Dr Gethin Rees
PROJECT REPORT ON POLICE CUSTODY NURSING

Matt Peel
REFLECTION ON COMPLETING UKAFN’S ASET AWARD

Independent Custody Visitor
SPENDING TIME WITH A CUSTODY NURSE
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The Helix | The Official Newsletter of UKAFN

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Welcome to our Spring edition of UKAFN’s newsletter. We are very proud to bring you a new modern look to our newsletter which we have called ‘The Helix 🧬’. I can’t thank Matt enough for the hard work he has put into this new look. So as always, the year is pressing on so quickly, we have light nights again and people are slowly coming out of their hibernation. Hopefully, we will get a repeat of last year’s summers weather (here’s hoping).

So what’s new with UKAFN…..

Conference 2019

I’m hoping you have all seen the conference information for this year. I know many of you have because we have sold three-quarters of the tickets already and we have 6 months to go. We will review numbers if we do sell out, which will be a first in our Conference history and a real achievement. Spaces will be dependent on the venue and might be beyond our control. So avoid disappointment and get your ticket today.

www.ukafnconf19.eventbrite.co.uk

This year’s title is ‘From party scene to Crime Scene’ and we have some international speakers as well as national ones. It will be an excellent conference and personally my favourite day in the UKAFN calendar, so I look forward to seeing you there.

Blue book update

The ‘Substance Misuse Detainees in Police Custody Guidelines for Clinical Management’ or Blue Book, is badged by the Royal College of Psychiatrists, and so while the work is done on the latest edition we are still waiting for the final sign off and
publication. Unfortunately, the cogs are turning slowly on this one, and I do not have any update for you, but we will advise once we hear anything different about this publication.

**ASET and Apprenticeship levy**

The UKAFN Advanced Standards in Education and Training (ASET) award is hoping to achieve apprentice status and be approved for the Apprenticeship Levy. To remind you of what this means. In April 2017 all companies with a wages bill over a certain threshold had to start paying a percentage into a pot. Those monies can only be claimed back by organisations for training and education for their staff. However, all courses must go through a process of approval and be awarded apprentice status in order to be paid for. This approval process is undertaken through a group representing the individual industry called a Trailblazer Group. Ours is called the Health and Justice Trailblazer Group. These rules apply to all industries, not just healthcare.

The work behind the scenes is hopefully drawing to its conclusion and we should have an outcome over the summer. This will mean your employer will be able to fund your completion of this valuable educational programme. Undertaking this course of study, I feel, is key to the progression of Forensic Healthcare in the UK, and will provide us all with evidence of our knowledge and advanced skills in our specialist clinical areas. Despite the hard work, it involves the course is good fun and a great networking opportunity as well.

**Membership**

Membership - Again our membership has continued to increase, month on month, which is great news as is provides us with a voice in the National discussion. Please look out for your renewal membership. I send these out at the beginning of your renewal month. We love having you on board and want to keep growing our numbers and with it our voice in this arena.

Final note - I recently watched a programme called “Police Code Zero” talking about the use of the red button on the police radio when they are in trouble and the number of assaults they endure. We must not forget that we see people when they are in crisis, intoxicated or just plain angry about the circumstances they find themselves in. We need to make sure we do everything we can to stay safe and look after ourselves in our work.

This isn’t just inside the job. Very sadly a nurse was killed recently on her way home from working a 12-hour shift, as she fell asleep at the wheel. Last month was stress awareness month, but this is something that should continue 12 months of the year. The job we do can be very stressful and whilst you may not feel under stress it can affect us all in many different ways. So take care of yourself, then you can take care of others.

That's it for me this time. I am really looking forward to seeing as many of you as possible at Conference. Fingers crossed for an amazing summer and stay safe. Till next time.
Introduction

The project was developed from an appreciation that there was little academic scholarship written about the practice of custody healthcare, especially following the introduction of Healthcare Professionals (HCPs) in 2003. Opening up the medical professional capable of providing healthcare in police custody also came against the background of transitioning to commissioning of service provision and the liberalisation of the market, enabling private providers to compete for contracts. I found the lack of academic interest in custody medicine particularly troubling when considered in light of these two major transitions. I initially looked for a description of Custody Nurse/HCP practice and was unable to find one, and so was then determined to conduct a project that at least provided a baseline for understanding what it is HCPs provide in police custody. On top of this, I was also interested in the ways that work is differentiated across service providers and regions.

The lack of extant scholarship meant that I was unable to access large quantities of funding and would first need to perform a pilot or seed-funding project in order to generate the baseline, as suggested, and to see if there was sufficient interesting material in order to perform a fuller-scale research project. As a result, the aims of the project were limited as to the funds I was able to apply for. It was also an ambition from the

Dr Gethin Rees is a Lecturer of Sociology at Newcastle University. Here he provides an end of project report on his study into police custody nursing.
outset however, that this would truly be seed-funding and that I would be aiming at more substantial funding in future. To this end my original research objectives were as follows:

- Establish a baseline description of custody nurse practice
- Identify the circumstances where practice differs
- Identify differences in practice based on service provider
- Conduct interviews with Custody Nurses
- Prepare an Investigator Award Bid
- Host a Planning Session for that bid

I will follow the logic of these objectives in the following pages, highlighting the findings, but also flagging up the next steps, with the aim to be able to provide more substantial policy impact in future.

I would like to take this opportunity to thank the United Kingdom Association of Forensic Nurses and Paramedics (UKAFN), and particularly Jennie Smith for all the help and support I have received while conducting this research, as well as all the nurses who I spoke to around the country, it was a pleasure meeting each and every one of you and hearing your stories. I hope that this is not the beginning of the end of this process, but the end of the beginning and that you will continue to work with me in developing future projects so that I can help you continue to do the brilliant jobs you all do.

**Methods**

Semi-structured qualitative Interviews were conducted with 20 custody nurses (17 women and three men) from seven constabularies in England (private provision x4, NHS provision x2 and Police-Managed x1). 13 nurses came from the four privately managed constabularies, four from the NHS managed constabularies and three from the Police-Managed ones. The four privately managed constabularies represented three different providers. Access was generated via the UKAFN, who advertised the project. All respondents received a participant information sheet outlining the aims, objectives and methods of the project and were asked for their consent for inclusion of the interview in the research after its completion so that they could be as informed as possible of what they had said and the ways it would be used in the research. All interviews lasted between an hour and two hours, were digitally recorded and transcribed verbatim. The transcription was then sent to the respondent for their approval and any changes or clarifications. No changes were requested.

The interviews were then analysed using the Framework Analysis method, generating 13 core themes: Becoming a Custody Nurse; Training; Custody Nurse Attitude; Representations of Detainees; Relationship between other Healthcare Professionals (including doctors) and Custody Nurses; Relationship with Police Staff; Consent and Confidentiality; Drugs and Alcohol; Other Medico-Legal Services; Forensic Evidence; Governance; and Procedures, as well as 95 sub-themes. The transcriptions were then ‘indexed’ according to the various themes and sub-themes and this generated ‘Framework Matrices’ which formed the basis for the analysis. All the findings from the rest of this report are based upon this analysis.

**Baseline Description of Custody Nurse Practice**

The first research objective of the project was to develop a baseline description of Custody Nurse practices. While this is not exhaustive and there were differences across
constabularies, the below constitutes much of the similarities in the role played by Custody Nurses in English custody suites.

**Teamwork with Desk Sergeant** - While there is substantial discussion in the social scientific and forensic medical literatures about the ‘dual-role’ between healthcare responsibilities and evidence-generation/Criminal Justice responsibilities, nurses were unanimous that their role was ultimately to ensure the safety of the detainee during the period of detention and for 24 hours afterwards. In meeting this aim, nurses liaise with the Desk Sergeant, to: risk assess whether a detainee poses a risk to themselves or others in custody; assess if they are fit to detain in police custody or should be sent to hospital or their own home (e.g. in cases where the detainee has a disability that would result in them having an uncomfortable night sleeping on a custody bed, which could jeopardise the quality of any further police interview); or assess if they are fit to be interviewed and/or need an appropriate adult to assist with the interview.

**Healthcare Assessments and Care Plans** - Further to assisting the Desk Sergeant with their decisions regarding the welfare of the detainees in custody, nurses also perform healthcare assessments on detainees who are flagged up as a risk following the Desk Sergeant’s risk assessment, or who directly ask to be seen by a HCP. Following the assessment, the nurse produces a care plan, which they share with the Desk Sergeant and Detention Officers either via a computerised system or a paper-based file, depending on the constabulary and on whether they have access to a computer system. The care plan can involve the dispensing of pharmaceuticals, and in the majority of constabularies this is based upon a Patient Group Directive (PGD), a list of approved pharmaceuticals, developed by the company responsible for the provision of nurses in the constabulary, but with recommended doses approved by the professional standards of the Nursing and Midwifery Council (NMC). Nurses can recommend the dispensing of pharmaceuticals in accordance with the PGD on the care plan. In cases where the approved medication on the PGD is inappropriate (e.g. the detainee is allergic, or there is no appropriate therapy on the PGD), the nurses can call a central call centre (again managed by the provider), who will put the nurse in contact with a doctor who is able to prescribe appropriate medication. Other options that nurses can include on a care plan are ‘watches’ split over various time periods (30 minutes, 60 minutes, etc.), where the detainee is checked at various intervals to ensure that they are safe.

**Caring for Chronic Conditions** - The majority of the work relating to diabetics, epileptics and asthmatics relates to confirming the person has the condition, sourcing their medication and updating the care plan to ensure that the detainee receives therapeutic treatments at the appropriate time.

**Drugs and Alcohol Cases** - Drugs and alcohol were unanimously considered to make up the overwhelming majority of work with which nurses have to deal, with alcohol withdrawal amongst alcoholics being flagged up as the biggest risk due to the potential for death in custody. Nurses were trained to use various standardised tests to address a person’s level of withdrawal (Clinical Opiate Withdrawal Score – COWS – and Clinical Institute Withdrawal Assessment for Alcohol – CIWA). While nurses were glad to have the scores and made use of them, their practice was not determined by these scores. In terms of the COWS score, it was often believed that while drug abusers claiming to be in withdrawal might be in pain, they were not clinically withdrawing. Using the score, they were able
to explain to the detainee why they were unable to provide further opiate-based medication. Similarly, if medication was given but the detainee died in custody, the nurse would be able to justify their provision of an opiate-based treatment based upon the detainee’s COWS score. The COWS score was hence used as a means to justify to other parties (i.e. detainees or the Independent Police Complaints Commission) the nurses’ practice, but that practice was not determined by the score. In alcohol withdrawal cases, the CIWA score was used more flexibly than the COWS; nurses were very concerned about alcoholics and would agree to medicate at the earliest sign of withdrawal on the scale, due to the potential for a death in custody.

Referral to Other Services - Nurses were expected to direct detainees to other services, in particular drugs and alcohol and mental health services. In constabularies with Liaison and Diversion (L&D) teams, this area of work was increasingly being pushed onto these teams, and the L&D workers were being treated as general social workers, although that was not their original role.

Evidence Collection - Nurses are also tasked with collecting trace evidence for forensic scientific analysis and the recording of evidence of physical harm. Such forensic evidence collection is required in cases of alleged sexual assault, where they take physical samples from the perpetrator and document any marks upon the body, and in road traffic accidents, where they take blood from the suspected perpetrator, whether that person is conscious or not. Nurses might also be required to provide evidence in a criminal trial, especially if the defence is based upon a procedural error made during arrest and/or questioning of the detainee (e.g. they did not consent to their blood being taken, or they had not been given insulin at the appropriate time prior to a police interview and therefore were not fit to be interviewed). In these cases, nurses rely upon their clinical notes taken during the detention period and prepare a statement for the trial, and may be required to speak to that statement at a later trial.

Differences in Practice

Given that interviews were performed across seven constabularies, made up of six different service providers (four different private companies, the NHS and direct police management), there was tremendous scope for differentiation of practice based on individual practitioner discrepancies, as well as local circumstances. Some of the important differences in behaviour are as follows.

Availability of Mental Health Teams - Mental health cases were often treated differently depending on whether the constabulary had a dedicated Mental Health team or an L&D team, and the time of the day the person was being seen. In cases where a support team was available, it was often the case that the custody nurses would perform an assessment with a member of the Mental Health team, the custody nurse dealing with the physical concerns. If a Mental Health team was not available, however, because it was out of office hours or the constabulary did not employ such a service, then the nurses had to assess mental health as well as physical health. In general, all the nurses were uncomfortable dealing with mental health cases as they did not consider it part of their expertise, and saw their role as referring the detainee on to a Mental Health Service.

Training - Custody nurses were often disparaging when it came to the training practices of other providers, or even their present provider’s training, compared to the training that they had received. They were
always very glad of their own training, while newer colleagues, or colleagues working for different companies, did not receive as well-rounded a package. Clearly there is an element of ‘othering’ here, as when I interviewed the nurses working for providers whose training had been criticised, they were similarly critical of their peers who worked for other providers. What was clear, however, was that the amount of training had reduced over time and moved predominantly to online portals, without a clear evaluation of whether the nurses had fully understood the topics (it was simply based on whether they could complete a multiple choice exercise at the end of a task). Nurses opined there was a lack of face-to-face training.

There was a specific research question focusing on differences in practice based on type of provider (Private, NHS or Police-managed). The results were less shocking than I expected.

Nurse Prescribing - The clearest distinction between NHS providers and private providers/the police concerned the training of nurses, specifically the promotion of nurse prescribing. Constabularies with NHS provision deliberately chose to have nurses on fewer shifts than their contract required (i.e. they did not work a full week as set out in their contracts), and as a result, nurses owed their employer time. This owed time was meant to be spent in training; the resources available to the NHS enabled nurses to take part in any training opportunities advertised by the local Healthcare Trust in their own time (and they could do shift swaps if a particular training opportunity was within their shift). In particular, the NHS advocated that custody nurses take the nurse prescribing course (and NHS nurses were keen to do it), which meant that, once completed, the nurses would not require a PGD in order to dispense medication, or need to check with a doctor via a call centre. As a result, putting nurses through the nurse prescribing course could be seen as a long-term resource saving, as it would mean that a doctor would not be required on call. Alternatively, in companies with private provision in particular, there was no interest in staff completing the Nurse Prescribing course, either from the employers or the nurses themselves. Nurses who spoke about Nurse Prescribing often commented that it was too much work and that they were towards the end of their career and wanted to step down rather than developing new skills. There was also an acknowledged high level of staff turnover in private provision, which would reduce the cost effectiveness of putting nurses through an expensive training course.

PGD - As nurses in private provision were not put forward for prescribing training, they were reliant upon PGDs in order to dispense medication. While the PGDs were developed with the NMC’s professional standards in mind, and nurses were aware that they could lose their nursing registration if they did not dispense medication in line with the PGD, they were often concerned when companies changed following a commissioning process, as it often meant that the PGD changed, often not, in the nurses’ opinion, for the better. They felt that the PGD was driven by economic efficiency rather than therapeutic benefit and that this might have risks later on.

Information Sharing - As mentioned above, the ideal situation is that the nurse can access information from SystemOne during the clinical assessment of a detainee, and from this and the detainee’s history develop a set of clinical notes, as well as a care plan, which should be uploaded to the police computer. The set of clinical notes might later be used as the basis for a statement for a criminal trial. Private companies considered such clinical
notes to be their property and as such required a request from the police to release these documents to the nurse in order to prepare the statement. While it was certainly the case that if the Crown Prosecution Service requested the statement then they were invoiced by the private provider, it was unclear whether this was also the case for the police. No such charge was required by NHS or police-managed providers.

One of the more fascinating findings however, was not based around the differences between private and public providers, but the similarities. Like private providers, constabularies provided by the NHS still used call centres as a way to track the throughput of work and audit. Part of this was a product of the fact that the constabularies had previously been provided for by a private provider and so the system was already in place, but also because under the commissioning process NHS providers are still required to demonstrate that they are meeting targets, are cost-effective etc. As a result the nature of the commissioning process of custody healthcare in England actually produces an homogenisation of processes between public and private providers. I will explore this further in future work. This was one of the more surprising findings of the project, I will explore more below.

**Unexpected Findings**

As well as finding the similarity between the various types of providers surprising, there were other findings from the project that I was not expecting.

**Teamwork** - The importance of interprofessional working between the Desk Sergeant and the nurses has been the biggest surprise of this project. Previous scholarship has emphasised that nurses have been able to maintain their independence from the police albeit being embedded. This is not something that I have found in the constabularies I have visited, regardless of the provider. Nurses expressed the aim of the custody suite team (i.e. nurses and Desk Sergeants) collectively was the avoidance of deaths in custody rather than a wider consideration of the detainee’s healthcare needs. Respondents mentioned protecting Desk Sergeants from a future IPCC investigation frequently and aimed to maintain a close relationship with Desk Sergeants, protecting them by avoiding Deaths in Custody. To this end, embedding and interprofessional teamwork have fundamentally changed the way medico-legal healthcare is practised.

**Privatisation and Salaries** - The provision of healthcare in police custody is the result of police commissioning, with companies (including NHS bodies) competing by submitting tenders. Contracts are awarded for between three to five years, and so a nurse working in custody might practise under numerous companies during their career. As they can be TUPE’d over and remain on their existing terms and conditions when a new company takes over a contract, the new company could potentially have employees on a range of different contracts. This led to nurses becoming quite despondent, as it had implications for their professional development. Many mentioned that they were unable to go forward for promotion, as it would result in them transferring to a different contract where they might not receive the benefits they presently had. Many noted that this reduced the morale of staff and also had implications for some working practices. Under some contractual arrangements the collection of trace material from sexual assault suspects is not considered core work but instead an activity that generates a bonus. One nurse mentioned that if she was coming...
to the end of her shift, she might pass on the sexual assault swabs (a work task considered unpleasant by most nurses anyway), as her colleague would receive a bonus for completing it. I did find it very interesting, however, that although there was a general disillusionment with privatisation, the nurses working for private companies were unanimous about not wanting the NHS to take over custody healthcare as they found NHS processes too bureaucratic and the private system enabled more flexibility. The best option for them was NHS Commissioning, rather than Police Commissioning, as it would introduce greater standards into the work, training and personnel contracts.

Tensions with other healthcare professionals - Nurses spoke regularly of the difficulties that they had interacting with other healthcare professionals. Interactions with colleagues in Accident and Emergency (A&E) presented particular difficulties (e.g. the management of intoxicated persons who needed more observation and potentially more care than could be provided in custody but were not necessarily sick and so should not be in A&E either, or A&E staff not providing information along with the detainee (if the detained person had needed to be seen in hospital) regarding what treatment the person had received in order to enable ongoing care), as did paramedics, who were increasingly bringing survivors of Road Traffic Accidents into police custody due to the fact that they would be seen and superficially treated in the police station far quicker than they would if they went to hospital. Similarly, nurses also gave examples of where they had had disagreements with Mental Health nurses about assessing a detained person for Crisis Care. All of these cases come down to the fact that there is little understanding of what the role of the custody nurse is, what they can/cannot do, what they can access and what they cannot, and so even amongst healthcare staff there is an ignorance around the custody nurse role.

Of course the area of greatest disagreement is with doctors, who continue to argue that the embedding of nurses in police stations is taking work away from them. It is interesting against this background, therefore, that the Faculty of Forensic and Legal Medicine, the professional body for Forensic Medical Examiners (police doctors), has created guidelines stating that a doctor must be called to remove a taser barb from a detainee. Constabularies are finding this very difficult to manage, as given that most providers now run nurse-led services, the doctors that are employed by the provider might be in a different county (available to the nurses employed by the company via a call centre), and so in the case of a taser barb the detainee has to be seen in hospital. Nurses, and the companies that employ them, are fighting this guidance, which does appear to be a strategy in maintaining some jurisdiction over the custody environment.

Next Steps

I am presently in the process of applying for a Wellcome Trust Collaborative Award in order to test the findings of the interview project and provide substantive policy suggestions for custody healthcare.

Conclusion

It is difficult to prepare a conclusion for a report such as this as it feels I am in a moment of transition between research projects, rather than at an end. The seed award project, while successful in achieving its ends, has only opened up more questions about the interprofessional relationships between HCPs/Custody Nurses and Desk Sergeants, the role
of commissioning (or more correctly, procurement) of services and the role of information systems in the risk assessment and provision of care in custody. I do not feel comfortable at this stage providing any advice to healthcare colleagues about ways to progress their work, without a larger project which observes the custody environment in action and speaks with all actors in that area (Police staff, detention officers, HCPs, detainees, L&D, etc.). Such a study is presently in development as discussed through the report and following the outcome of that more definitive evidence will be set out.

What this project has achieved however, is set out some of the key responsibilities Custody Nurses have and the ways they manage the chaotic environment of police custody. It has highlighted the excellent work that they do, in liaison with police and detention officers to ensure the safety of those detained in police care. All nurses reported to me about life-saving activities that they had performed with the assistance of police colleagues, and that while interacting with the police was sometimes difficult, nurses worked hard to make the custody team function and keep people safe. It was an honour to hear these accounts.

Moreover, it has highlighted some of the similarities and differences between forms of providers and while there might be a belief that different providers do things differently, it is less stark than some might think. Commissioning processes in particular result in an homogenisation of practice in order to ensure comparisons during competition for contracts. What this can result in however, is a difficulty with contracts as colleagues in the same constabulary might be on different terms of service, which could lead to a drop in morale.

I will continue to discuss teamwork, commissioning and contracts in the academic publications that will develop out of this project and would be more than happy to distribute those papers. I would also be more than happy to continue our conversations so that you can follow up on where this project is going and perhaps continue to be involved.

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I have wanted to reflect on my recent studies for some time now, but something always seems to get in the way. However, recently I was required to give evidence in court. In particular, the court wanted to explore my decision around someone (the defendant) being fit to interview. After court, I thought about how well it encompassed the Advanced Standards in Education and Training (ASET) award by UKAFN which I gained from completing the Postgraduate Certificate in Advanced Forensic Practice at Staffordshire University. So first a little about me, I started custody nursing in 2012, and I immediately knew it was a good fit for me. I've always been interested in crime and policing. I have previously worked in a medical assessment unit which looked after people following overdoses, alcohol and drug withdrawal. I nursed lots of homeless individuals and people who inject drugs. I also enjoyed nursing those from the local remand prison, which some other colleagues found challenging at times.

I do not consider myself academic. Mostly because when people say academics I think geeky and I don't like to think of myself as geeky. I struggled through school scrapping through my GCSEs. Even at nursing school, I did not excel. I struggled and had to appeal to have another attempt at a research essay in my second year.

I can remember during my custody induction being told about a course at Staffordshire University. I immediately thought I wanted to do it. Although I loved custody work, I struggled with the lone-working and making decisions without the back up of a big team. So I thought I want to know as much as I can about this, because as we all know it is really complicated at times. At the time the only UKAFN ASET badged award was being delivered at Staffordshire University. The UKAFN ASET is designed to be offered by any higher education institute which meets the standards. There are several universities across the UK developing awards which are hoped to reach the ASET standard.

I paid for the course myself, at the time I was working with a private company and there was no appetite for funding places. Now with the apprenticeship levy hopefully your organisations will see the benefit in supporting this training. The cost was about £2000, but the university...
allowed payments to be made in manageable instalments, which was really important for me at the time. As I was saving up to buy a new house.

I started the award in January 2013, it was mostly distant taught, but I was required to attend ten face-to-face study days, spread over the 12 months. It was great to meet others from across the UK working in police custody and sexual offences. It was interesting to hear others had similar issues and how other areas had looked to address these. It was also beneficial to work with the sexual offences students.

The ASET badged award at Staffordshire consists of three modules; introduction to forensic science, professional legal skills for non-lawyers and clinical competencies in forensic examination.

Introduction to forensic science - This is one of the best and interactive modules I have ever studied. Not only do you get to understand the fundamental principles of forensic science, but you also get to don a white suit and process your own crime scene in a crime scene house. Yes I know, attending crime scenes and processing them is not part of my routine work. But, being taught to a level above your current level of work means you are so much better at your level. Like learning to drive, to drive better at 50 mph, you need to learn to drive at 60 mph, and so on.

Legal skills for non-lawyers - This module assess your statement writing and giving testimony in court, using a purpose-built courtroom within the university. We are all required to write statements for the police, and this module addresses this, ensuring you have a full understanding statement writing, types of evidence and the legal system.

Clinical competencies in forensic examinations - This module ran throughout the whole year and involved completing a competency portfolio and a reflexive essay. Reflexivity is being able to examine our own feelings, reactions and motives and how these influence our thoughts and actions in a situation. It is a step beyond reflection, and it is fair to say it takes a little getting your head around.

So I was asked to see a man who had been arrested for a serious offence. However, police had failed on all previous occasions to interview him as he presented himself as profoundly disabled. I was given some collateral history, details of previous clinical examinations and some medical notes provided by the gentleman and the police.

The assessment was challenging and complicated. Following the assessment, I deemed him fit to be interviewed, and his presentation of being profoundly disabled was inaccurate. This decision was not reached easily or quickly. But the ASET training, study and knowledge has educated me to make these difficult and high-stakes decisions, considering all the information. Throughout being reflexive so not to allow my attitudes, values and beliefs to unduly influence my decision making.

He was ultimately interviewed, charged and sent to court. He was additionally charged with perverting the course of justice. At court I was dreadfully nervous, I struggled to even read the affirmation. But I fell back on my training and experience from the ASET. I kept my answers short and to the point. On cross-examination, I was accused of bullying the defendant and being railroaded into my decision by the police. On the stand, I was able to explain reflexivity, and how being aware of my own attitudes, values and beliefs help prevents being railroaded. So my final word is if forensics is a good fit for you, do this course. The benefit has being immeasurable.
It’s been a little while since I have blogged, been a little while since I have been in custody too, so I was really pleased to have been invited along to Basingstoke Police Investigation Centre, (PIC), to shadow a shift of a Custody Nurse. I have shadowed Custody Sergeants, Designated Detention Officers, the inspectorate and Independent Custody Visitors (ICV) in custody, and so was really pleased to learn more about the healthcare a detainee can receive whilst in custody, and also to hang out in custody for a while. We at the Independent Custody Visitor Association (ICVA) write a lot about how things in custody should or could be, and so it’s massively important to spend time there and ensure that our approach isn’t distanced from the environment we are seeking to monitor/improve.

Before I get going on the main content of the blog and my observations on healthcare in custody, a massive thanks to Dave, the Lead Nurse for Hampshire who arranged the visit with me. Not only did Dave sort out my coming into custody and prove to be a mine of information, he had done a 19 hour shift the day before due to the snow and closed roads, and still came to pick me up in the snowy early hours of a Sunday morning – Dave you are a star, thank you!

So, to healthcare then, I read all of the inspectorate reports that come out, I receive and look at the ICV reports that are aggregated up to me from schemes, and it’s fair to say that healthcare can be a bit of a ‘frequent flyer’ in terms of issues that are raised by both parties. Delays are the most common feature, certainly in terms of ICV reports, and during my time shadowing the inspectorate, delays in access to medication which could ease or stop withdrawal could be reasonably said to have had an unnecessary and frankly pretty dire effect on at least one occasion.

In Hampshire, the custody suites have 24/7 healthcare cover from custody nurses and

Spending Time with a Custody Nurse

Sherry Ralph is the Chief Operating Officer for the Independent Custody Visiting Association and writes after spending a shift with UKAFN’s Dave Tremlett

Association (ICVA) write a lot about how things in custody should or could be, and so it’s massively important to spend time there and ensure that our approach isn’t distanced from the environment we are seeking to monitor/improve.
paramedics. I wasn’t sure as to what a custody nurse could and couldn’t do in terms of detainee medical care, if they screen everyone etc etc so was keen to find out. I was also keen to learn more about how 24 hr care had been put into custody, who ran it, what worked well in terms of providers?

Dave explained that the custody nurses are able to meet the majority of requirements a detainee might need, including assessing physical and mental health needs, dealing with acute and chronic disease processes alongside medical emergencies when they present.

HCPs are able to dispense and administer medication, from something for a headache or minor injury through to medication to treat alcohol and opiate withdrawal.

Ultimately, they will clinically assess their patient and advise the Custody Sergeant whether they are fit to detain and fit to interview, if they are not fit to interview a time will be suggested when the detainee will be. They suggest the level of observations the detainee should be checked and make onward referrals if appropriate for example if an appropriate adult is required.

HCPs won’t screen every detainee, they see these who request to see them and those who consent to seeing them following an identified need from the custody staff. How this works is that the custody staff put in a call to a centre, they log it, phone the HCP who is sat in the suite to ask them to see the detainee. This seems like a slightly bonkers arrangement when the staff are co-located and tends to be the case nationally, but providers are looking to improve technology to streamline this process. It allows for recording of Key Performance Indicators (KPI) in terms of response times etc, (I shan’t get into a discussion of the usefulness of KPIs but am sure you will all have an opinion on them)!

A detainee assessment was great to see, I won’t go into details of the detainee for obvious reasons, but Dave covered all of their medical issues in depth, ensuring that the detainee didn’t require medication from home or from the stocked medication held in custody. He thoroughly checked on the detainee’s emotional wellbeing gently exploring whether there was any history of self-harm or harming thoughts. There was also a fairly lively chat about football - (went right over my head but they seemed to enjoy it) and this changed the demeanour of the patient. I think over and above the details of this assessment which meant that the detainee got the care they needed and were pronounced fit to interview, were the interpersonal skills and friendliness shown.

There is no doubt that it was a professional meeting, but it was also was a non-police member of staff there to talk to the detainee, with some smiles along the way, something which we seemed very far from when the detainee first entered the room. It’s this care, whether from a HCP, an ICV or a member of the custody suite staff that, I think, determines how a detainee copes with their time in custody, it shapes their interactions with everybody else and ultimately provides reassurance and calmness in a time of extreme stress.

In terms of the arrangements of how the healthcare service is commissioned, in Hampshire the team are currently managed by a local service provider which started in January 2019. I think it is fair to say that there is a reasonable churn of healthcare providers in custody, with some national organisations and some more localised arrangements. We discussed whether a national approach or a local one worked best in a healthcare context and found positives for both approaches.

Certainly, on a local level, it seems as though
having a local provider has worked for the Hampshire team, having a clear regional accountability structure and a reportedly flexible approach to the needs of the team, suites and the detainees from the new provider alongside the historic structure known by the Constabulary has assisted a smooth transition between providers recently.

As with all things custody, systems and recording are interesting in terms of healthcare. I was amazed to learn that computerised records only landed about a year ago for the HCPs in Hampshire, meaning an ongoing health record was being built up for those detainees who are brought into custody more than once. Prior to this, paper files were kept, and then archived off site after a short period, meaning that there was no historical health information for returning detainees available. Things still aren’t perfect, the HCPs need to enter things twice, once on a health record and then also the pertinent info onto the custody record. The new healthcare computers aren’t yet networked into GP surgery records although they have the capability to do so, but that feels as though it’s the next step towards joined up, effective healthcare. What is clear though is that records are heading in the right direction so that HCPs will have a health history and be able to ensure the best care and assessment of detainees.

I have to confess to not undertaking the full 12 hour shift, but I think I definitely got a flavour of the work of HCPs, why embedded healthcare is good practice in a more nuanced way and saw some excellent work with detainees and in terms of partnerships along the way. Will I always choose to get up at 5.30 on a Sunday to shadow a shift? No probably not, but I am glad I did this time!

Dave Tremlett. If you want to know more about Dave or custody healthcare issues then you can follow him on Twitter as ‘Police Custody HCP’ (@NurseCustody).

Sherry spent a shift with UKAFN’s Steering Group Member and Lead Nurse for custody

The Helix | The Official Newsletter of UKAFN

The Independent Custody Visiting Association (ICVA) provides leadership to Independent Custody Visiting schemes in the UK, helping to define their aims and ensuring that schemes remain up to date in policing reforms. A member of many nationwide groups, ICVA will continue to use this platform to lead schemes on changes to the custody arena.

A crucial role in supporting local schemes and scheme managers. A key role is to provide effective, timely and consistent support to its schemes. This covers a range of activities but at the heart of our support is to ensure schemes have all of the tools they need and want to be able to deliver effective oversight of detainees rights, entitlements and wellbeing.

ICVA has an on-going national role to represent ICV schemes as an integral part of policing. It does so as a member of the National Preventive Mechanism (NPM), alongside Independent Custody Visitors Scotland and the Northern Ireland Policing Board Independent Custody Visiting Scheme.

Webpage & Social media

www.icva.org.uk
@custodyvisiting
@projectICVA
FFLM | Mental health care & learning disability day for healthcare professionals / clinicians working in GFM & SOM

The Faculty of Forensic and Legal Medicine (FFLM) will be holding their next Mental Health Care and Learning Disability Day for Healthcare professionals / clinicians working in general forensic medicine and sexual offences medicine day on Saturday 08 June 2019 in Birmingham.

Confirmed speakers include:

- **Professor Keith Rix**, Visiting Professor of Medical Jurisprudence and Honorary Consultant Forensic Psychiatrist, Norfolk and Suffolk NHS Trust
- **Raquel Correia**, Consultant Clinical Psychologist, The Havens, Kings College Hospital NHS Foundation Trust

This year the UKAFN conference will focus on party drugs and the impact of this on Forensic Healthcare Practitioners working in both police custody and sexual assault examination settings.

#UKAFNConf19 | From Party scene to crime scene

This year the UK Association of Forensic Nurses and Paramedics conference will take place on 21 September 2019 at College Court Hotel and Conference Centre, Leicester. The conference will cover the following:

- **Chemsex** - the use of drugs before or during sex
- **Party drugs** - commonly used party drugs, festival testing, harm reduction and legal and ethical aspects
- **Club medicine** - frontline experiences of dealing with clinical aspects of party drugs
- **Pill farms/mills** - an operation in which a doctor, clinic or pharmacy prescribes or dispenses narcotics without a legitimate purpose

**Date:** 08 June 2019  
**Location:** Birmingham  
**Cost:** £150 - 200  
[www.tinyurl.com/y2wchq62](http://www.tinyurl.com/y2wchq62)

**Date:** 22 September 2019  
**Location:** Leicester  
**Cost:** £50 (UKAFN members)  
[www.ukafnconf19.eventbrite.co.uk](http://www.ukafnconf19.eventbrite.co.uk)
**RCN | Safeguarding children & young people**

To protect children and young people from harm, and help improve their wellbeing, all healthcare staff must have the competencies to recognise child maltreatment, opportunities to improve childhood wellbeing, and to take effective action as appropriate to their role. This intercollegiate document provides a clear framework which identifies the competencies required for all healthcare staff. Levels 1-3 relate to different occupational groups, while level 4 and 5 are related to specific roles. This version of the framework also includes specific detail for chief executives, chairs, board members including executives, non-executives and lay members.

www.tinyurl.com/ycrj662p

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**FFLM | Forensic science subcommittee - Jan 2019**

The FFLM’s Forensic Science Subcommittee meets every six months to review and revise the Recommendations for the collection of forensic specimens. The Committee also considers questions sent in by members of the FFLM and other interested parties. Here are the questions with answers from the past year.

www.tinyurl.com/y73fd7pr

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**FFLM | Recommended equipment for forensic sampling**

The Faculty of Forensic and Legal Medicine have updated their document ‘Recommended equipment for obtaining forensic samples from complainants and suspects’.

www.tinyurl.com/yaanva85

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**FFLM | Labelling samples**

The Faculty of Forensic and Legal Medicine have updated their document ‘Labelling forensic samples’. The simple guide illustrates the recommended labelling of samples and evidence bags.

www.tinyurl.com/ycttlh9t

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**SIGN | Children & young people exposed prenatally to alcohol**

Alcohol consumption in pregnancy has the potential to cause significant fetal damage. In 1973, a cluster of birth defects resulting from prenatal alcohol exposure (PAE) was first described as the clinical entity fetal alcohol syndrome (FAS). Diagnostic criteria for FAS...
include evidence of PAE, evidence of structural or functional central nervous system abnormalities, a specific pattern of three facial abnormalities and growth impairment (either prenatally, after birth or both). Exposure to alcohol during pregnancy can result in other fetal injuries. These wider patterns of effects, along with FAS, constitute the continuum of structural anomalies and neurocognitive and behavioural disabilities associated with prenatal exposure to alcohol which has been labelled FASD.

The SIGN guideline provides evidence-based recommendations on measurement of alcohol consumption in pregnancy and consensus-based recommendations on:

- identification of children at risk of FASD
- criteria for diagnosis and use of FASD as a descriptor
- the medical assessment
- physical examination
- sentinel facial features
- neurodevelopmental assessment
- the multidisciplinary assessment team
- special considerations in the neurodevelopmental assessment
- management and follow up of children and young people affected by PAE.

Future Learn | Addressing violence through patient care 🎥

Future Learn is offering a free online course where you will learn about some of the key concepts and challenges in the field of medical peace work, particularly the importance of violence prevention and peace practice for healthcare professionals.

You will cover aspects of theory, field work and advocacy focusing on working with domestic violence, refugee healthcare and healing torture victims. In each case you will consider the specific challenges of treating these victims of violence and the role you play in helping them.

www.tinyurl.com/ybzctu3q

MHRA | Diazepam diversion down by 73% 🌟

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued a February update into the diversion of medicines from the legal supply chain into the criminal market. Recent figures into bulk orders of diverted medicines between January 2016 compared to March 2017 figures show:

- trading of Diazepam is down by 73%
- trading of Nitrazepam is down by 30%
- trading of top strength Temazepam is down by 18%
- trading of Zolpidem is down by 18%.

www.tinyurl.com/y3m648mx

NHS England | Gabapentin and Pregabalin now Schedule 3 Controlled drugs 🪐

As of 1 April 2019 both gabapentin and pregabalin have been reclassified as Schedule 3 controlled Drug under the Misuse of Drugs Regulations 2001, and a Class C of the Misuse of Drugs Act 1971. This means they are both subject to controlled drug prescription requirements. Additionally, in police custody a detainee may now only self-administer the above under the supervision of a healthcare professional.

www.tinyurl.com/y29naeep
Independent prescribing is intended to support and enhance the overall delivery of care to patients within a wide range of circumstances and the devolution of prescribing from medical practitioners has been in place for several years. In 2018, legislation was passed in the UK allowing for paramedics to also undertake training to become independent prescribers. Independent prescribing is now carried out by those paramedics who are practising at an advanced level and have a role in clinical practice for which prescribing is a benefit to patient care. This book is the first guide on independent prescribing for paramedics reflecting the 2018 legislation. Bringing together a range of specialist authors, the book supports the College of Paramedics' practice guidance and also covers the theoretical knowledge and context associated with independent prescribing. It will appeal to any paramedic working at an advanced level with an interest in independent prescribing as well as senior student paramedics who are interested in further development post-registration.

Chapters include
- Law and ethics
- Assessing health: History taking and consultations
- Basics of pharmacology
- Decision making for prescribing
- Prescribing as part of a team
- Publish health and prescribing
- Medicines optimisation
- Patients factors and prescribing
- Continuing professional development and reflective practice

Author: A. Blaber, H. Morris & A. Collen.
Year: 2018
Publisher: Class Professional Publishing
Pages: 200
Cost: £30
The purpose of this study was to identify the extent and types of drugs found in alleged drug facilitated sexual assaults (DFSA) in 37 states and 1 territory of the United States. DFSA is any crime in the course of which the victim is administered a drug or other incapacitating substance in order to affect control over their actions, decision-making or mental or physical capabilities for the purposes of non-consensual sexual contact. In total, 1000 cases were reviewed. Between the cases that gender was provided (n=613), most of the victims (91.68%) were woman, mean age of 26.8 years old. Blood and/or urine samples were tested. Twenty-one point six percent (21.6%) of the cases were negative for intoxicating substances. A hundred and one (n=101) different substances were detected. Overall, ethanol was the most prevalent substance, detected in 30.9% of the cases (n=309 cases), followed by cannabinoids (THC/THCCOOH/11-OH-THC) (28.8% of cases), amphetamine/methamphetamine (16.5% of cases), cocaine/metabolites (10.4% of cases), and clonazepam/metabolite (7.6% of cases). The mean, median and range concentrations of ethanol in blood (n=309) were 98.6 mg/dL, 82.0 mg/dL and 9.2-366 mg/dL, respectively. Ethanol and cannabinoids were the most frequent combination found. The absence of alcohol and drugs in some cases may represent delay in collecting samples.

ONS | 14% increase in reported sexual offences

The Office for National Statistics (ONS) has released its latest data on crime in England and Wales, which cover the year ending September 2018.

The figures confirm that sexual offences reported to the police are still on the increase, continuing a trend that has lasted over four years.

The statistics reveal reported rapes increased by 16% over the year, and sexual assaults by 13%. This amounts to an overall 14% increase in police-recorded sexual offences. The Government’s own estimates are that still only around 17% of those subjected to these serious, traumatic crimes currently choose to report to the police.

Letter to NHS commissioners of services for victims of sexual assault

A letter from Jackie Doyle-Price, the Minister for Mental Health, Inequalities and Suicide Prevention and Kate Davies, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning to NHS commissioners.

The letter asks commissioners to look at how they are meeting their responsibilities for victims and survivors of sexual assault. It sets out the importance of commissioning better services that support victims in an informed and consistent way.

Male rape short film wins award

The winners of a hard-hitting short film which shows the devastating impact male rape has on its victim have been
announced during an awards ceremony at Sunderland University.

‘Talk to Me’ was part of a series of powerful short films created by students in collaboration with Northumbria Police and SARC (Sexual Assault Referral Centre) who were looking at ways to raise awareness and support males who find themselves the victims of a sexual crime, which remains undisclosed in many cases.

www.tinyurl.com/y3zteqat

Scottish Gov | National Forensic examination standards

New nationwide standards are being introduced to ensure consistent delivery of forensic medical examinations for victims of sexual violence.

Healthcare Improvement Scotland has been commissioned to produce the standards, which will ensure best practice is applied when examining victims following a rape or sexual assault – including the conditions and way examinations are handled.

The new standards will build on the good work of the National Coordinating Network for Forensic Medical Services and put beyond doubt what is expected in the delivery of care for victims. It will also ensure NHS boards are clear in their role, helping ensure greater consistency throughout the country.

www.tinyurl.com/ymh8whx

NICE | Sexual Health Quality Standard

National Institute for Health and Care Excellence

This quality standard covers sexual health, focusing on preventing sexually transmitted infections (STIs). It describes high-quality care in priority areas for improvement. It does not cover harmful sexual behaviour or contraception.

www.tinyurl.com/y4mvoz6o

NICE | Child Abuse Quality Standard

National Institute for Health and Care Excellence

This quality standard covers recognising, assessing and responding to abuse and neglect of children and young people under 18. It covers physical, sexual and emotional abuse. This quality standard describes high-quality care in priority areas for improvement. It does not cover areas of national policy, such as legislative changes and statutory requirements.

www.tinyurl.com/y6r7ojvf

Children’s Commissioner | Keeping Kids Safe

Anne Longfield, the Children’s Commissioner for England, has published an in-depth study looking at children in England who are members of gangs. The report, “Keeping kids safe: Improving safeguarding responses to gang violence and criminal exploitation”, estimates there are 27,000 children in England who identify as a gang member, only a fraction of whom are known to children’s services. Some of these children may only identify loosely with a gang and may not be involved in crime or serious violence: more concerning is the estimated 34,000 children who know gang members who have experienced serious violence in the last year.

www.tinyurl.com/y4k7636j
FOCUS | POLICE CUSTODY

FFLM | Managing exposure to blood-borne viruses 🦠

Healthcare Professionals (HCPs) may be asked to see police staff following a potential exposure to a blood-borne viruses, namely hepatitis B, hepatitis C, and Human Immunodeficiency Virus. It is important to recognise and manage incidents effectively. Ensuring all the relevant information is collated; and, where possible, take a blood sample from the source and send it to the relevant department.

www.tinyurl.com/y9ucnadw

FFLM | Taser® 🔫

TASER® conducted energy devices are battery-operated, pistol-like devices and one of several less-lethal options available to the police. These recommendations outline the clinical effects and management of individuals subjected to a Taser® discharge. While the FFLM still advocates a ‘registered medical practitioner - a doctor’ must ultimately examine the individual. UKAFN believes it is more important individuals are examined by a professional with the appropriate knowledge and skills and it working towards this end.

www.tinyurl.com/y7o8a6nj

The Guardian | My working week 🎨

This article follows the work of a ‘police doctor’ for one week (mon-fri), and a taste of the cases covered. If you would like to contribute to the ‘My working week’ series email sarah.johnson@guardian.com.

www.tinyurl.com/y7xpmkbc

Cheshire Constabulary custody rated ‘very good’ overall 🚑

A joint inspection by Her Majesty’s Inspectorate of
Constabulary and Fire and Rescue Services (HMICFRS) and Her Majesty’s Inspectorate of Prisons concluded that “leadership and accountability” for custody services was “good”.

Health service provision was deemed “very good”, and officers and staff “engaged well with partner agencies, particularly to divert children and people experiencing mental ill-health from custody”.

It also identified a strategic focus on reducing reoffending, which inspectors said was “unusual to find in our inspections of police custody”.

This second edition is written to improve our knowledge and to provide practical support to clinicians working in prisons. It also has relevance for clinicians working in other secure environments and in the community. NHS England (NHSE) has supported this second edition recognising the importance of prescribing work-streams.

This edition will be of use to prescribers working in the community whose patients spend time in custody, when a patient is expecting a custodial sentence and when patients leave prison and return to general practice.

Other clinicians who may find this guidance a useful reference include forensic physicians and custody nurses; consultant psychiatrists; non-medical prescribers; pain clinic specialists and hospital clinicians.

Roxanna Dehaghani of Cardiff University titled ‘Observations on PACE C safeguards and defining vulnerability’.

Other clinicians who may find this guidance a useful reference include forensic physicians and custody nurses; consultant psychiatrists; non-medical prescribers; pain clinic specialists and hospital clinicians.

Learning the Lessons | Mental Health 👍

The Independent Office for Police Conduct published their latest Learning The Lessons. This issue, no 34, in February 2019. This issue focuses on mental health and vulnerability. It includes an article by Dr Roxanna Dehaghani of Cardiff University titled ‘Observations on PACE C safeguards and defining vulnerability’.

www.tinyurl.com/y4z4gj22

Gov | Prescriptions for people in custody 🔥

The process of collecting prescriptions for people in police custody is complicated. Requiring consent from the individual. Typically this is arranged in prison. However, this frequently clashes with the time people are transported between court and prison - from 5pm to 7pm - when medical and pharmacy services are closed, delaying the prescribing process.

Working with Innovate UK, the Department of Health in Northern Ireland has up to £1.25 million for projects that can ensure medication continuity for people entering custody.

This is a Small Business Research Initiative competition with funding provided by the GovTech Catalyst, which helps the public sector identify innovative technologies to improve public services.

www.tinyurl.com/y43apovx
COMPETITIONS

We have one copy of ‘Independent Prescribing for Paramedics’ to give away

A. Blader, H. Morris & A. Collen • 2018 • Paperback • Class Professional Publishing • 1st Edition • 200 pages • £30

To enter the prize draw email your name, and role to:
ukafn.newsletter@gmail.com

With the subject heading ‘IPfP’

The draw will take place on 1 July 2019

(see terms and conditions)

We have one copy of ‘Clinical Forensic Medicine 3rd Ed.’ to give away

W. McLay • 2009 • Paperback • Cambridge University Press • 3rd Edition • 260 pages • £72

To enter the prize draw email your name, and role to:
ukafn.newsletter@gmail.com

With the subject heading ‘McLay’

The draw will take place on 1 July 2019

(see terms and conditions)

Terms and conditions
• UKAFN members ONLY
• One entry per member per competition
• Winners will be notified by email
• Prize as stated, no alternative
• Winners may be announced in the UKAFN newsletter, Facebook and Twitter pages

Jo Hood (Clinical Lead) - Nursing in Criminal Justice Services

Stephen Dolphin (HCP) - Improving the Psychological Wellbeing of Children and Young People
FROM PARTY SCENE TO CRIME SCENE

This year the **UK Association of Forensic Nurses and Paramedics** conference will take place on **21 September 2019 at College Court, Leicester**. The conference will cover the following:
- **Chemsex** - the use of drugs before or during sex
- **Party drugs** - commonly used party drugs, festival testing, harm reduction and legal and ethical aspects
- **Club medicine** - frontline experiences of dealing with clinical aspects of party drugs
- **Pill farms/mills** - an operation in which a doctor, clinic or pharmacy prescribes or dispenses narcotics without a legitimate purpose

**WWW.UKAFNCONF19.EVENTBRITE.CO.UK**

**UK ASSOCIATION OF FORENSIC NURSES & PARAMEDICS**
POSTGRADUATE CERTIFICATE IN ADVANCED FORENSIC PRACTICE (CUSTODY / SEXUAL ASSAULT)

THIS COURSE IS BADGED BY UKAFN, MEETING THE ADVANCED STANDARDS IN EDUCATION AND TRAINING (ASET) IN FORENSIC PRACTICE.

Is this course for you?
Are you working independently in police custody or sexual examination settings? Are you required to provide written and oral testimony in court? Then this course is for you.

Course content
You will gain the legal, forensic and clinical knowledge and skills to work with individuals in an evidence-based manner and become a competent witness in court.

- Introduction to forensic practice
- Professional legal skills for non-lawyers
- Clinical competencies in forensic examination

About this course
This course has been designed for nurses and paramedics who work in forensic medicine. It is the first forensic qualification, professionally badged by UKAFN and FFLM, as meeting the ASET standard.

Key facts
Mode of study:
Distance taught with 10 attended study days

Duration:
One year (12 months)

Course begins:
13th January 2020

Tuition fees:
£2,535

staffs.ac.uk/postgraduate

Key features
- This innovative course is the first of its kind in the UK
- Successful students will also receive a UKAFN ASET certificate
- We have dual healthcare, crime scene and courtroom facilities
CONTRIBUTING TO ‘THE HELIX’ - AUTHOR GUIDE

How do you get started?
You have decided that you want to publish an article because you have something to say that you want to share with others. If you are uncertain about what you want to say it is worth spending a short time thinking about it - but only a short time. The sooner you start writing, the better! Once you start writing then your ideas should begin to flow and, rather than a blank screen, you will have something to edit.

Don’t try to write the article from start to finish: start wherever you have an idea and move about between sections until you have completed. Don’t edit as you go along; wait until a complete first draft is done and then start to edit and revise.

You may find it valuable to seek out a critical friend. This is someone who whose opinion you respect and whom you can trust to provide honest feedback and guidance during the various stages of writing your article.

Author guidelines
• Minimum 500 words.
• Maximum 5,000 words.
• Appropriate headings permitted.
• If references used a Harvard style (support available)

Types of articles
Any article will be considered that directly related to forensic healthcare, both sexual offences and general forensic. Articles not directly relating to the above, but still relevant to forensic healthcare practitioners will also be considered.

How to submit
Please send any articles to Matt Peel the editor of ‘The Helix’ via email. You are welcome to discuss any article before or during submission; ukafn.newsletter@gmail.com.