# THE POLICE AND THE EMERGENCY DEPARTMENT

## Police right of entry to ED

Under PACE 1984 the police have a legal right to enter an Emergency Department in certain circumstances without a search warrant in order to prevent crime and/ or make an arrest:

- To arrest someone for an arrestable offence or for whom there is a warrant for arrest if the police officer has reasonable grounds to believe the person is there;
- To recapture someone who has escaped from the police, court, prison or compulsory psychiatric admission;
- To save life or limb or prevent serious damage to property;
- To deal with or prevent a breach of the peace

There are some miscellaneous statutory powers of entry other than to make an arrest eg under The Misuse of Drugs Act 1971 which enables a constable to enter the premises of a producer or supplier of controlled drugs and inspect the relevant books and stock. This obviously applies to an Emergency Department.

Right of entry does NOT include access to notes or computer data.

Right of entry does NOT mean that police can enter and remain in the resuscitation room when a patient is being treated for an acute life-threatening event. They can be asked to remain outside the room if confidentiality issues prevail.

A prisoner or person in custody has the same right to confidentiality as any other patient. Police must therefore be asked to step outside the patient's cubicle unless the patient is asked and states he is happy for the police to remain during the clinical consultation.

A constable can detain and search an individual in an Emergency Department if he has reasonable grounds to suspect the individual has prohibited things on his person namely stolen goods, offensive weapons, items for use in stealing, controlled drugs and firearms.

Police can be asked to leave an Emergency Department. The Emergency Department is on land belonging to the Trust Board who have the right of exclusive possession. The person in charge of the department at the time is the agent of the hospital. Through him/ her the hospital can exclude anyone and once told to leave they become a trespasser unless they have a specific legal power of entry. This applies to the police and/ or anyone else.

It is an offence to obstruct a constable in the execution of his duty. This can include disposal of evidence or warning or assisting a suspect to escape. Ensure that any disagreement with the police is witnessed and contemporaneous notes made.

Other rights of entry exist with a search warrant or by order of a circuit judge. Medical records are classed as "excluded material" and cannot be accessed by a search warrant. Only a circuit judge may make an order for the production of such material and only in very limited circumstances.

**Duty to notify police**

A suspected terrorist MUST be immediately reported to the police. It is an offence to fail to report ANY information that may lead to the apprehension of a terrorist or prevention of terrorism.

The GMC, CEM and ACPO have agreed that the police must be informed when a patient seeks treatment for a gunshot or knife wound (unless the knife or blade injury is accidental or a result of self harm). The patient's identity need not be disclosed. The patient's consent to disclose their name and other information must be sought where possible. If the patient refuses to allow their identity to be disclosed, or consent cannot be sought, information may be disclosed only where you judge that disclosure would prevent others from suffering serious harm, or would help prevent, detect or prosecute a serious crime. This particularly covers all cases of murder and attempted murder. However, since all ambulance calls to "violent scenes" necessitate CAC to notify the police, all such incidences will already be police cases prior to presentation at the Emergency Department. Technically, this advice covers air rifle wounds although this is acknowledged to be a "grey area".

The GMC advises that cases arise where disclosure in the public interest may be necessary such as when someone may otherwise be exposed to death or serious harm. This gives ethical permission to a doctor who **believes** an issue to be in the public interest to reveal details without consent. It does not put the doctor under a legal duty to do so. The doctor concerned can then divulge information and identities to the police during or post attendance at the Emergency Department. It is advisable that a junior doctor first contacts the Consultant on call to clarify and agree with the decision to divulge and to document such discussion in the clinical notes. This covers the scenario where an Emergency Department patient is suffering a condition which may impair his driving, such as an individual who is going to commit the criminal offence of driving while under the influence of alcohol: the doctor's civic duty overrides the professional duty of confidentiality since the patient's actions constitute a "serious public danger". Other conditions that could potentially come under such a heading, depending on the clinical scenario, include eye injuries or treatments affecting vision, drugs affecting concentration, epilepsy, cardiac arrhythmias, plaster splints or poor blood sugar control. The patient should be warned not to drive and the warning documented in the notes. See ED webpage on "Fitness to drive criteria".

**Police requests for information**

All clinical information is confidential and without consent may not be disclosed except in **certain defined circumstances** (see below). The police do NOT have access to clinical records. Without a patient's consent they may not be told any medical details, nor of any of his injuries, nor the time of his arrival or discharge nor even if the patient has attended at all. All ED

attendance registers and computer screens are therefore confidential and must not be shown to the police. It is the responsibility of the ED's senior medical staff to ensure this does not occur.

It is, however, a criminal offence to fail to disclose when asked information which may lead to the identification of a driver who is alleged to be guilty of a motoring offence under the Road Traffic Act 1988. Clinical details must not be disclosed, only the patient's name and address etc that allows his/ her identification.

Where a serious criminal offence has occurred police may ask for the names of all Emergency Department attendees as part of their investigation. "Fishing expeditions" are not allowed. An officer of Inspector or above must write to the Consultant on call itemising events, justifying his rationale for seeking information and detailing the information required. Details will have to narrow the search eg time of event, age or nationality of assailant, distinguishing features or injury etc. Once in receipt of the letter the Consultant on call can authorise release of personal information relating to identity but not clinical details. The Emergency Department does have a duty to comply with the police to help trace the offender.

**Blood, breath and urine samples**

Under PACE 1984 blood, semen, urine, pubic hair and body swabs (other than the mouth) count as an "intimate body sample". There is no legal obligation on Medical staff to assist police by taking intimate body samples from a patient. Medical staff SHOULD DECLINE police requests to take intimate body samples from patients. If the patient consents to the taking of blood samples a police surgeon should carry this out. There is no objection to Emergency Department staff making available routine items of medical equipment, eg needles and syringes, to enable the police surgeon taking the sample. If the patient is under 14 years the parent or guardian must consent. If the patient is between 14-17 years then both the patient's and his/ her parent or guardian's consent is required. Where samples are taken, these must be paired samples with one being taken by the police and the other being given to the patient.

The police officer wishing to breathalyse a patient or the police surgeon responsible for obtaining the required body samples MUST seek the consent of the Emergency Department doctor caring for the patient prior to taking the sample. The doctor can consent to the sampling PROVIDED the patient is clinically safe and is well enough to give informed consent. This means that any patient with a head injury must have a GCS of 15 and no confusion or severe head injury symptoms. This should be documented in the patient's clinical notes. Patients CAN still give consent if drunk. If the doctor refuses police access to blood or breathalyser sampling because of the patient's inability to consent then care must be taken to preserve patient confidentiality by not revealing the clinical reasons behind the decision – just state the patient is "unfit".

The Police Reform Act 2002 has made an exception in the case of a patient who has been involved in a **road traffic accident** who is incapable of consenting (eg because of unconsciousness). A police constable may request a medical practitioner to take a specimen of blood but:

- The medical practitioner must NOT have any responsibility for the clinical care of the patient;
- If the medical practitioner is willing to take a sample of blood without the patient's consent it will not count as assault and shall be lawful for him to do so;
- The medical practitioner not involved in the patient's care can be asked BUT cannot be compelled or required to take blood samples and can choose not to do so where this would be contrary to his ethical beliefs;
- The sample of blood taken cannot be tested unless the patient (once he has recovered sufficiently to regain capacity) consents to it being tested. The blood cannot be tested prior to consent being obtained;
- The police constable MUST first consult the medical practitioner in charge of the patient's care and this doctor can object if the requirement, the obtaining of the sample or the warning of the consequences would be prejudicial to the proper care and treatment of the patient. Thus the doctor in charge of the patient's treatment retains the right to object so as to safeguard the patient's proper care and treatment.
- **A police surgeon remains the preferred option for all such blood samples.**

All blood samples taken in the Emergency Department must be taken for the purposes of direct clinical care only. No blood alcohol levels or toxicology must be requested unless it is clinically indicated. Police requests for such tests must be declined. Any doctor can be asked in a court of law to justify why they took blood, requested tests and how they added to their patient's management. Police can be informed that pre-transfusion blood samples have been sent to which laboratories (eg haematology or biochemistry) but not what tests have been requested. Document this in the notes PLUS whether the patient has received morphine or diamorphine prior to obtaining blood. This is because blood transfusions can complicate blood DNA analysis and the police need to be able to retrospectively legally apply (via a circuit judge) for access to the bloods for forensic purposes. Diagnostic specimens cannot be used by the police without patient consent or a court order.

**Drug issues**

The Misuse of Drugs Act 1971 makes it an offence to possess, supply or possess with intent to supply any controlled drugs. ED staff should therefore think carefully before removing a drug package from a conscious patient whom the police are not pursuing when the drugs are clearly for the patient's own use. The law does not require it. Do not touch the drug. Having taken possession of a drug from a conscious or unconscious patient, other than one lawfully prescribed, it must be destroyed or given to a police officer. Therefore Emergency Department staff must never give illicit drugs removed from a conscious or unconscious patient to a an accompanying friend or relative nor return them to the patient. Returning someone's own drugs to

him/ her amounts in law to the crime of supplying. The patient should be given the option of drug destruction in the ED or anonymous surrender to the police (R v Maginnis 1987). Any drug destruction should be witnessed and documented in the notes or the drugs handed to the on-call pharmacist for destruction and documented. Remember that if ED staff are aware that the police are in pursuit of the patient for drugs offences then destruction of the drugs can amount to destruction of evidence and obstruction of the police in the execution of their duty or an act tending and intended to pervert the course of public justice. An issue can arise where the quantity and type of drug found indicates that the drugs are not solely for the patient's own use. If the patient is a "dealer" then the individual is committing a serious arrestable offence and potentially endangering lives. In this situation ED staff have a duty to inform the police since the GMC acknowledge that such a breach in confidence is for the public good provided no clinical details about the patient's attendance are divulged. Thus the police can be informed of the individual's identity, his presence in the department but not the medical reasons why and the drugs can be given to the police.

**Police and the mentally ill patient**

Section 136 of the Mental Health Act 1983 allows the police to arrest a mentally disordered person in a public place and take them to a place of safety, such as a police cell, for psychiatric assessment. The Emergency Department is NOT a designated place of safety and ED staff should NOT accept custody or care of such a patient. The section is NOT a licence to transfer the patient from police cells to the ED. If the police do bring in a patient under S136 MHA then the police MUST stay with the patient until the patient has been fully assessed by a psychiatrist and a diagnosis and management decision reached. S136 does not allow treatment of the patient. When a life-threatening condition is present the doctrine of necessity applies and the patient can receive the treatment required, in the absence of consent, to preserve life and stabilise their condition.

**Rape victims**

Ensure no danger to life but do not get involved. Persuade the patient to allow police involvement. Police have special examination and assessment centres specifically designed for rape victims. Do not allow the patient to undress or wash and do not examine the patient (unless clinically indicated) since this risks destroying or contaminating vital forensic evidence. All examinations are to be performed by police surgeons.

**Forensics**

**Continuity of evidence issues:** the body belongs to the Coroner and police must stay with the body until it goes to the mortuary. They do not have to be in the resuscitation room while treatment is ongoing prior to death. Provided there is documented continuity of care between successive medical practitioners and accurate notes that illustrate such continuity has occurred then no evidential problems will occur. It is the doctor's decision whether police can be present during treatment – and also the patient's if they are able to express an opinion since duty of patient confidentiality still prevails. Police do need to be in proximity to stop cross contamination of evidence and

prevent other individuals (eg relatives, friends) coming in and removing or interfering with evidence. Treatment takes precedence over evidence.

**Clothing:** do not cut through defects in clothing eg the stab wound tears or openings. Cut up seams where possible. This allows maximal "trace and biological analysis".

**Clothing and discharged patients:** it is for the police to arrange for removal of clothing with the patient, not the EDs duty

**Babies:** keep all clothing, shawls and nappies. Bag individually.

**Fire victims:** clothing needs to be placed in special nylon bags provided by police (if available) to stop evaporation of chemicals (eg volatile accelerants). This helps forensics differentiate between arson or accident, victim or perpetrator.

**Offender and victim are in the ED at the same time:** staff must take great care over documentation and make very effort to avoid cross contamination. Use gloves and chaperones. Change gloves between patients.

**Exhibits:** evidence must display continuity and integrity and therefore bagging of all evidence is vital to ensure that sample contamination does not occur and forensic capabilities are maximised. If items of clothing are passed to the police then the nurse/ doctor should document the name and number of the constable in the patient's notes so that the clinical record proves continuity. All police exhibit labels need to be signed.

**Body movements:** the time the body is moved to the mortuary must be documented.

**Bagging:** this allows exhibits to be kept "sterile" from cross contamination and is vital. If a victim can undress then need clean paper on the floor (eg from dressing pack) to catch debris for forensics (eg hairs etc). This paper should also be bagged. Consider bagging each item of clothing individually if able. Doctors gloves should also be individually bagged and handed over.

**Doctor's DNA:** doctors can be asked to provide DNA samples to remove confusion in cases of cross contamination BUT the samples are/ must be later destroyed. There is no database for DNA of non-convicted individuals.

**Firearm injuries:** debris from the wound (wadding and casings) is required for forensics in order to allow identification of the gun used. Wound edges that are burnt and sooty from point blank injury can be swabbed for dust if time and circumstances allow. Retain all projectiles removed from wounds but use plastic forceps to handle if possible – metal forceps cause imprinting that creates confusing "false" evidence. Treatment takes precedence over evidence.

**Gloves:** fingerprints can go through gloves and cause DNA contamination.

**Murder victims:** do not undress if dead. Can undress as part of trauma team management. Leave all medical appliances used (eg venflons, ETT etc) in situ.

**Medical appliances/ items:** do not remove form deceased patients. If are removed or fall out (eg venflon) then put a dressing over the area and write on it what was in the wound. Forensics and Pathologists do not want to mistake a chest drain wound for a stab wound. Notes should clearly document all invasive procedures and the trauma charts should accurately record sites of placement.

**Photographs:** these can only be taken for clinical reasons and purposes not forensic purposes. Polaroids and photos taken in the ED are not admissible as evidence. If the existence of a photo is declared in the doctor's statement and the criminal case is sufficiently serious then the SCO can retrospectively apply to take a copy of the photograph. It is therefore advisable to inform the police of the existence of such photographs. The photographs form part of the medical records and must stay with the patient's notes. If the patient cannot or will not agree to release of the notes and/ or photograph a court can subpoena the notes to enable police and forensic access to copy them. Technically photographs still need written patient (or next of kin) consent to be taken **except** where ED photos are part of clinical care eg it is known that photos of compound fractures reduce the infection rate from 50% to 40%. Thus such images without consent are justified. The photographs cannot then be use for other purposes (eg examinations, teaching) without consent being sought. However if the photograph only adds to the documentation then consent is still required

**Rectal temperature probes:** use of these can affect biological swabs and risk inducing anorectal injury. Therefore record if done and whether probe or thermometer used. Treatment overrides evidence.

## THE POLICE AND THE EMERGENCY DEPARTMENT: ANSWERS

1. The fact that he is drunk does not invalidate his consent – still able to consent. However, has a head injury with a GCS 14/15 and cannot therefore give informed consent. On clinical grounds, as patient's physician, you must refuse the breathalyser test. As acting clinician you cannot take the blood samples – these are intimate body samples under PACE. Best advice is to request a police surgeon to be called. You do have the option of allowing a medical colleague not involved with patient's care to take the 2 samples if you agree and it does not impinge on patient's clinical care. 1 sample for police and one to be given to the patient. Police will then have to seek retrospective consent from the patient once he is well enough to give it.

2. The patient must be informed that he is not safe to drive – which requires a driver to have 2 hands on the wheel to be in full control. Inform your patient his insurance may well be invalid and that it is a criminal offence to knowingly drive without insurance. Document in the notes. Outside of documentation insurance issues are beyond the scope of ED doctors. No civic duty to inform police but try and persuade patient to see sense. Not sufficiently serious to justify a breach of confidentiality. However, if alcohol involved the legal responsibility changes. Again try and persuade patient to stay, take taxi, be collected etc and document efforts. If you fail and the patient is clearly going to drive then civic duty comes into play and overrides professional duty of confidentiality since constitutes a "serious public danger". Drink driving is a criminal offence and there is a serious risk of harm to others so immediately inform the police. Do not reveal clinical reason for attendance at ED only that drunk and intending/ trying to drive.

3. A drug packer is committing a criminal offence and whose actions will go on to damage the health of others. Cannot give guarantee since could result in obstructing a constable in the execution of their duty. If the police indicate their suspicion that he has drugs on him and are pursuing the patient then cannot pervert the course of justice. If police are not in pursuit there is no requirement to report a crime. Request patient to come in for the sake of his health and safety and warn him that failure to do so could result in his death. Once the drugs appear you must remove them from him and cannot give them back to him or you commit the offence of supplying under the Misuse of Drugs Act. You must either destroy the drugs (single packet for own use scenario) or hand them to the police (which can be done anonymously). Technically the drugs are the property of the patient and cannot be destroyed without their permission however the average drug user faced with the choice of destruction or handing drugs to the police will allow destruction. Colleague witness vital and both document in notes. Since serious criminal offence occurring need to consider informing the police – discuss with Consultant on call and document. Remember that destroying drugs in certain scenarios amounts to obstruction of the police.

4. You seriously suspect NAI but have no right or ability to physically detain father and child against his will. Clearly child is at risk and you have a legal duty to act in the best interests of the child so delay father's escape by cajoling, negotiation and all lying soothing tactics possible while police are called via 999 (usually by nurse in charge). Police can then take child into police protection using their powers under the Children Act 1989 and ensure child remains in hospital for treatment and CP examination. If the child has

left call social services immediately, report concerns and that child at risk – liase with them to ensure that SS and police go to the address given to remove child. If have car registration, give it to SS and police. Confidentiality issues not exist.

5. Advise the Inspector that you are sympathetic but cannot give him the information he requires. Do not allow access to computer or data systems. Give him the name of the Consultant on call for the night and the name of the Clinical Director and ask him to write a letter itemising events, the nature of the request and the information required. "Fishing expeditions" are not allowed and he will hive to give details to narrow the search, eg time of event, age of assailant, distinguishing features, which hand if possible etc. Once ED has the letter and can narrow the search the Consultants will reveal appropriate personal information (but not clinical information) on those individuals that attended with hand injuries since a serious offence has occurred and department has a duty to comply with the police in tracing offender.

6. Duty to inform police - immediate police notification of the patient's presence in the department, but not their identity, is mandatory. Plus if patient requiring an urgent laparotomy for major life threatening haemorrhage then a serious arrestable criminal offence has occurred and in practice you should inform the police since this may be a murder/ attempted murder case (minor knife wounds do not constitute such an issue and do not need reporting). This comes under the heading of "common good" since not only has one offence been committed but another is being threatened to follow via his "friends". Ask patient to allow his name to be disclosed – if he refuses then document that you have informed him you may have to reveal it in order to help detect and prevent a crime. You do not reveal clinical details but can indicate severity of injury (mild, moderate, severe, life threatening/ critical).

7. Statutory duty to disclose patient's identity, ie name and address, under the Road Traffic Act. Disclosure should include the nature of the injury without revealing full clinical details eg "mild, moderate, severe or critical". The degree of injury is important for scene of crime implications re: forensics.

8. Refuse – you are only allowed to take samples from patient if the patient consents OR the patient is an RTA victim in which case a doctor who is not treating the patient can take the sample if you, the patient's clinician, agree. Under PACE 1984 blood is an intimate body sample and should therefore be taken by a police surgeon. There is no legal obligation to assist police and it is advisable to decline the request. You can make departmental equipment for blood samples available to the police surgeon. However you can let the police constable know that blood specimens were taken and sent to the labs pre-transfusion/ morphine etc. Police can then formally retrospectively apply for access to these stored samples for forensic purposes if so required.