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Forensic and prison doctors conference
Conference report

Monday 17th July 2023
BMA House, London

'Promoting Safeguards for Persons Deprived of their Liberty in the UK and across Europe'
Dr Alan Mitchell, president of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT)

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has 45 members, one is elected from each member state of the Council of Europe. The committee is independent, apolitical and governed by the European Convention on the prevention of torture. The CPT visits prisons and is given unlimited access to staff and documentation and carries out private interviews with detainees and staff. The committee complements judicial mechanisms to prevent deliberate or accidental ill treatment and undertakes periodic visits and ad hoc across member states. The visits can last from a few days to a fortnight. A visit comprises a 50:50 ratio of lawyers and doctors who can't visit their home country. After a visit, the CPT sends a report to the government which includes recommendations, comments and requests for information. The government then sends a response to the CPT. As for police custody, the CPT looks at the correct material conditions (i.e. cell size, equipment etc) and the length of detention which should be a matter of hours, not days, weeks or months. The CPT has three safeguards: notification of custody, access to a lawyer and access to a doctor. The last periodic visit to the UK took place in 2021. There were many positive elements in the report and some recommendations for police stations. The CPT also raised concerns about men in prison in the UK such as the waiting time to see a dentist, confidentiality in administering medicine and the detail in escorting prisons to psychiatric hospitals. The problems for women in prisons was more serious. It was noted a number of women with severe mental health disorders who could not be provided with adequate care in prison was "profoundly worrying" and recommended a "rapid urgent pathway to a mental health care facility for prisoners with acute mental disorders be created". It also recommended psychiatric inpatient units should improve access to outdoor exercise, give patients greater involvement in their treatment plans and increase psycho social treatment.

Giving effective evidence, and courtroom skills
District Judge Quentin Purdy (Ret'd)

A judge for 15 years and called to the Bar 40 years ago, Judge Purdy noted he had seen a staggering number of very ineffective experts lacking in courtroom skills give evidence. All sorts of people could be experts, some were ordinary witness of fact, some were present to give both fact and opinion. An expert can express an opinion in their area of expertise. He advised before attending court, you need to prepare a report. Your report is your evidence. It might be the totality of your involvement so that you don't need to go to Court. You need to be happy with it and ensure it conveys everything. Your medical terminology needs to be understandable for the lay person. Bear in mind the range of courts and that for the last 10 years. Coroner's courts were run by coroners and the coroner was looking to

the doctor to share their expertise. Criminal courts involved a judge and a jury. The judge will have seen your report but the jury might not understand it. Magistrates' courts could be very difficult and it wasn't always possible to know who the magistrate was. Also, judges have a lot to get through so that may appear to put pressure on you to get through your talk. There are formal procedures to follow e.g. the police provide you with information you must comply with. Judge Purdy gave several tips including explaining medical technology and staying within your field of expertise otherwise you may lose your credibility, people will notice and you won't and not get the credit deserved. Also, avoid the overenthusiastic solicitors' instructions, as you could end up expressing an opinion which is not your own and the opposition will unpick it. If you don't understand something, say so. Do not arrive late looking dishevelled and as if you are trying to pull it together. Your presence may permeate so dress for the occasion. Establish good contact with whoever you are going to meet. Arrange your papers in a suitable fashion and ensure you know your voice can be heard, not all microphones work, especially in old buildings. People give up on inaudible voices and don't speak too quickly or slowly; your pitch must be right and don't let it drop. All this creates a presence so that you can convey you know what you are doing. At the conclusion of evidence, ask yourself if there is anything more you wish to get across. Finally, be yourself!

Delivering secure care in Northern Ireland

Dr Richard Kirk

Dr Kirk noted he had been a prison GP for ten years and was also familiar with community practices. Most people's first image of Northern Ireland was the troubles but in recent years, the conflict had fallen away from the headlines. However, the troubles needed to be taken account when discussing services. Dr Kirk felt calling the civil war the troubles minimised the harm and damage. 4,000 people had lost their lives during the conflict and it hindered democracy to this day. In general, the bombing and shelling had ceased. However, violence still occurred and the shadow of an 'unwelcome guest' could still be felt. The threat of terrorism was always present and when it was raised to 'severe' the police and prison service were under a specific threat and other prison staff by association. This had an impact on doctor recruitment. At the front door of all Northern Ireland's prisons was an armoury and some prison staff kept weaponry at home. Some prison service colleagues had been killed. A lot of prisoners suffered from generational trauma e.g. they had lost a father or grandfather etc. Over 22,000 adults suffered from mental illness as a result of the conflict. Whilst the prisoner numbers were not as high as the average global population i.e. 77 per 100,000 as opposed to 144 per 100,000, the number was rapidly increasing but there weren't more healthcare workers. Also, since 2022, Northern Ireland had no functioning government and so doctors hadn't been offered the 6% salary increase but there were more prison officers. In 2012 staff transferred to DoH from DoJ. A lot of progress had been made since then e.g. multi-disciplinary teams had been introduced and bespoke healthcare which involved patient engagement and peer mentoring teams had been set up. Dr Kirk ended his presentation by noting he felt people's lives could be changed and he recommended working for the prison service. He added the 10th RCGP, RCN & RCPsych Health and justice summit, entitled 'Building bridges in health and justice' was taking place 9 - 10 October 2023 in Belfast which would be a good opportunity to discuss the above issues.

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Delivering effective healthcare in custody and workforce implications
Ms Abi Bartlett, Head of Nursing and Allied Health Professionals, Hanham Secure Health Ltd.

Ms Bartlett discussed delivering effective healthcare in custody and workforce implications for long term conditions (LTC) management starting with the implications on the healthcare system. Core20PLUS5 NHS England is an approach which aims to reduce healthcare inequalities. It is designed to support Integrated care systems to drive targeted action in healthcare inequalities management. The patient demographics in secure and detained settings include those who have experienced substance misuse and severe mental illness for example. This has an impact healthcare provision in relation to LTCs compared to the general population; people aged under the age of 75 in contact with mental health services in the UK have death rates that are two times higher for cancer and five times higher for liver disease for example. Multidisciplinary team working in secure and detained settings can offer a holistic approach. In detention, the impact of the environment and situation on the person can include limited space to exercise, high carbohydrate diet, medication, lack of personal/private space. Care provided in secure and detained settings should be large in, scope be varied, specialist and generalist as well as multidisciplinary and multi-agency. Ms Bartlett asked whether we are delivering a truly integrated healthcare service when it comes to the custodial setting? Are the regional secure and detained settings linked into the wider system? She concluded her presentation by discussing the Implications of managing LTCs on the workforce i.e. valuing the workforce and structuring the approach to managing LTCs. Training staff to develop expertise in LTC increases knowledge within the team and improves retention opportunities for progression. Having a system that supports care delivery saves time and releases time to care.

Key learning from doctors behaviours with regards to deaths in custody
Ms Katie Sutherland LLB, HM Acting Coroner for North Wales

Ms Sutherland noted the Coroners and Justice Act 2009 outlined the duty to investigate certain deaths if a coroner has reasons to suspect the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or in state detention. In 2022, there were 301 deaths in total in prison custody, 74 of which were self-inflicted. 69 occurred in the male estate and 5 occurred in the female estate. Where someone has died whilst in custody or state detention there must be an inquest even where there is a natural cause of death. Unnatural causes of death Inquests must be held with a jury. Inquests, properly conducted and where the conclusions are heeded, hold organisations and individuals to account publicly and they identify and record the facts. Inquests are fact finding and establish who has died, where, when, why and how. Schedule five of the Coroners and Justice Act 2009 states a senior coroner may require a person to attend and give evidence or produce any documents which relate to a matter that is relevant to an inquest. This has consequences e.g. it is an offence for a person to do anything that is intended to have the effect of distorting or otherwise altering any evidence, document or other thing that is given, produced or provided for the purposes of an investigation, or intentionally to suppress or conceal a document that is, and that the person knows or believes to be, a relevant document. Ms Sutherland noted the jury would consider healthcare involvement e.g. did healthcare and mental health staff take sufficient steps to identify and record a detainee's risk of suicide and/or self harm? Did they put in place sufficient measures to try to reduce the risk of suicide and/or self-harm or share sufficient information about the detainees' risk of suicide and/or self-harm with prison staff, so as to enable

prison staff to make appropriate decisions themselves about reducing the risk? Ms Sutherland also advised when providing evidence to the coroner, you are assisting the coroner in determining who it is that has died, when, where and how. She noted some dos and don'ts, what should be covered in the statement and gave some tips as to how to give some reasons behind deaths in custody.

The state of forensic pathology in the UK
Chair of the College Forensic Pathology SAC, Dr Nigel Cooper

Dr Cooper opened his talk by noting when he had become a forensic pathologist in the '80s, forensic pathology (FP) tended to be an academic subject. There was a lot of undergraduate teaching and training was relatively informal. In England and Wales during the '90s the relevance of FP in undergraduate curriculum was reduced. New consultant contracts were introduced. There was also a series of scandals which all resulted in lower numbers of forensic pathologists. However, FP was not low profile due to the media and the government although their reports were often ignored. The 1989 Wasserman Report gave the Home Office (HO) responsibility for FP; they created the first HO Register and introduced quality control and procedures. Then, in the 2000s there was a cull of pathologists, 10% of them were removed. The government went further after the 2023 Leishman Review which recommended FPs should be employed by the Forensic Science Service and that forensic pathologists should work from group practices, be paid a national fee and undergo an annual audit.

In the UK, forensic pathology currently involved minimal research and teaching, had a low international profile and formalised and funded training. Most forensic pathologists were self-employed and charge a fixed case fee. Trainees were part funded by the Home Office (HO) but it was hard to recruit trainees in the areas where training was provided. Medico legal death investigation had lost its edge and medico legal examinations in differed in areas. In Scotland one office oversaw all of them, whereas in England, Wales and Northern Ireland the work was undertaken by coroners. In England and Wales, coroners were employed by local authority and were "supervised" by the Chief Coroner at the Ministry of Justice. They were an independent legal authority and did not have budget as such. Most medico legal death investigations were done by private arrangement by hospital pathologists. There were a small number of pathologists within salaried posts but no KPIs nor audits and the Ministry of Justice didn't take responsibility for them. Pressures to the system included a shortage of autopsy pathologists, changes in training, poor remuneration and organ and tissue retention. The 2015 Hutton Review reported death Investigation should be regionalised, held on largely on NHS premises and led by FPs who should all be employed by the NHS. Most coroners report the coroner post-mortem examination service could be improved by proper pay, more scanning and centralisation. A report of the Justice Committee of the House of Commons 2021 noted the shortage of pathologists (there are currently 580 vacant consultant posts), and also stated nobody was responsible for service provision. It also noted the standard fee was very small and needed increasing, the lack of PMCT was unfair to many and suggested pathologists should be salaried and work from regional centres. A contract came into force 6th September 2021. It Involved 50% of the tender, fixed fees, the introduction of a post-mortem computed tomography (PMCT) service and KPIs. The service must comply with regulations and show good value. The lesson that have been learnt include the importance of teamwork, PMEs were expensive, there would ideally

each mortuary would have a scanner, trainees should be enthused, productivity mustn't be overestimated. Finally, if you provide a good service, coroners will use it and others will copy it.

Closing remarks

The Forensic and secure environment committee chair, Dr Marcus Bicknell thanked attendees (both online and in-person), the speakers and staff members for the day. He then officially closed the conference.