were out last night to fit an alarm in her house, as her perpetrator is out on bail but he has broken bail before, we discussed how this is all they can do, though she still doesn't feel 100% safe, she does feel more secure.

**May 2017**
- The examination was very discreet and it was wonderful to be able to have a shower afterwards.
- I would feel comfortable calling my solo with any questions, he has been great.
- Had a male examiner, would have wanted a woman to do it.
- It was Ok they all really tried to make it as easy as possible.

**June 2017**
- It was uncomfortable but the lady who did it was really nice.
- It was actually fine, I was nervous but I just wanted to get it over with.
- They did the medical in the police station and it was awkward because it was a man. He did try and be nice but it would have been easier if it was a woman.
- Caller described the forensic exam as ‘horribly invasive. Caller didn't enjoy being filmed.
- They were clear with her about what they found.
- I had my tests 11 hours after the incident.
- They were very respectful and did their best to put me at ease. I was glad to have a female doctor. I feel really worried about the possibility he may have passed on an infection.
- It was actually fine, I've had two kids so it didn't phase me too much.
July 2017

- The way they dealt with what was going to happen felt.
- Quite patronising and it was embarrassing to be told I could not go to the toilet and that when I did I had to give them a specimen and the toilet paper I used. I feel this could have been dealt with more sensitively.
- Doctor was a man. Explained by SOLO that most doctors who carry out examinations are men and understood/accepted this but still uncomfortable and would have rather had a woman.
- It was really scary, I freaked out when I realised it was a male doctor, and wouldn’t let him near me. I was greetin’. After that, a woman examined me, but he had to stand and watch.
- It was really unpleasant. I had to do it with a previous case as well. The person doing was lovely and reassuring, I don't think they could make it any better.
- It wasn't nice having a male doctor after what had just happened, it was quite frightening. However, he was really nice and talked me through everything he was doing.
- I refused a medical.

August 2018

- The workers put her at ease during a horrible process and arranged sexual health follow up for her.
- Quite a difficult experience but did not feel any changes could have been made.
- They made me feel comfortable. It helped to have a female doctor.
- It was a male doctor, not offered a woman and this was uncomfortable.
- Female Doctor and nurse. Explained the process step by step. Offered to stop at any points she was uncomfortable.
- It was overwhelming, I know it's their job, I think they kind of knew I felt a bit stunned.

September 2018

- I was allowed my friend in with me to hold my hand the whole time which really helped.
- Another survivor who wasn’t offered an exam feedback: I wasn’t offered one as I had consented to sex earlier that night.
- Found it very upsetting, saw a baby's mobile up on the ceiling and made her think of children and babies that might have been abused.
- It was alright, no don’t think anything could have been different.
- Another survivor who wasn’t offered a forensic examination feedback: She feels like she should have been offered a test to see if there were drugs in her system. Her and friend suggested they might have been drugged and the officers dismissed it as ‘you’ve had a bit to drink’. Worried that an opportunity to tell if they had been drugged was lost.
- They explained it all, they were nice.
- Explained after I arrived that the purpose was also for DNA/evidence purposes. (She thought it was just a general medical examination). ‘Nurse at XXXX was SO lovely. Making me laugh. She was brilliant.’ Police came in and double checked I knew what was going on, which was good. An A&E doctor told her she could go to Archway and just get seen.

October 2018

- Female doctor was great and the female officer stood by my head and held my hand.
- Was offered it but didn’t have one as the police said it was over a month ago.
- Wouldn't have to go XXXXX for it so was glad they found a local doctor.
- It was horrible, they took my clothing, I know they tried to make it as easy as possible
- Very intrusive but it was all explained to her. Her SOLO or friend held her hand throughout
They did a vaginal exam even through that the nurse especially was really supportive. Kept reassuring me and saying it will be over soon, encouraged me to breathe, told me every step of what was happening.
Survivor raised this as a concern but she said that they did not offer a forensic exam.
Survivor said - Doctor was nice, officers were kind, It was terrifying, she did know she had a choice but 'wanted to give all the evidence I could'
The doctor that did this was lovely.
Very happy with the police and the effort they have made. 5 stars out of 5.

November 2017
Suite could have been warmer- it was freezing cold and uncomfortable.
It was horrendous, so soon after the rape, and being examined by a male doctor.

December 2017
I was taken to XXXX for tests. It felt really intrusive but I knew it had to be done. The staff were really nice.
She did not feel comfortable going with the police.
I had asked for a female doctor but there was a male doctor. I just had to go with it.
I felt very uncomfortable with the male doctor. It's the only thing I can fault them on.
I had a female doctor and nurse. It wasn't pleasant, but they made it as easy as they could.
There was quite a long wait, which made me nervous, and I didn't like being examined by a male doctor.
I was offered a woman doctor. Mentioned that the person who carried it out felt clinical.
A trainee was present, survivor felt too intimidated to say she was not comfortable with this. Survivor had 3hrs at home after statement was taken before being taken for forensics - survivor was not told this would be the time she was picked up.
It was unpleasant, but they were really good.

January 2018
Felt they did well.
It was fine, a female doctor came from XXXXX to do it. The only thing that surprised me was that it was recorded.
Only on bits of skin/body that were shown so didn't have to remove any clothes (swabs etc). Woman who carried this out made it as comfortable as possible and had warm way of being.
It was fine, it's not the most comfortable thing but they were very comfortable to be around.

February 2018
Survivor didn't have a medical but she felt like they kept pushing her to have one. 'I felt pressured into having a medical exam. I also feel pressure to make a formal complaint and I don't feel ready. The Police turned up on Friday unexpectedly and this was the straw that broke me and I overdosed that night.'
They were absolutely lovely.

March 2018
Survivor was not offered a forensic exam despite being told the case was potentially rape? Her mum took her to GP and he swabbed her for DNA.
5.
Annex E – Quality Indicators

Transfers to Emergency Departments
Indicator GH2: % of episodes where people are transferred from police custody to Accident and Emergency by Scottish Ambulance Service as an emergency during their custody episode.

Indicator GH3: % of episodes where people are transferred from police custody to Accident and Emergency by Police Scotland during their custody episode for routine care. The rationale behind both of these indicators is to ensure appropriate use of resources and reduce inappropriate referrals.

The data below shows the number of transfers from police custody suites to Emergency Departments by the Scottish Ambulance Service between April 2009 and March 2016.

Figure A: Number of transfers from police custody suites to Emergency Departments by the Scottish Ambulance Service 2009/10 to 2015/16

Figure B: Transfers to Emergency Departments as a percentage of all police custody episodes 2009/10 - 2015/16
In 2015/16 there were 966 transfers to Emergency Departments. The majority are emergency transfers. Numbers have fallen slightly in the last 2 years. The percentage of ambulance transfers of all custody episodes is very small (<1%). In 2015/16 there was a slight fall from a previous upward trend.

**Drugs**

Indicator D9: *% of new patients at specialist drug treatment services who report funding their drug use through crime*. The rationale behind this indicator is that by individuals engaging in treatment they are less likely to have problem drug use and engage in criminal activity. The graph below has been developed using data from the Scottish Drug Misuse Database at Information Services Division which collects information on those entering specialist drug treatment services for the first time. One of the questions asked is whether they fund their drug use through crime. Completion rates for this question are around 75%.

![Graph showing percentage of new patients in specialist drug treatment services who report funding their drug use through crime by service base in Scotland, 2006-2015](image)

**Figure C: Percentage of new clients in specialist drug treatment services who report funding their drug use through crime by service base in Scotland, 2006-2015**

The graph shows percentages from both community and prison based services. Data is missing at Scotland level for 2012 and 2013 as some areas did not submit data. Generally there has been a downward trend within community based services. Percentages in prison based services are higher and have seen an upward trend in Prisons since 2013.
Indicator D10: **% of people who die of a drug related death who have been detained in police custody in the preceding 14 days**. The rationale behind this indicator is that there is potentially a decreased tolerance from drugs following incarceration which may increase the risk of a fatal overdose and also to help ensure that detention in police custody does not have a significantly detrimental impact on health and wellbeing.

![Graph showing the percentage of Drug Related Deaths (DRD) within 14 days of police custody release as a % of the total number of DRDs in Scotland](image)

Source: The National Drug-Related Deaths Database (Scotland) Report: Analysis of Deaths occurring in 2014, Information Services Division

Figure D: % of Drug Related Deaths (DRDs) within 14 days of police custody release as a % of the total number of DRDs in Scotland

The National Drug-Related Deaths Database includes the number of drug-related deaths following police custody contact. Where known, a quarter (26%, 128/489) had been in police custody in the six months prior to death. In 2014, 41 individuals were reported to have been in police custody in the four weeks prior to death and 71 in the twelve weeks prior to death. However, given the issues with missing data, these figures may underestimate the actual level of police custody contact.

The established evidence of increased overdose risk after release from prison custody or following hospital admission suggests it is vitally important that services, both drug-related and non-drug-related, work together to promote retention in treatment, continuity of care and awareness of overdose risk. If higher risk factors of drug use can be identified during service contact there is potential to reduce the number of drug-related deaths by undertaking targeted harm reduction measures (e.g. Take Home Naloxone (THN) distribution). Providing THN Kits to people in custody who are identified as at risk of opioid overdose is a key recommendation in the *Delivering Quality Alcohol, Drugs and Tobacco Healthcare Services to People in Police Custody in Scotland – Guidance for Police Scotland and Healthcare Professionals* (Police Care Network 2017).

---

2 Due to problems accessing police custody records in Glasgow, police custody contact data was missing for 15% (86) of the cohort.
## Annex F - Child and Adolescent Forensic Medical Examination Course

### Programme for the day

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.15-09.30</td>
<td>Registration &amp; Tea/Coffee</td>
<td>Dr Sarah Hill, Consultant Paediatrician, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>09.30-09.50</td>
<td>Welcome &amp; Overview</td>
<td>Dr Sarah Hill, Consultant Paediatrician, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>09.50-10.40</td>
<td>Pre-pubertal Female Genital Anatomy – normal variants and abnormal findings</td>
<td>Dr Sarah Hill, Consultant Paediatrician, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>10.40-11.30</td>
<td>Pre Pubertal Male Genital Anatomy - Anal Abuse and Genital Abuse of Boys</td>
<td>Dr Lila Agrawal, Consultant Paediatrician, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>11.30-11.45</td>
<td>Refreshments</td>
<td>Dr Amgaad Faltaous, Consultant Paediatrician and Forensic Physician</td>
</tr>
<tr>
<td>11.45-12.30</td>
<td>Non accidental injury</td>
<td>Dr Amgaad Faltaous, Consultant Paediatrician and Forensic Physician</td>
</tr>
<tr>
<td>12.30-13.15</td>
<td>Lunch</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td>13.15-13.35</td>
<td>Role of the FP in Paediatric Examinations</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td>13.35-14.15</td>
<td>Forensic Scientific Evidence &amp; Forensic Sampling</td>
<td>Carol Rogers, National Lead Forensic Scientist for sexual offences, Scottish Police Authority</td>
</tr>
<tr>
<td>14.15-14.45</td>
<td>Report Writing Essentials</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td>14.55-15.00</td>
<td>Refreshments</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td>15.00-15.50</td>
<td>Follow up and through care:</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td></td>
<td>• STIs &amp; Sexual Health</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td></td>
<td>• Approach to adolescents</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td></td>
<td>• Contraception &amp; pregnancy testing</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td></td>
<td>• Psychological Support: Children and Families and Staff</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
<tr>
<td>15:50-16:00</td>
<td>Summary and Close</td>
<td>Dr George Fernie, Clinical Advisor to the Police Care Network &amp; Forensic Physician, NHS Lothian</td>
</tr>
</tbody>
</table>