The Medical Care of Suspected Internal Drug Traffickers – Independent Report of the Chief Medical Officer's Expert Group

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Introduction

The smuggling of illegal narcotics into the UK by way of internal concealment poses unique challenges, not simply in terms of the detection and apprehension of suspected individuals, but in the provision of care and any subsequent medical attention they may require. Recognition of the potential risks faced by such detainees and the need to ensure their safety and wellbeing during the jurisdictional process is essential.

At present, variable factors affect the care and management of individuals who, amongst other terms, are referred to as 'Body-Stuffers', 'Body-Packers' and 'Swallowers'. Collectively this population is described as Suspected Internal Drug Traffickers (SIDTs). SIDTs are managed by UKBA in a variety of different settings as the jurisdictional process unfolds, including the location where they are apprehended; on the way to and within the custodial setting; and the magistrates' court where charges against them are made. In each environment, the situation risks complication due the potentially sudden and serious, but uncommon, occurrence of a medical emergency. Such an emergency may result from the rupture of a package containing drugs.

While different methods of internal concealment must be taken into account, the likelihood and timing of such an event can often not be anticipated, particularly when SIDTs do not confirm whether they are smuggling drugs by internal concealment.[1] Therefore, the training of custodial staff, the accessibility of appropriate healthcare facilities and the appropriate environment for the detention of those at risk are important concerns. The recommendations contained in this guidance are intended to assist in the ongoing development of clinical guidance on the care of such detainees, and to inform the future planning of services.

The UK Border Agency (UKBA), which enforces immigration and customs regulations and manages border control for the UK has reported that approximately 150 SIDTs are detained at Heathrow Airport each year, with a trend towards the detention of fewer individuals over recent years.[2] In the six-month period between August 2010 and January 2011, UKBA informed the group that 64 SIDTs were detained. Over the last 25 years, 7 SIDTs have died in UKBA custody after arrest as a consequence of rupture of a package of

drugs concealed internally, with two of these deaths occurring since 2006.[3]

In May 2007, an inquest was held into the death of an individual who had arrived at Heathrow with approximately 1kg of cocaine concealed internally in the digestive tract and who later died whilst in the custody of HMRC. Following this inquest, the Coroner, Mr Andrew Walker, wrote to HMRC under Rule 43 of The Coroners' Rules 1984 recommending actions that could be taken to prevent the recurrence of such a fatality (Annex A). These recommendations were:

- The development of a policy '[…] to take account of the medical care necessary where a detained person is believed to have swallowed drugs and has identified additional high risk factors […]'; and

- Provision of the '[…] opportunity for a consultation with an independent medical practitioner with appropriate training following a decision to charge a detained person who is suspected to have swallowed packages of drugs. This consultation should be separate from the attendance of a forensic medical examiner necessary before a person is charged.'

Following receipt of the Coroner's letter, Mr Mike Eland CB, Director General of HMRC, wrote to the then Chief Medical Officer (CMO) for England, Sir Liam Donaldson. In his letter, Mike Eland highlighted a problem with HMRC's contracted Forensic Medical Examiners (now referred to as Forensic Physicians) in various locations across the UK giving differing medical advice on the care of SIDTs and the difficulty this situation was creating for the formulation of national policy and application of uniform standards of care. Mr Eland sought the CMO's help and advice in formulating Departmental and clinical guidance on the issue of the medical care of SIDTs, including for those groups deemed to be at high risk. (Annex B).

Guidance was also sought on the HMRC policy, and current UKBA policy, of not 'routinely' seeking hospital admission for detainees with 'internal concealments'. This issue had arisen at the inquest, where medical opinion had both supported HMRC's stance and considered that the individual in question would have died irrespective of where they had been detained. Legal argument on behalf of the individual's family sought to persuade the court that HMRC was wrong in not sending the individual to hospital, but the court did not uphold this argument. The relatives registered a claim under the Human Rights

Act in the Central London County Court in 2008 and UKBA are currently exploring options before any decisions are made concerning the case.

Since Sir Liam convened the Expert Group on the Medical Care of SIDTs, the group has benefited from a wide range of clinical expertise and has included representatives of the General Medical Council, Medical Royal Colleges, National Poisons Information Service, NHS service providers and UKBA. Members of the Expert Group visited Heathrow and the UKBA custody suite at Colnbrook, where they followed the pathway of custody from the apprehension of a suspect to their detention and this first hand evidence informs the recommendations made.

The recommendations that the Group make are intended to bring clarity to the medical implications of the custodial pathway followed by SIDTs whilst in the detention of the UKBA, to highlight changes that could be made to improve the care and medical management of this group of detainees and provide a starting point for the development of detailed and comprehensive care pathways. The Group was not tasked with, or resourced to, work up detailed pathways of guidance, but the immediate implementation of simple mechanisms, such as a modified early warning system and a standardised protocol for the management of SIDTs, could improve the safety and wellbeing of detainees, and provide improved assurance of the quality of care offered by staff working in UKBA settings.

Finally, given that health is a devolved government responsibility and the medical care of SIDTs whilst in custody is a UK wide issue, UKBA will wish to consider the applicability of the recommendations made here with appropriate health officials in Wales, Northern Ireland and Scotland. Differences in the delivery of healthcare services across the UK devolved administrations, particularly in England, suggest that UKBA may wish to consider such discussions a priority.

Dr Anita Donley
Chair of the Expert Group

Chapter 1: Background - The Custody and Detention of Suspected Internal Drug Traffickers at Present

UKBA operates a number of custody suites, mainly at major ports and airports, including Heathrow, Gatwick, Birmingham, Dover and Manchester, with the suite at Heathrow dealing with over 80% of the total number of SIDTs apprehended by UKBA each year. The custody suites are operated in accordance with the statutory requirements set out in the Police & Criminal Evidence Act 1984 (PACE), and UKBA staff are obliged to abide by the Codes of Practice issued under that Act, particularly Code of Practice C.[4]

In practice, UKBA custody suites operate differently to those of the police in dealing with individuals concealing drugs internally, something that is in part due to the different nature of the cases that each organisation usually deals with. The Expert Group was informed that police forces have found in recent years that those involved in drug dealing on the street typically swallow small amounts of drugs at low levels of purity in packages that are often inadequately wrapped - often in little more than a piece of cling film. These cases are generally referred to as 'Body-Stuffers'. In contrast, UKBA SIDT cases usually involve drugs of high purity in large amounts that are wrapped more securely and which, in many cases, appear to be manufactured for the purpose; these cases are generally referred to as 'Body-Packers'. Usually 75-100 individual packages are found, and on one occasion the quantity was over 1 kilogramme.[5]

UKBA and Police Policy and Current Guidance

There are at present notable divergences between UKBA and police policy, which it is useful to summarise.

Police policy is that all detainees suspected of internally concealing drugs should be taken immediately to hospital, taking into account the possibility of the sudden release of such drugs from inadequate packaging. In contrast, UKBA guidance makes no such recommendation and, unless the individual becomes demonstrably unwell, these individuals remain in UKBA custody suites. The group were informed that it is current UKBA policy that all detainees with a suspected internal concealment should be transported as soon as possible to the custody suites at either Heathrow or Manchester where

there are care and monitoring facilities, with staff that UKBA consider to be competent in the management of these individuals and in the early identification of potential problems.

All SIDTs detained in police custody are routinely assessed by a forensic physician or HCP to establish fitness to be detained. Detainees in UKBA custody are not routinely assessed by a forensic physician or HCP unless deemed advisable by custody staff.

The Drugs Act 2005 amended the Criminal Justice Act 1988 and the PACE Acts of England and Wales and Northern Ireland. Some of the amendments empowered the police, subject to a number of restrictions, to authorise intimate searches, X-rays and ultrasound scans of persons suspected of having concealed Class A drugs with the intention to supply or export them.

The Police and Criminal Evidence Act 1984, as amended by the Drugs Act 2005, provides grounds under which an intimate search for drugs may be carried out in England, Wales and Northern Ireland. This requires the authorisation of a police officer of the rank of Inspector or above, who has reasonable grounds for believing that a person has concealed a Class A drug which he or she intended to supply to others or to export and that an intimate search is the only practicable means of removing it. Such a search, when carried out for secreted drugs, must be carried out at a hospital or other medical premises (not a police station) by a suitably qualified person (defined as a registered medical practitioner or registered nurse). In these cases, the responsibility for performing the examination lies with the forensic physician/nurse and not the hospital doctor.[6]

UKBA officers have similar powers to the police to authorise intimate searches, again in the context of PACE, but have no powers to authorise the use of forensic imaging. In Scotland, a Sheriff's warrant may authorise an intimate search, 'in the interests of justice and to obtain evidence.

The Drugs Act provides for a detainee to have an X-ray or ultrasound carried out if s/he is '…suspected of having swallowed a Class A drug and was in possession of it with appropriate criminal intention before his arrest'. The imaging must be authorised by an officer of Inspector rank or above and must be performed by a registered medical practitioner or nurse at a hospital, doctor's surgery, or other medical premise.[7]

Code C of the revised PACE Act stipulates that where there is any doubt about the condition of a detainee, especially when substance misuse may be involved, 'the police should always act urgently to call an appropriate healthcare professional or an ambulance'

Similarly, the National Policing Improvement Agency's draft protocol for the management of detainees that are suspected of swallowing or packing drugs recommends that the person arrested should be conveyed to hospital as quickly as possible as a medical emergency if the following conditions are present:

- Reliable intelligence indicates that the individual has either ingested a package of drugs, or they are seen to do so, or admit having done so; or

- Reliable intelligence indicates that the individual has a package of drugs or packages of drugs hidden in any intimate orifice.[8]

Other existing guidance of note is the advice of the National Poisons Information Service, which can be found on TOXBASE, its computerised database.[9] The Faculty of Forensic and Legal Medicine published guidance in September 2010 on *Acute behavioural disturbance: guidelines on management in police custody*, and The British Medical Association and the Faculty of Forensic and Legal Medicine have also published guidelines for doctors asked to perform intimate body searches.[10]

Forensic Physicians

Forensic Physicians (FP), previously referred to as Forensic Medical Examiners, are qualified doctors who practice in a variety of settings including contributing to the care of individuals in custody. The Royal College of Physicians Faculty of Forensic Medicine is the body that sets standards for specialist practice, and the Expert Group recommends that the evolution of UKBA policy is developed with the assistance of this group of experts.

The Metropolitan Police issue a comprehensive set of guidelines, *Good Practice Guidelines for Forensic Medical Examiners*.[11] The following is an excerpt from this guidance, which provides advice on detainees who have swallowed drugs:

If the FME is telephoned regarding a detained person who has swallowed drugs they should be aware of the advice contained in MPS Special Notice 37/97, which states that:

'A prisoner who has or is suspected of having swallowed drugs, must be treated as having taken an overdose and an ambulance should be called. If the prisoner refuses to go to hospital and declines any medical assistance the refusal should be noted on the custody record and their condition closely monitored for signs of deterioration. In these circumstances, the FME must be called. On arrival, a full assessment should be performed by the FME to consider whether hospital transfer is required. If so, the FME should explain to the detained person why such transfer is in their best interests.'

The Transport of Detainees

UKBA has four customised vehicles to facilitate the transfer of detainees. These vehicles are equipped with two cells and an on-board captive toilet, which allows for any waste matter passed to be removed hygienically and examined at static facilities in the receiving suite. Details of the various routes and the location of nearby hospitals are held in the vehicles, and staff undertaking these duties are supplied with mobile phones to contact emergency medical assistance if required. A first aid kit is also provided. Journey times can be significant due both to the distances involved, and because of the potential for traffic delays at certain times of the day - for example, Dover to Colnbrook is a journey of around 100 miles. UKBA informed the Group that UKBA officials do not routinely seek the advice of a FP on the advisability of transfer. There is reduced capacity for adequate monitoring of detainees' health status and no clear guidance regarding the monitoring of detainees during such transfers.

One result of UKBA's transfer policy is that FPs in locations close to the main custody suites may have significantly more direct experience of the assessment of SIDTs than FPs working in other locations who encounter this population of detainees less frequently. Should the detainee be referred to hospital, UKBA officials are required to be with the detainee for the duration of the hospital stay. Were hospital referrals/admissions to become more frequent, this would potentially have implications in terms of workforce and service capacity for both UKBA and the Health Service.

The Risks of Internal Drug Concealment

Individuals naive to any substance that they are carrying internally are at increased risk from the effects of package leakage, whereas habituated users will have some tolerance to the effect of the drug(s) they conceal. In the event of a package leak, even habituated users are at risk from large doses of internally concealed drugs. The Expert Group was advised that this risk occurs mainly, but not exclusively, in Body-Packers, a group of SIDTs that is defined in the next chapter.

The packages can cause gastrointestinal obstruction and this complication can arise regardless of the ingested agent and in the absence of package leak. The use of constipating agents by Packers increases the risk of obstruction. Affected individuals typically present with abdominal pain, vomiting (which may become blood stained and/or faeculant) and absence of flatus or faeces rectally. Cardiovascular collapse (fast heart rate, low blood pressure, impaired consciousness) may be present. Gastrointestinal obstruction is a medical emergency requiring immediate surgical treatment in most cases, although it is sometimes possible to remove the obstructing packages without the need for an open surgical operation.

In the context of SIDTs, it is difficult to put a time course on the likely effects of any of the agents concealed or ingested, or to predict their kinetics with any accuracy. As long as a leaking package is present in the body, it will act as a drug reservoir, releasing the agent(s) at an unpredictable rate. Single, or multiple, packages may leak. A detailed review of the clinical pharmacology and toxicology of the drugs usually concealed by SIDTs is outside the scope of this guidance.

A Typical Pathway

It is useful to outline a typical sequence of events that follows the apprehension of a SIDT, to remand in custody at Heathrow Airport. The following diagram illustrates this pathway:

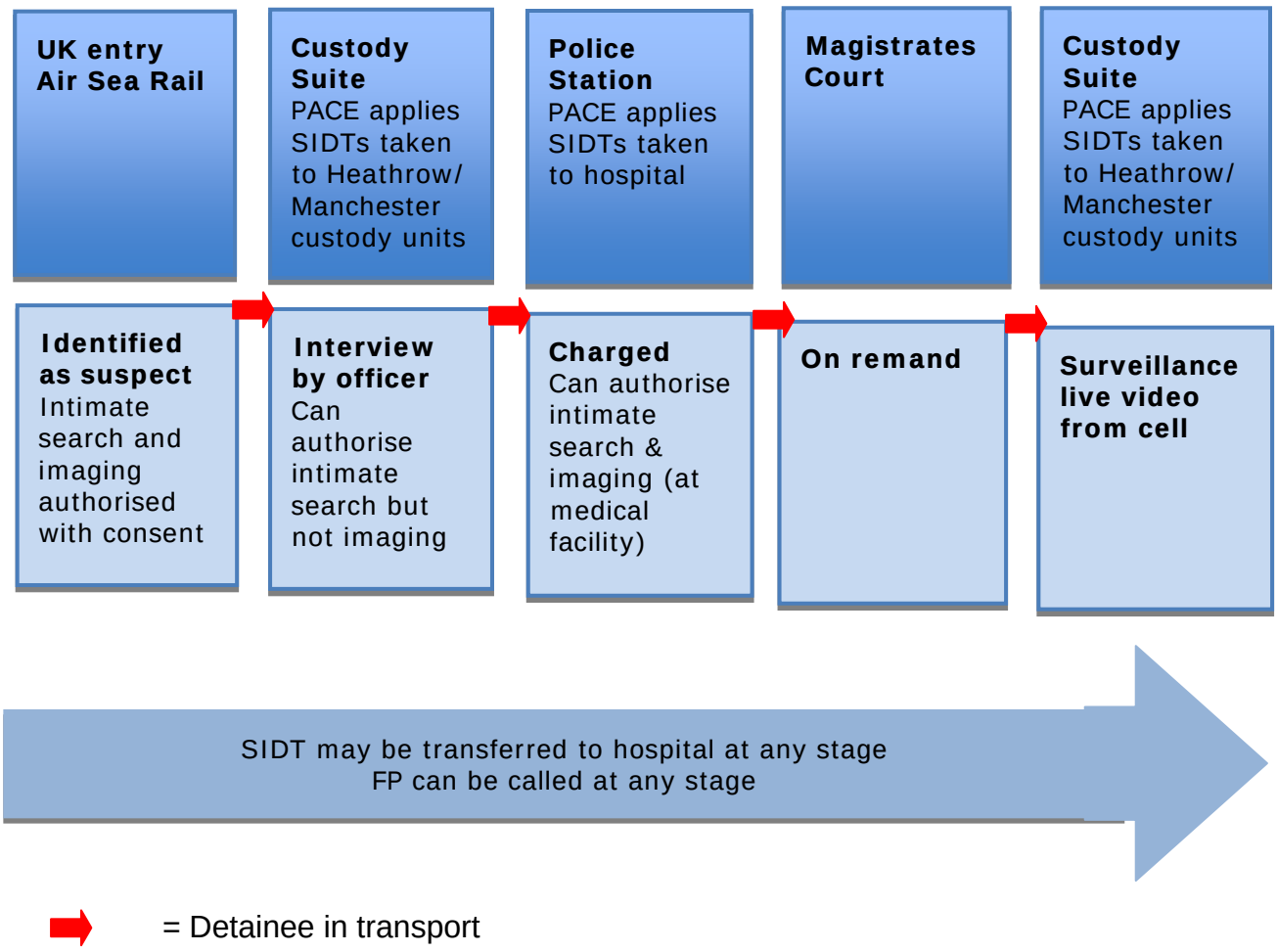


Diagram 1 Pathway taken by detainee from identification as SIDT to remand in custody at Heathrow

The initial intervention is at the UKBA control desk where a suspect passenger will be stopped and questioned, and a search of their baggage carried out. If an individual is suspected of smuggling drugs internally, they may be asked to consent to a scan using low dose X-ray technology, which is available at the airport and operated by UKBA officers. Alternatively, or in addition, officers can authorise, with the consent of the suspect, a urine sample for testing. This procedure is

normally carried out under section 62 of PACE on suspects who have been arrested and notified of their rights as set out in the PACE Codes of Practice. UKBA officers can also authorise intimate searches.

If UKBA suspicions have been confirmed by X-ray results, the individual will be arrested and transferred to the Colnbrook custody suite at Heathrow. SIDTs already under arrest will be transferred if a urine sample has confirmed the presence of drugs. The receiving Custody Officer will then ascertain if there are adequate grounds for detention and complete a custody record that accompanies the detainee wherever they are moved. A Person Escort Record (PER) form is also completed whenever the detainee is moved, and accompanies them in transit. The PACE Act requires that detainees are made aware of, and have access to, legal and medical advice without prejudice or unnecessary delay. It also requires that competent and independent language translation is made available.

At this point a SIDT would be assessed by a FP if:

- Additional health problems arise. For example, detainees are not allowed to self-administer drugs prescribed for pre-existing conditions whilst in custody and these must be administered by, or on instruction from, a FP.

- The detained individual shows signs of problems related to the drug suspected to have been ingested, as judged by custody staff. The Custody Officer (on the basis of Codes of Practice and their experience) will either request a FP to assess the individual; or, if they adjudge the situation to be urgent and serious, will call the emergency services and a FP simultaneously.

Next, the case will be referred to the UKBA Criminal and Financial Investigation Team based at Staines. The detainee is then assigned an Investigating Officer who will examine the evidence and interview the detainee under caution on audiotape, allowing opportunity for the detainee to make a statement. Where the Investigating Officer believes there is enough evidence to charge the individual, the case will be reported to the Crown Prosecution Service, which will review the evidence and make the decision to charge.

The detainee will then be taken to Heathrow North Side Police Station and charged with an offence of being knowingly concerned in the importation of a controlled drug, contrary to section 170 of the

Customs and Excise Management Act 1979.[12] The detainee may be held at the police station before being transferred to Uxbridge Magistrates Court where they may be remanded in custody to allow for the preparation of case papers. Where the detainee has still to pass all of the drug packages, the court will remand them back into UKBA custody under section 152 of Criminal Justice Act 1988.[13]

Access to interpreters and legal services is intended to be provided in a timely fashion. The National Register of Public Service Interpreters is centrally managed by the Ministry of Justice which holds a list of interpreters for almost every language and in many locations. The list is professionally accredited and security vetted. Access to an interpreter out-of-hours can usually be arranged, but telephone services are available if necessary. The Legal Services Commission arranges access to legal advice and solicitors, although there is some variability of access to solicitors nationally.

In producing this guidance, the Expert Group was made aware of a number of variable factors that affect the custodial pathway followed by SIDTs in the UK, leading to a potential divergence in the quality of services made available. These issues are addressed in the following three chapters and some generic elements are listed as follows:

- The location of a person when identified as a suspect;
- The availability and appropriate use of clinical investigations. For example, access to a means for obtaining and analysing blood samples, imaging facilities and expert medical opinion where appropriate;
- The distance and mode of transport from where an individual is apprehended to the place at which they are charged and remanded, including the custody suite;
- The facilities available at the point at which the SIDT is held, including the custody suite. For example, live video surveillance of cells and availability of medical equipment;
- The induction, education and training of custodial staff, particularly UKBA contractor employees, regarding the recognition of behavioural and physical signs of drug intoxication;

- The level of induction, education and training of FPs in different locations nationally;

- The consistency of policies and procedures in various locations and at various points in the custodial pathway. For example, SIDTs held by UKBA and in police custody;

- The audit and quality assurance framework for policies, procedures, induction, education and training of all involved in the care and management of SIDTs whilst in custody.

Chapter 2: The Care and Management of Suspected Internal Drug Traffickers

The Expert Group felt that a comprehensive and coordinated approach to the effective monitoring, assessment and management of SIDTs would improve safety and assure the quality of care provided to this group of detainees by UKBA. The group concluded that operationalising standard protocols and pathways of care could achieve this. As a first step, standardisation of current practice by using a combination of urinalysis, X-ray and observation of physical condition will significantly improve on current practice. Such a standardisation of process should be developed as part of the protocols for monitoring of SIDTs in UKBA custody.

This chapter provides guidance on the care and management of SIDTs in relation to the stages of the pathway that have been outlined. The chapter begins by focussing on the methods used in internal drug smuggling and the associated terminology used to describe these.

4.1 - Terminology and Methods of Internal Concealment

At present, confusion arises from the way in which responsible authorities attribute different meanings to a common lexicon that is used to describe those who conceal drugs internally, and there is a need for greater consistency.[14] It is recommended that UKBA and those in the medical profession providing clinical services to SIDTs use those terms that pertain to the specific method of concealment. These subgroups are described under the following headings, along with an overview of associated evidence relating to incidence and outcome. It is worth noting that flexibility in the approach to the investigation, management and care of individuals engaged in different forms of internal drug concealment may be required.

Body-Packers

Body-Packers may ingest large quantities of packaged drugs, as much as a kilogramme, concealed in packages varying from a small number to 200 individual packages, but normally in the range of 75-100 packages. While each package contains a potentially lethal amount of drug, these are now usually machine manufactured using a material that does not leak, resulting in a uniformity of size and weight. Four

different types of packaging have been described.[15] While heroin used to be the drug of choice for Body-Packers this has been superseded by cocaine, with packages containing approximately 5–12 grams of the drug.[16] Body-Packers sometimes ingest anticholinergics, such as diphenoxylate/atropine, to inhibit intestinal motility. This reduces potential for defecation during the journey and the subsequent loss or discovery of the drugs.[17]

Since 1999, Hillingdon Hospital has received the majority of Body-Packers from Heathrow. Between January 2000 and January 2005, 2,508 suspected Body-Packers were detained at Heathrow, of whom 590 were referred to Hillingdon Hospital and 61 admitted. Abdominal pain was the most common presenting complaint, with an average number of 70 packets swallowed/passed. The majority (92%) of those admitted were managed conservatively. Six patients were treated successfully for cocaine poisoning and 5 required surgical removal of cocaine packets. There were no deaths.[18]

A study conducted at Ashford Hospital (two miles from London Heathrow Airport) between January 1996 and December 1999 reported 572 cases of Body-Packers over a four year period.[19] Individuals assessed represented 27% of the total cases detained for smuggling by internal concealment into the UK over this period. One-hundred-and-eighty individuals were shown to be carrying packages on X-ray. Thirty-six cases were admitted with suspected overdose or gastrointestinal obstruction, of whom 7 required surgical intervention. No deaths occurred.

Other large published series of relevance are summarised in a recent review by Booker et al.[20]

Body-Stuffers

In the case of 'Body-Stuffers', drugs are usually either unpackaged or poorly packaged and as a consequence leakage may occur over the hours following their ingestion, causing significant symptoms. Some individuals also hide illicit drug packages in the rectum or vagina with the same intent (these individuals are sometimes known as 'Body-Pushers').[21] Drugs hidden by Stuffers in the vagina or rectum are less likely to cause significant symptoms, as the packages are not subject to the digestive processes. The features that develop will depend not only on the packaging, concentration and amount of the drug, but on whether the package was intended for individual use and thus presenting a lower risk, or as a 'dealing stash' intended for distribution

and so presenting a higher risk.

A study by Havis et al. of 43 drug-related deaths in police custody in England and Wales between 1997 and 2002 found that 16 were due to internal drug concealment.[22] In eight of these 16 cases, the deceased were known, or believed, to have concealed drugs by swallowing them at the point of initial contact with the police. This study identified that there were delays in identifying deterioration, variable implementation of resuscitation and that the time taken for the Forensic Medical Examiner to attend varied. The police force adopt a 'safety first approach' and usually transport those arrested after 'stuffing' to hospital without delay.

A further two studies on Body-Stuffers are by Jordan and Moriera, as referenced.[23] Although of less relevance to a UK population as methamphetamine is less commonly seen, an additional study by West dealing with methamphetamine body stuffers is also referenced.[24]

Vulnerable groups

A future analysis of the demographics of the SIDT population over the last five years would allow for the appropriate development of detailed, specific guidance for categories of vulnerability. As this data was not available to the group, we cite vulnerable groups in terms of differing characteristics with regard to physiology, pathology or mental capacity. Groups that may be vulnerable or require special consideration include:

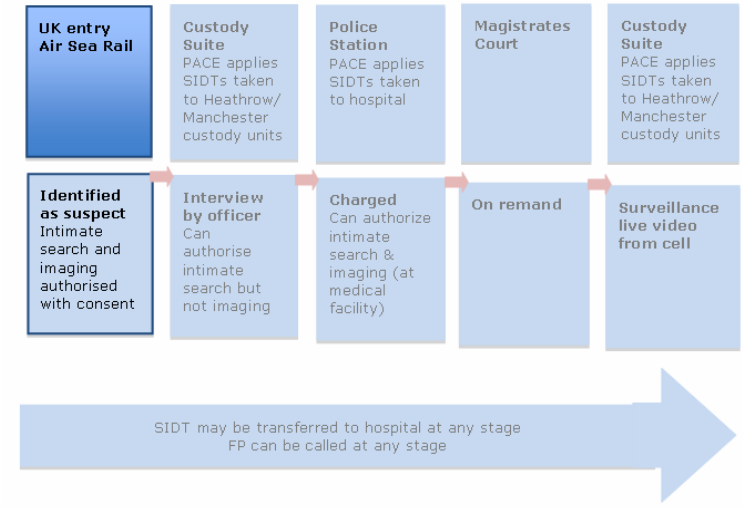
- Those lacking capacity, such as individuals with learning disabilities;
- Individuals with mental health problems;
- Children and young people;
- Those with significant pre-existing illness; and
- Pregnant women (A healthcare professional should offer women of childbearing age a pregnancy test and determine whether the woman should be referred for assessment in hospital. If a woman implies that she could be pregnant, this should be accepted to be true until proven otherwise and any decision to

refuse further investigations should be respected. No imaging tests should be undertaken without medical advice).

Whilst the group understood that SIDTs are not characteristically older people or the very young, development of specific guidance will necessitate a more extensive analysis of the particular vulnerable subpopulation of SIDTs and recorded experiences of the custodial pathway followed by such individuals. With this understanding, appropriate advice can be given with regard to the monitoring of such individuals, the location of their custody and care, and any specific requirements they may require. The development of specific pathways of care appropriate to their needs are advised as part of the overall development of protocols for the management of SIDTs.

The Expert Group recommends that UKBA should commission, with advice from Medical Royal Colleges and the UK Departments of Health, the development of detailed clinical pathways and standardised national protocols for the healthcare of SIDTs in custody. This should help to address current variability in the arrangements for the care and monitoring of SIDTs and improve the quality and continuity of their care.

4.2 - Initial Investigations



It should be noted that consent must be sought from SIDTs for any examination, medical investigations (including low dose scanners), or procedure in accordance with GMC guidance.[25] Should a detainee refuse to provide their consent for any proposed assessment or treatment, they are entitled to do so. This would have to be recorded

by the FP following an assessment to ensure that they had the appropriate capacity to make this decision. Guidance relating to the issues of consent and capacity is provided in Chapter 4.

Toxicological investigations

A FP, and hospital medical staff if the SIDT is in hospital, will advise on the appropriateness and timing of any investigations during the pathway of care, including an accurate urine test for drugs of abuse. A urine screen that is positive for one or more drugs of abuse suggests that either the patient has used the drug in the previous few days, or at least one packet is leaking. It should be noted that a positive screen can also arise because of surface contamination of packages. A negative screen strongly suggests that no packet is leaking. Screens should be performed immediately if the patient develops features of intoxication, or otherwise on a daily basis to confirm the diagnosis. However, the priority in those who develop intoxication is clinical management and stabilisation and a drug screen should not delay their management.

While a negative drug test is helpful, a positive test should be interpreted with caution as it does not necessarily indicate package rupture or that the patient is at higher risk.

Radiological Investigations

At the beginning of the custodial pathway, an individual suspected of smuggling drugs internally may be asked to consent to a scan using low-dose X-ray technology.

The advent of low-dose 'body scanners' has changed the investigation pathway, substantially increasing the use of imaging in drug package detection. These machines can be situated in an airport terminal or other appropriate location, do not require the transfer of the subject to a hospital X-ray department, and use a much lower radiation dose than is involved in conventional radiography, typically 0.25 – 3 microsieverts. Nevertheless, all such exposures are subject to Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R), including:

(i) The need for all such exposures to be justified and optimized;

(ii) The need for written protocols and procedures governing the use of such equipment;

(iii) The need in particular for a written policy defining the range of circumstances under which an individual is scanned and the place of this test within the overall detection process. For example, to consider what, if any, other tests should be performed and the results available before scanning;

(iv) Referral to be made by a registered health professional;

(v) Entitlement of the operators with a defined scope of practice by the employer;

(vi) Appropriate training for operators;

(vii) Clear definition of responsibility for clinical evaluation of the images;

(viii) The retention of records of the exposures and of their clinical evaluation;

(ix) The appointment of a Medical Physics Expert as well as the Radiation Protection Adviser appointed under Ionising Radiation Regulations 1999 (IRR99).[26]

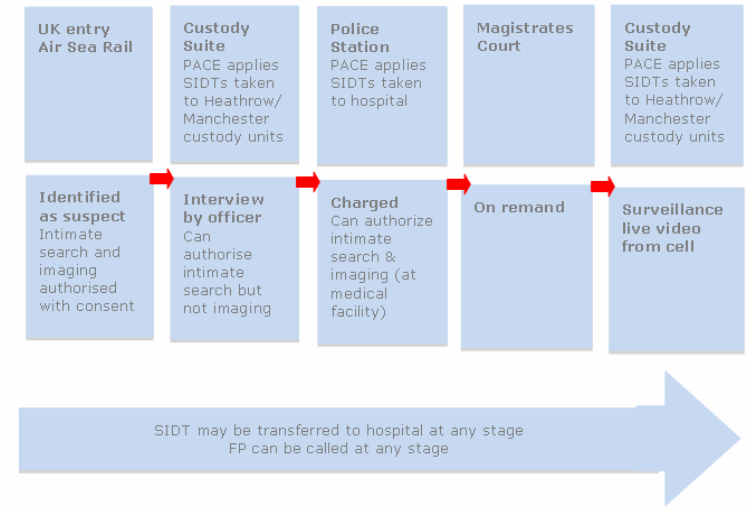
The accuracy of low dose body scanners for drug package detection is currently unknown and, to the Expert Group's knowledge, no direct comparison between this technique and conventional radiography has been performed. False positive tests are known to occur, usually in individuals with constipation, but no data are available with regard to their frequency. The false negative rate is also unknown.

As a result of the direct observations and discussions of current practice in the use of low dose body scanners in non-hospital settings, the Expert Group recommends that UKBA should review compliance with Ionising Radiation regulations, particularly with respect to the use of low dose body scanners and other equipment used outside health care settings.

The IR(ME)R regulations require that a referral for imaging comes from a registered health professional. The way in which this requirement is met in the environment in which UKBA officers are

working needs to be clarified. One option may be that a senior medical officer could be approached to agree a list of criteria against which the UKBA official might assess an individual's suitability for imaging. In essence, the medical officer would be delegating the task of referral to the UKBA officer but would need to be confident of the officer's competence to carry out that task; the medical officer would retain responsibility in law for the referral. This potential solution could be discussed with the relevant IR(ME)R Inspectorates in England and the devolved administrations.[27]

4.3 – Transport of Detainees

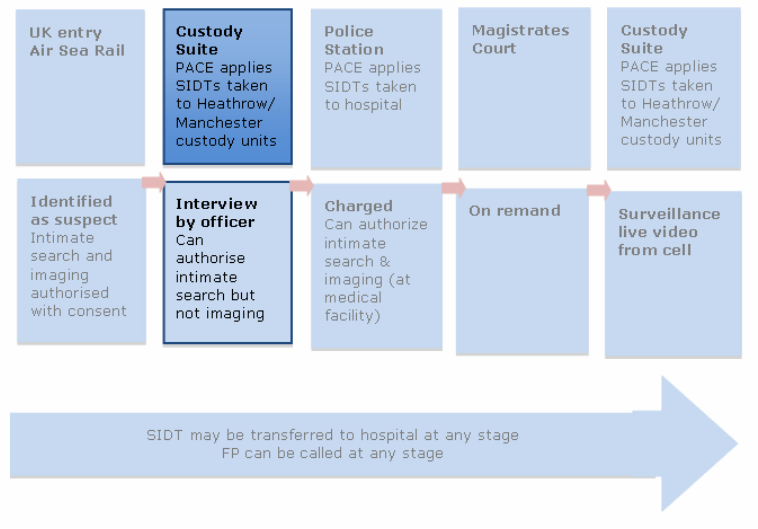


As has already been outlined, SIDTs are physically transported from one setting to another at different stages of the custodial pathway; for example, from the point of apprehension to the custody suite. A number of recommendations are of relevance to this. Recommendations 3 and 4 address the development of detailed clinical pathways and the need to ensure that custodial staff, including those accompanying SIDTs in transport, are appropriately trained and able to apply a custodial early warning score, as detailed in the following section. As detailed in the previous chapter, UKBA officials do not routinely seek the advice of a FP prior to the transfer of a detainee, and this might be reviewed as part of the development of the pathways.

A latter recommendation, Recommendation 9, addresses the options for reducing the number of occasions on which a SIDT is in transit between locations. Whilst geographical co-location of different stages

of the pathway would be challenging, UKBA may wish to consider whether it is possible to do so.

4.4 – Detention in a UKBA Custody Suite



Modified Early Warning Score Systems

The use of early warning systems is now widespread in clinical care, with Modified Early Warning Score (MEWS), or Patient at Risk, processes adopted widely in Emergency Departments in the UK.[28] MEWS is a form of track and trigger scoring system that is based on routine observations. It has been demonstrated to be an effective triage tool in the acute setting, with higher admission MEWS correlating with increased risk of death, CCU/ICU admission to a critical care or intensive care unit, and longer hospital stays independent of patient age.

Early warning scoring systems were originally developed with two specific aims: to facilitate timely recognition of patients with established or impending critical illness; and to empower nurses and junior medical staff to secure experienced help through the operation of a trigger threshold which, if reached, required mandatory attendance by a more senior member of staff.[29] The MEWS score can detect subtle changes in physiology, which will be reflected in a change of score should the patient's condition improve or deteriorate. MEWS is supported by the Royal College of Surgeons and the Association of Anaesthetists of Great Britain and Ireland, and was a recommendation of a recent National Confidential Enquiry into Patient Outcome and Death (2005) study and report. The Resuscitation

Council UK also published guidelines and recommendations in 2010 that included reference to EWS, and EWS are mentioned in the Audit Commission Report of 1999.[30]

MEWS is based on data derived from four physiological readings (systolic blood pressure, heart rate, respiratory rate and body temperature), and one observation (level of consciousness). The resulting observations are compared to a normal range to generate a single score. A score of five or more is clearly linked to increased likelihood of death and admission to an intensive care unit.[31] Analysis of the critical events preceding a number of adult cardiac arrests demonstrates significant antecedents, usually related to abnormalities of the airway, breathing, and circulation.[32]

MEWS processes allow an evidence-based risk stratification of patients and also the anticipation of possible deterioration of patients.[33] Heart rate, respiratory rate and oxygen saturation readings have been shown to be able to detect early deterioration.[34] An improvement in serial MEWS within four hours of presentation to hospital predicts improved clinical outcomes.[35] However, MEWS is not a comprehensive clinical assessment tool or a replacement for clinical judgment and is validated only for adult patients. The MEWS/observation of physical signs should be undertaken regularly and documented on a standardised patient observation chart.

A Custodial Early Warning System (CEWS) could be developed as an adaptation of MEWS, with incorporation of the RCUK recommendations to the custodial environment utilising those validated measurements to assist custody staff in making appropriate and timely judgments. Additional parameters might be included to encompass the different environment and presentations that relate to custody. A CEWS could, for example, rely on the regular monitoring and recording of blood pressure, pulse, temperature, AVPU scale for the assessment of consciousness - as an appropriate substitute for the Glasgow Coma Score (GCS), and respiratory rate. Physical examination is the most important component as any deterioration warrants immediate hospital attention. Hospital staff could be provided with a CEWS proforma, as the usual hospital monitoring processes may not identify drug intoxication.

The Detention of SIDTs in Custody

The Expert Group recommends that the development of detailed clinical pathways and standardised national protocols for the healthcare of SIDTs in custody should include a modified version of an early warning system for the custodial environment, a Custodial Early Warning System (CEWS) as described above, and that Body-Packers should be only detained in custody if constant observation with CEWS scoring can be provided and any observed changes acted upon immediately. A fuller Modified Early Warning System (MEWS) should be used in health care settings where a wider range of physiological variables can be monitored by healthcare staff.

The Expert Group concluded that Body-Packers in particular should only be detained in custody if:

(i) Twenty-four hour observation with a modified early warning system (CEWS) can be provided and any observed changes acted upon immediately;

(ii) There is rapid access to an emergency department with 24/7 acute surgical facilities;

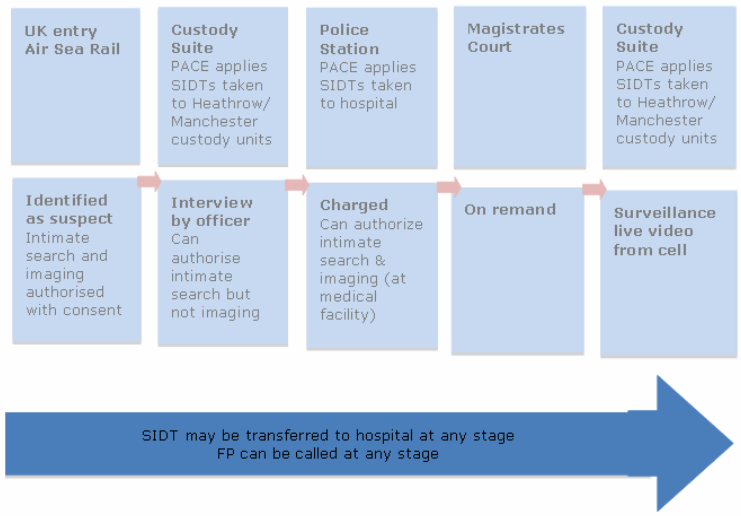
(iii) Custody staff are suitably trained (healthcare Professionals should hold an Immediate Life Support certificate); and

(iv) All necessary emergency drugs and equipment are provided and staff are fully trained to use the equipment and to administer these drugs.

If these facilities and trained staff are not available twenty-four hours a day seven days a week, Body-Packers should be referred immediately to an emergency department with acute surgical facilities available, as this group of SIDTs are at particularly high risk. As Body-Packers who have not passed drug packets by the fifth day following ingestion are at a higher risk of intestinal obstruction, they should be referred for hospital assessment at this time. Finally, in the development of clinical pathways, consideration should be given to the circumstances that give rise to the assessment of SIDTs. At present this is dependent upon the condition of the individual, but thought could be given as to whether it is necessary for all SIDTs, regardless of

their presenting condition, to be assessed by a FP.

4.5 - Management of SIDTs while in UKBA Custody in a Hospital



In developing pathways of care in custody, UKBA and the Royal College of Physicians' Faculty of Forensic and Legal Medicine should take account of the specific investigations and interventions that can only take place within the setting of a hospital. Whilst the following detail does not represent a comprehensive guideline for the care of SIDTs in a hospital setting, it reflects some of the considerations for their care and management that would need to be made.

Radiological investigations

The role of imaging is confined to Body-Packers as it has a limited role in the care of Body-Stuffers and Pushers. Imaging is used for two distinct purposes in the care of suspected Body-Packers: The investigation of suspected complications of drug concealment in a symptomatic individual, and the detection of drug packages in an asymptomatic individual. When used in the context of a patient with abdominal symptoms due to obstruction, the imaging pathway will be the same as for any other patient with suspected bowel obstruction, perforation or other abdominal catastrophe. The principal techniques used will be plain radiography of the chest and abdomen, ultrasound and computed tomography (CT) scanning.

The use of radiographic imaging for purposes of detection of drug packages in an asymptomatic individual constitutes a medico-legal

radiation exposure and is subject to the IR(ME)R regulations, as outlined earlier in the chapter. Such an exposure may only be carried out with the consent of the subject and should be avoided in pregnant women. In addition, abdominal X-ray should be avoided in the second half of the menstrual cycle if there is a possibility that a woman could be pregnant.

The accuracy of different radiographic techniques for drug package detection has been investigated and factors that have been shown to influence the likelihood of detection include:

(i) The number and size of the packages;

(ii) The package density;

(iii) The position of the packages;

(iv) The time of ingestion relative to time of radiography;

(v) The body habitus of the subject; and

(vi) The degree of suspicion by the observer.

Reports of the sensitivity of plain radiography vary from 47-90%.[36] One difficulty is that the false negative rate cannot be established as an asymptomatic individual with a reported negative radiograph is usually discharged without follow-up.

The role of ultrasound remains unclear. It has been reported to be of similar accuracy to abdominal X-ray and to be far less accurate than CT.[37] CT is very accurate with detection rates of 96%, but has rarely been employed in asymptomatic individuals due to the higher radiation dose involved.[38] Recent studies on CT by Yang and Sengupta have been considered.[39] At present CT should be reserved for serious and life-threatening conditions such as bowel obstruction, because of the high radiation dose involved, but the future development of low dose CT techniques may cause this view to be revised.

Removal of packages in Body-Packers and Body-Stuffers

In the past, early surgery was advocated in Body-Packers once the diagnosis became apparent. However, with the development of

improved packaging, a more conservative management approach can now be adopted, unless symptoms develop. Literature shows that there is a complication rate of less than 5% with this more conservative approach.[40]

Immediate surgery is indicated if acute intestinal obstruction develops, or when packets can be seen radiologically and there is radiological, clinical or analytical evidence to suggest leakage - particularly if the drug involved is a central nervous system stimulant, such as cocaine.[41] In this situation, the clinical consequences of poisoning are more serious and management is more difficult than for opioids (for which an infusion of an opiate antagonist) or cannabis. A high rate (40%) of postoperative wound infection has been found, which was correlated with the number of enterotomies.[42] It is recommended that investigations be performed postoperatively to discount the possibility of missed packages.[43]

Packets that remain in the stomach may be retrieved by endoscopy and by inducing emesis, but these are potentially dangerous procedures and are best avoided.[44] Optimal management of patients with packets in the small bowel is uncertain and conservative strategies have their advocates.[45] If there is no clinical, analytical or radiological evidence to support leakage, the use of sorbitol or lactulose, with or without bowel stimulants (for example, Bisacodyl) to encourage transit through the gut, is successful in many cases. Alternatively and, for faster results, whole-bowel irrigation using polyethylene glycol electrolyte solutions can be used.[46] Liquid paraffin should not be used because it can weaken rubber, leading to bursting of the packets. Activated charcoal has been advocated by some, but induces constipation when used in substantial doses to surround a large number of packages, and is therefore contraindicated. It may be useful in individuals with package rupture whilst stabilising for surgery.

Packets in the colon or rectum are probably best managed by giving Sorbitol or Lactulose and allowing them to pass spontaneously, with least risk of rupture. Packets in the vagina can usually be removed manually and with ease.

In Body-Stuffers, packets in the vagina and/or rectum can usually be removed manually.

Recommendations

1. UKBA and healthcare professionals should use agreed and consistent language and terminology, pertaining to specific methods of smuggling, when referring to the population denoted as SIDTs.

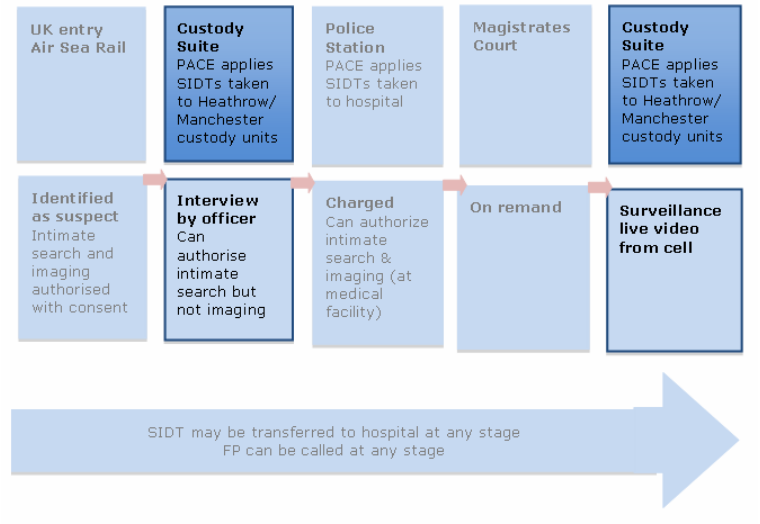
2. UKBA should review compliance with Ionising Radiation regulations, particularly with respect to the use of low dose body scanners and other equipment used outside health care settings.

3. UKBA should commission, with advice from Medical Royal Colleges and the UK Departments of Health, the development of detailed clinical pathways and standardised national protocols for the healthcare of SIDTs in custody. These pathways should include a Custodial Early Warning System (CEWS) for use in the custodial environment, and conventional Modified Early Warning System (MEWS) for use in health care environments; guidance on rapid access referral for transfer of SIDTs to appropriate receiving hospitals/provider units; and detail specific circumstances when medical or other healthcare professional advice should be sought. Attention should also be given to the care of SIDTs with mental health issues or impaired capacity, women who may be pregnant, minors and other vulnerable individuals.

Future decisions regarding the commissioning of health services relating to individuals in UKBA custody will be assisted by the development of such clinical pathways and protocols.

4. Body-Packers should be only detained in custody if constant observation with CEWS scoring can be provided and any observed changes acted upon immediately. There must be available rapid access to an emergency department with acute surgical facilities and all necessary emergency drugs and equipment available twenty-four hours, seven days a week. Staff should be fully trained to use both the equipment and to administer these drugs. If these facilities and trained staff are not available, Body-Packers must be referred immediately to an emergency department with acute surgical facilities available twenty-four hours, seven days a week.

Chapter 3: UK Border Agency: Environment, Staffing and Resources



UKBA informed the group that the majority of Body-Packers arrested in London are held in the detention unit at Colnbrook, which has extensive CCTV and provision for the twenty-four hour supervision of the detainees. However, several problems exist with the detention centre, with the first of these being that a patient trolley cannot be accommodated in the lift. As the unit is on the third floor, this impedes the rapid transfer of a moribund patient and means that any ongoing resuscitation would have to cease during transfer. There is also limited medical equipment available and Health Care Professionals (HCPs) are not based on site.

Detainees suffering a cardiac arrest due to internal concealment of illegal drugs are likely to require more advanced medical intervention such as intubation, drugs or surgical intervention and the detention centre is a substantial distance from the nearest emergency department (Hillingdon Hospital) with the journey taking about twenty minutes at best. Basic Life Support is not a current requirement for UKBA Custody Officers and while medical staff are available in a neighbouring immigration suite, their level of training is undetermined.

Using Colnbrook as an example, this chapter makes recommendations on the appropriate facilities and equipment that should be made available in all UKBA custody suites. The chapter also addresses the training of UKBA staff, both permanent and contracted, and considers the monitoring of detainees whilst in custody.

Investigating Officers suite at Heathrow

The custody facilities at Heathrow and Manchester include in-cell CCTV allowing twenty-four hour remote detainee monitoring of detainees, something that is also available at Dover, and special toilet facilities that allow for the hygienic recovery of packages. These facilities are also available at Gatwick, which is used as an auxiliary custody suite. A full list of the facilities available at Colnbrook includes:

- A video surveillance room;
- Twenty detention cells, four with en-suite facilities for detainees other than SIDTs;
- A specialised toilet unit in the detention cells for recovery of samples for testing;
- Facilities for less able bodied detainees
- EMIT room for Enzyme Multiplied Immuno-Assay Test; and
- Two fridges with chemicals and storage space for DNA samples.
- Exercise yard

When visited in 2010, the Investigating Officer's suite at Colnbrook included a room for a FP with a desk, basic medical equipment and an examination couch. Whilst the FP provides necessary medical equipment, usually bringing a doctor's bag, other equipment included:

- An Automated External Defibrillator;
- Drugs, including: analgesic and non-steroidal anti-inflamatory agents (Dihydrocodeine, Diclofenac, Mefenamic acid); a minor tranquilliser (Diazepam); an anti-anginal agent (Glyceryl trinitrate); a proton pump inhibitor (Omeprazole); a hypnotic (Temazepam); an antibiotic (Amoxycillin) an antihistamine (chlorpheniramine); nicotine patches; laxatives (Lactulose), and suppositories.

If a detainee requires medication for any existing medical problem, the FP will provide a prescription. It is the responsibility of the detention staff to obtain the prescribed medication in a timely way.

The Expert Group recommends that a standard list of medical equipment and medication should be provided in custody suites where SIDT are held. The medication and equipment provided (including automatic defibrillators) should be in stock, in date, and serviced according to the manufacturer's specification.

Training for UKBA Staff

SIDTs are held in custody in a number of differing environments supported by a variable mix of permanent and contracted staff with varying levels of experience. On the evidence provided by UKBA and HMRC, the training for each staff group differs.

Training of UKBA Custody Officers

UKBA Custody Officers carry out procedures in line with the PACE Act regarding any detainee. The Custody Officer is the person in charge of the custody suite and is trained and designated as such under section 36 of PACE. Induction for new Custody Officers is not formal, but rather they will spend some time being mentored and working with an experienced colleague. UKBA custody officers are not trained in first aid.

UKBA provides training for Custody Officers, which includes:

- *UKBA Custody Duty of Care* - This package highlights the duty of care the Custody Officer has towards detainees;

- *UKBA Custody Medical Care* - This package is designed to enable the Custody Officer to understand the importance of medical care in detention;

- *UKBA Secondary Examination Area Training Internal Concealments* - This package identifies the indicators associated with internal concealments and the procedures to be followed in dealing with a passenger suspected of carrying drugs internally; and

- *UKBA Custody Special Groups* - This package covers the correct way of dealing with Special Groups. For example, juveniles; mentally disordered or mentally vulnerable persons; illiterate persons; blind or deaf persons; and non-English speaking persons.

Training of UKBA Contracted Staff

Training and induction arrangements for UKBA contractors at present include:

- The legal framework including documentation;
- First Aid to approved standards/control and care of the prisoner/detainee;
- Identification of, and procedures for dealing with, vulnerable detainees;
- Security procedures for dealing with vulnerable detainees;
- Control and restraint procedures, including awareness on the use of handcuffs;
- Escorting procedures;
- Suicide awareness;
- Record keeping, including witness statements and custody/remand entries;
- Health and safety;
- The searching of detainees, rooms and vehicles;
- Giving evidence in court; and
- Food hygiene.

UKBA contractor SERCO have informed UKBA that all current Custody Support Officers will undergo refresher training at intervals of no more than two years, with some aspects being delivered on an annual basis.

The refresher training will comprise a minimum of two days for control and restraint, three to four days for first aid and four days for general custody training.

Where similar circumstances pertain in other parts of the country, UKBA contractor staff are not used. In such circumstances, customs officials take on this role (as they did at Heathrow before UKBA contractors undertook this).

The lack of permanent staff with consistent and detailed training in custodial issues was of concern to the Expert Group, as was the quality of training provided and the ability of staff to identify deterioration in the condition of detainees.

It is therefore recommended that appropriate training for custody staff, both permanent and contracted, should be introduced as a part of the standardised national protocols for the care of SIDTs outlined in Recommendation 1. This should include the use of CEWS, and be introduced to allow for the identification of individuals at high risk, the adequate monitoring of detainees, and the early identification of signs of toxicity. UKBA should also ensure that staff are competent in recognising signs of drug intoxication, including acute cocaine toxicity, as well as understanding the requirements of duty of care. All custodial staff (permanent and contracted) should be trained in Basic Life Support, recognition of the signs and symptoms of drug intoxication and other common clinical conditions. Finally, a protocol should be developed which defines the circumstances when custody staff should seek advice from a FP.

Current arrangements for Monitoring SIDTs in UKBA Custody

UKBA contractors (SERCO since 2005) provide staff to act as jailers. These individuals are selected from a cohort with a low turnover of personnel and are trained by the UKBA contractor according to a template provided by HM Customs and Excise (HMCE), which originates from when the initial system was designed. The staff observe detainees by viewing live video relayed from custody cells, with all video recorded and held for 30 days. The Custody Officer will review the videotape or visit the detainee in their cell to investigate, should they exhibit signs, or behaviour, of concern.

Procedure documents for staff which were supplied to the group by UKBA, recommend observation for signs such as dilated pupils and

sweating. While the video may allow assessment of unusual behaviour or restlessness, other physical signs of drug intoxication such as dilated pupils and/or increased sweating would not be evident. The documents refer to 'irregular behaviour', which was described on the visit to Colnbrook to include evidence of suspicious movement under blankets, efforts by detainees to reach underneath their clothing and attempts to covertly pass packages. If such behaviour were witnessed on video surveillance, HCPs and an ambulance would be called, depending on the custodial staff's assessment of the urgency of situation.

Enhancing Current Monitoring and Surveillance

One option for improving the observation of SIDTs in UKBA custody would be to refer all such cases to a hospital unit for assessment, something that would represent a significant change to current arrangements. An alternative would be the development of a small number of specialist units attached to hospitals, incorporating arrangements for temporary custody and the medical observation of SIDTs. This represents the safest option for medical care in concentrating specialist facilities and expertise, but would require significant change to current arrangements, including the creation of such facilities with a co-located (temporary) custodial environment.

As recommended in the preceding chapter, the Expert Group suggest that a Custodial Early Warning system would provide a more formalised and clinically orientated observation process, which should be undertaken by adequately trained and fully resourced UKBA staff and contracted health professionals in current settings. This recommendation should be implemented as soon as possible to identify circumstances in which SIDTs should be transferred immediately to hospital whilst the other two policy options described above are considered.

Ensuring the Safety of UKBA Staff

The employer's duty of care is broad and extends to both those being detained and those caring for detainees. The health and safety of both is laid out in legislation and associated Codes of Practice and guidance. The Management of Health and Safety at Work Regulations 1999 are especially relevant as these describe the duty to assess and control risk.[47]

In relation to detainees, employees face four groups of health risks:

- Violence (from aggressive detainees);
- Mental pressure;
- Infection risks arising from countries of origin; and
- Infections risks arising from contact with body fluids.

Officials are trained in managing aggressive detainees and to deal with the mental pressures associated with their work.

Support should be in place for officials to promote and maintain their psychological wellbeing. This support should conform to the recommendations in the recent NICE Guidance on Promoting Mental Wellbeing in the Workplace.[48] An important component of this is to make sure that employees are aware of, and have access to, support in response to stressful incidents in the workplace.

The infection risks arising from contact with international travellers are usually small and are not unique to contact with SIDTs. An exception is tuberculosis, which is a recognised risk in detention facilities and is a disease that is relatively common in travellers from some areas. The main infection risks arise from potential contact with enteric agents (in the handling of materials contaminated with faeces), and from potential agents associated with blood-borne diseases. Detainees may be drug users, and inadvertent exposure to blood or bodily fluids may place the staff at risk. As such, a protocol for post exposure prophylaxis (hepatitis and HIV) should be in place for staff.

Good hygiene measures, including the use of personal protective equipment, prevent enteric diseases. Similar measures minimise the likelihood of infection by blood borne viruses. Where an employee is directly exposed to body fluids, for example from a bite, scratch, contaminated sharp, or body fluid splash on a mucous membrane, urgent advice should be sought from a specialist in occupational medicine, microbiology, or emergency medicine. It is important that staff are familiar with the local procedures for dealing with body fluid exposure. Those caring for detainees should be immunised against hepatitis B and tuberculosis.

Forensic physicians with differing experience of SIDTs

FPs working in different settings and geographical locations in the country have different experience of SIDTs. Some will frequently encounter such individuals and others less frequently. In order to assure a common level of essential knowledge and skill for FPs working in this area the Expert Group recommend that the Royal College of Physicians, through the Faculty of Forensic and Legal Medicine, develop a postgraduate education programme for FPs, covering the medical care of SIDTs in custody. This should be considered as a mandatory element of Continuing Professional Development for those in the specialty working in environments where SIDTs may be encountered. This is in order to ensure that FPs working in different settings have a common level of essential knowledge and skill.

Recommendations

5. A standard list of medical equipment and medication should be provided in custody suites where SIDT are held. The medication and equipment provided (including automatic defibrillators) should be in stock, in date, and serviced according to the manufacturer's specification.

6. Appropriate training for custody staff, both permanent and contracted, should be introduced as a part of the standardised national protocols for the care of SIDTs in Recommendation 3. This should include the use of CEWS, and be introduced to allow the identification of individuals at high risk, the adequate monitoring of detainees, and the early identification of signs of toxicity.

7. UKBA should ensure that staff are competent in recognising signs of drug intoxication, including acute cocaine toxicity, as well as understanding the requirements of duty of care. All custodial staff (permanent and contracted) should be trained in Basic Life Support, recognition of the signs and symptoms of drug intoxication and other common clinical conditions.

8. All Health Care Professionals working in UKBA environments should ensure that they hold a current Immediate Life Support (ILS) certificate with additional training in the recognition and management of conditions presenting in custody.

9. Consideration should be given to the feasibility of developing a small number of specialist units attached to hospitals, which incorporate arrangements for temporary custody and the medical observation of SIDTs. This represents the safest option in that it would concentrate specialist facilities and expertise in a few sites, but would require significant change to the current distributed arrangements, including a co-located (temporary) custodial environment.

10. The Royal College of Physicians, through the Faculty of Forensic and Legal Medicine, should develop a postgraduate education programme for FPs, covering the medical care of SIDTs in custody. This should be considered as a mandatory element of Continuing Professional Development for those in the specialty working in environments where SIDTs may be encountered in order to ensure that FPs working in different settings have a common level of essential knowledge and skill.

Chapter 4: Ethical Considerations

People who are identified and detained by UKBA as SIDTs are a mixed population. UKBA note that the SIDT population includes individuals acting as 'professional couriers' who are fully cognisant of the potential implications of their actions, and who conceal drugs internally, sometimes on repeated occasions. However, some SIDTs may be vulnerable, falling into those groups defined in chapter 2. Some may have been subjected to coercion or other pressures, and there may be a perceived risk to their own safety as well as that of their families if they admit to carrying packages of drugs. Such individuals often have no understanding of the legal and health system in the UK and may fear the consequences of any admission of information. SIDTs may not have English as a first language, or even speak it at all. Even where English is spoken or understood, illiteracy may affect the person's ability to understand the process. In view of these factors, the initial management of such individuals is crucial and their welfare should be the primary concern of all those who come into contact with them in a professional capacity, informed by current national guidance.[49]

Some general principles apply:

- SIDT in UKBA custody are entitled to receive the same standard of health care as any other patient;

- Those providing treatment and care must be aware of the obligation to respect the person's human rights (for example, right to life (Article 2), right to private and family life (Article 8), and be conscious of how these rights can be compromised;[50]

- When undertaking assessments of SIDTs, providing advice and undertaking investigations or treatment, doctors and other healthcare professionals are subject to the same ethical and professional standards as they are for all other patient groups. All healthcare professionals must follow the standards set by the professional regulators (for example, The General Medical Council, The Nursing and Midwifery Council), including in relation to consent and confidentiality;[51]

- Healthcare professionals responsible for providing care to SIDTs must recognise and work within the limits of their competence and keep their knowledge and skills up to date.

The following paragraphs set out how these principles apply in relation to a range of relevant factors, including access to information, meeting language and communication needs, obtaining consent, and respecting confidentiality.

Access to Information

Detainees must have access to information concerning their rights and entitlements in a format and language that they understand, as well as access to legal and medical advice and care. Detainees in UKBA custody should be given information in a way that they can understand as early as possible about:

- Any medical assessments or procedures that they will be asked to undertake (for example, X-rays, CT scans), the purpose of these and what they will involve;

- The roles and responsibilities of those undertaking any clinical investigations or procedures or providing medical advice, care or treatment;

- Their right to confidentiality and any limits on this;

- How medical care will be provided and decisions made about their care. For example, whether they need to go to hospital;

- The health risks of concealing drugs internally and what can be done to minimise these risks (for example, taking food and water);

- The right to refuse to agree to undertake any investigation or treatment, and any consequences of such a refusal.

Language, advocacy and communication

As outlined at the beginning of this chapter, literacy problems may affect detainees' ability to understand the process into which they enter. The importance of communicating information in a way that people can understand is crucial.

This may require information to be given to people in different formats and indicates that the need for access to interpretative and communication support might need to be reconsidered. Arrangements

surrounding provision of information and the identification of the need for an independent advocate should be reviewed. Where a detainee is perceived to be vulnerable in any way, PACE Code C requires the provision of an 'appropriate adult' who will fulfill this independent advocacy role. Language translation should be provided in an independent manner.

The provision of a standardised leaflet to all detainees, made available in several languages and describing the custodial process, the law in the UK, medical risk and possible interventions, is advised.

Confidentiality

All detainees have a right to confidentiality, but it is not an absolute right. Doctors and other healthcare professionals owe a legal duty of confidentiality to their patients.

The detainee should be informed about how information about them (including information they disclose to a UKBA official, nurse, FP or hospital doctor) will be used, to whom it may be disclosed to and for what purpose, and of any right they have to object.

Consent

Key principles regarding consent include:

- Respect for the individual's right to determine what happens to their own body (autonomy) is a fundamental principle of good practice;

- Valid consent requires the individual patient to be competent, informed and not under duress;

- Adults should be assumed to have capacity to consent to a proposed investigation or treatment;

- A competent adult has the right to refuse any investigation and treatment and cannot be treated against their will unless they require compulsory treatment for a mental disorder (under the relevant mental health legislation in the UK).

Individuals should understand that they can change their mind about consenting to a course of investigation and treatment. Difficulties may be encountered in ensuring that decisions are voluntary, a full exploration of the issues and guidance is provided by the General Medical Council.

Capacity

Where there is doubt about an individual's capacity, an appropriate assessment of capacity should be carried out by the Forensic Physician in the first instance. Where someone is assessed to lack capacity to make a particular decision, decisions must be made in accordance with the law (Mental Capacity Act, Adults with Incapacity (Scotland) Act and the common law in Northern Ireland.)[52]

Key issues in considering capacity are that:

- Capacity is decision specific (i.e. the person must have the capacity to make the particular decision at the particular time);
- A person must be assumed to have capacity unless proven otherwise;
- Where there is doubt, capacity must be properly assessed;
- If a person is assessed to lack capacity, they must be treated in accordance with the law (see above); and
- Capacity must be monitored in situations where it may be fluctuating.

Detainees who lack capacity can be treated in their 'best interests', under the Mental Capacity Act 2005 in England and Wales and the common law in Northern Ireland, or for their 'overall benefit' under the Adults with Incapacity (Scotland) Act 2000.[53] Decisions made in a patient's best interests or overall benefit should take account of that patient's own likely wishes. Patients cannot be given treatment for which they have made a valid advance refusal, unless it is compulsory treatment given under mental health legislation.

Treatment for a mental disorder

The Mental Health Act 1983, as amended, in England and Wales specifically excludes compulsory treatment in prison, as does the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Mental Health (Northern Ireland) Order 1986.[54] If a detainee is suspected to have a mental disorder requiring treatment, they should be transferred out of the prison or detention setting as soon as possible and transferred to an appropriate setting for assessment and treatment.

Raising concerns

All healthcare professionals have a duty to raise concerns if they feel that patient safety is at risk for whatever reason, and the GMC and Nursing and Midwifery Council have issued guidance on this matter.[55] Initially, the healthcare professional should raise the matter with the appropriate person in the employing or contracting body, and the organisation's policy and procedure for raising concerns should be followed.[56]

Recommendations

11. UKBA should review current information supplied to detainees and arrangements for independent advocacy and respect for human rights.

By reviewing current arrangements, UKBA should ensure that an independent advocate is made available to detainees according to need and that information given to detainees covers the medical and legal aspects of detention, and is presented in an easily understandable format. All custodial and healthcare staff must be aware of the obligation to respect the person's human rights and be conscious of how these rights can be compromised.

12. Forensic physicians independently retained by UKBA must be contracted as self-employed individuals. This is in order to ensure the provision of independent and objective advice to UKBA, so that FPs may fulfil their duty of care to SIDTs in custody. A confidential consultation between the FP and SIDT in custody, in addition to the attendance of an FP that is required before an individual can be charged, will support this. Similar provisions could be considered for all HCPs providing care in custodial situations with regard to their employment status and professional standards of practice.

Conclusion & Summary of Recommendations

The recommendations contained in this guidance should prove helpful to UKBA in developing an equitable strategy for the detention and care of SIDTs, which assures the safety of the clinical care provided to them and that the correct jurisdictional process is followed.

Through the course of its work, the Expert Group found a number of areas in which improvements could be made. It identified clear governance issues for UKBA with regard to the commissioning of healthcare services and the quality assurance (QA) mechanisms used nationally and locally, as well as current QA processes which focus on adherence to jurisdictional procedure. Any commissioned clinical pathways/protocols must be in keeping with GMC guidance and requirements and UKBA should remain vigilant in ensuring that this is the case.

Issues were also found around the contracting of FPs and healthcare professionals, as well as the training of custody staff and UKBA subcontracted employees. It will be important for UKBA to ensure appropriate training for permanent and contracted custody staff as part of the protocols to be developed under the recommendations.

Whilst UKBA will be responsible for implementing the majority of the recommendations contained in this guidance, there are relevant considerations for other organisations. Alongside UKBA, The Royal College of Physicians (RCP) will need to consider how to develop the recommended clinical pathways and protocols, together with the involvement of Forensic Physicians and the Faculty of Forensic and Legal Medicine, expert toxicological advice, other national professional authorities for nurses and other Health Care Professionals, and health service providers. As any clinical pathways/protocols that are developed by the RCP should be in keeping with GMC guidance and requirements, the GMC should be kept informed and asked for advice and comment where relevant.

In implementing these recommendations, all authorities must take into account the general ethical principles to ensure that the welfare of suspected SIDTs is the primary concern of all those who come into contact with them.

As the new arrangements for commissioning health care emerge, there will need to be clarity over the commissioning of services for offender

health in the future, with clearer definition of the respective roles of UKBA and/or the NHS Commissioning Board, particularly with respect to responsibility, accountability, standards and quality of care. Further information about the NHS Reforms and Commissioning of services is given in the Background chapter.

Finally, to help predict the implications of implementing these recommendations and subsequent policy development, UKBA may find it beneficial to evaluate the available historical data on the numbers of SIDTs held annually in the different custodial settings in the UK, together with information on numbers referred and/or admitted to hospital. Evaluation of the current UKBA estate of custodial suites, transport facilities and other settings in which SIDT are managed during the pathway from apprehending to completion of detention will also be needed. This data is not collected routinely and the Expert Group was unable to evaluate these aspects fully as a consequence.

Summary of Recommendations

The recommendations of the Expert Group are listed in full as follows:

1. UKBA and healthcare professionals should use agreed and consistent language and terminology, pertaining to specific methods of smuggling, when referring to the population denoted as SIDTs.

2. UKBA should review compliance with Ionising Radiation regulations, particularly with respect to the use of low dose body scanners and other equipment used outside health care settings.

3. UKBA should commission, with advice from Medical Royal Colleges and the UK Departments of Health, the development of detailed clinical pathways and standardised national protocols for the healthcare of SIDTs in custody. These pathways should include a Custodial Early Warning System (CEWS) for use in the custodial environment, and conventional Modified Early Warning System (MEWS) for use in health care environments; guidance on rapid access referral for transfer of SIDTs to appropriate receiving hospitals/provider units; and detail specific circumstances when medical or other healthcare professional advice should be sought. Attention should also be given to the care of SIDTs with mental health issues or impaired capacity, women who may be pregnant, minors and other vulnerable individuals.

Future decisions regarding the commissioning of health services relating to individuals in UKBA custody will be assisted by the development of such clinical pathways and protocols.

4. Body-Packers should be only detained in custody if constant observation with CEWS scoring can be provided and any observed changes acted upon immediately. There must be available rapid access to an emergency department with acute surgical facilities and all necessary emergency drugs and equipment available twenty-four hours, seven days a week. Staff should be fully trained to use both the equipment and to administer these drugs. If these facilities and trained staff are not available, Body-Packers must be referred immediately to an emergency department with acute surgical facilities available twenty-four hours, seven days a week.

5. A standard list of medical equipment and medication should be provided in custody suites where SIDTs are held. The medication and equipment provided (including automatic defibrillators) should be in

stock, in date, and serviced according to the manufacturer's specification.

6. Appropriate training for custody staff, both permanent and contracted, should be introduced as a part of the standardised national protocols for the care of SIDTs in Recommendation 3. This should include the use of CEWS, and be introduced to allow the identification of individuals at high risk, the adequate monitoring of detainees, and the early identification of signs of toxicity.

7. UKBA should ensure that staff are competent in recognising signs of drug intoxication, including acute cocaine toxicity, as well as understanding the requirements of duty of care. All custodial staff (permanent and contracted) should be trained in Basic Life Support, recognition of the signs and symptoms of drug intoxication and other common clinical conditions.

8. All Health Care Professionals working in UKBA environments should ensure that they hold a current Immediate Life Support (ILS) certificate with additional training in the recognition and management of conditions presenting in custody.

9. Consideration should be given to the feasibility of developing a small number of specialist units attached to hospitals, which incorporate arrangements for temporary custody and the medical observation of SIDTs. This represents the safest option in that it would concentrate specialist facilities and expertise in a few sites, but would require significant change to the current distributed arrangements, including a co-located (temporary) custodial environment.

10. The Royal College of Physicians, through the Faculty of Forensic and Legal Medicine, should develop a postgraduate education programme for FPs, covering the medical care of SIDTs in custody. This should be considered as a mandatory element of Continuing Professional Development for those in the specialty working in environments where SIDTs may be encountered in order to ensure that FPs working in different settings have a common level of essential knowledge and skill.

11. UKBA should review current information supplied to detainees and arrangements for independent advocacy and respect for human rights.

12. Forensic physicians independently retained by UKBA must be contracted as self-employed individuals.

Background Information & Glossary of Terms

UK Border Agency (UKBA)

The United Kingdom Border Agency (UKBA) was created in law in April 2008 and established as a result of the Borders, Citizens and Immigration Act 2009. The Agency integrated the work of the Border and Immigration Agency, UK Visas and the border-related responsibilities of HM Revenue and Customs to create a single authority for immigration and customs control and to tackle smuggling, immigration crime and border tax fraud. This includes responsibility for the operational enforcement of prohibitions and restrictions on the import and export of goods including drugs, HMRC's Police and Criminal Evidence Act custodial functions and facilities, and the attendant responsibility for the detention and care of those suspected of smuggling drugs. UKBA is a Home Office agency operating across the UK that is accountable to the UK Parliament. UKBA operates under the different legislative frameworks for England and Wales, Northern Ireland and Scotland.

The Expert Group was informed that UKBA has approximately 8,000 officers in the Border Force directorate, which is responsible for ensuring that only legitimate travellers and goods are allowed to enter and leave the UK. The targeting and interdiction of Class A drugs is a priority for the Border Force directorate. UKBA takes a targeted, risk-based, approach to intervention that is informed by intelligence gathered from a variety of sources. Trace detection technology and X-ray, as well as detector dogs, are used to scan and examine baggage, vehicles and freight in order to detect drug smuggling.

A significant proportion of the Class A drugs detected by UKBA are smuggled by SIDTs, who therefore constitute a significant proportion of UKBA detainees. Of the 508 detainees remanded in custody in the HMRC suite at Heathrow between September 2006 and August 2007, 159 (almost one in three) were SIDTs. Specific information about the geographical origin and reasons for the drugs trafficking activity of SIDTs is outside the remit of this guidance.

In recent years, internal drug smuggling has become an issue in Northern Ireland where UKBA has noted an increase in SIDTs, particularly in Belfast. Whilst it is a small number in comparison to the UK mainland, the city is now ranked third for the highest number of SIDT arrivals. UKBA informed the Expert Group that predicting future

trends in the numbers of SIDTs held in UKBA custody would be difficult.

Jurisdictional and Legislative Context

The legislative context has changed since HMRC requested advice from the CMO, and there are have been associated changes in jurisdictional responsibility.

The Police & Criminal Evidence Act 1984 (PACE) outlines the measures and safeguards available to those under investigation who are suspected of committing a criminal offence. Section 114 of PACE enables application of the provisions of PACE to investigations conducted by officers of UKBA, whilst section 22 of the Borders, Citizenship and Immigration Act 2009 further applies PACE to customs investigations carried out by UKBA. Similar provision exists in Northern Ireland by way of the Police & Criminal Evidence (Northern Ireland) Order 1989, whilst the powers of UKBA officers in Scotland are contained in Part III of the Criminal Law (Consolidation) (Scotland) Act 1995.

PACE Codes of Practice are relevant here, particularly those issued under sections 60, 60A and 66, dealing with issues such as searches of premises (Code B), detention of suspects (Code C) and the conduct of interviews (Code E). Code of Practice C is relevant to the care of SIDTs and contains specific guidance on the care of SIDTs in paragraph 9.3.[57]

Further guidance is available in the 2006 Guidance on the Safer Detention & Handling of Persons in Police Custody. Whilst the Codes of Practice have been approved by Parliament, and PACE has the force of law as primary legislation, the Safer Detention guidance has no force in law. However, this is a source of reference to both officers carrying out custody functions and to anyone charged with investigating any incident in a custody suite, including a death in custody.

The Drugs Act 2005 modifies the Police and Criminal Evidence Act 1984 (PACE, specifically section 55 as 55(1)(a). The Corporate Manslaughter and Homicide Act 2007 will apply in all custody areas from the summer of 2011, and any ‘system failure’ resulting in the death of a detainee will leave responsible individuals in these areas liable to a potential charge of manslaughter.

Application of PACE to UKBA as set out above, means that all of these documents would have equivalent force in respect of investigations and detentions by officers of UKBA as in regard to police officers.

NHS Reforms

Following the current re-structuring of the NHS and health service provision, the newly formed NHS Commissioning Board will commission health care services for people in prison and other custodial settings, high security psychiatric services and the armed forces, although precise arrangements as to how this will work are yet to be defined. Public health services for people in prison and other custodial settings will become the responsibility of the newly established public health service, Public Health England.

The way in which offender and prison health services are commissioned is also changing. Implementation of reforms following The Bradley Report in the 43 police forces in England and Wales has resulted in a review of the feasibility of transferring the budgetary and commissioning responsibility from the Home Office to the NHS.[58] Following Ministerial approval, this is likely to be a phased approach at a local level resulting in the move of healthcare provision to being commissioned by the NHS.

Glossary & Abbreviated Terms

Body-Stuffers - Individuals who swallow a small number of packages containing an illicit drug, usually heroin, cocaine, cannabis or an amphetamine, in an unplanned attempt to conceal evidence when on the verge of being arrested.

Body-Packers - Individuals who swallow a substantial number of packages containing illicit drugs for the purpose of smuggling (sometimes called ‘mules’ or ‘swallowers’).

Body-Pushers - Individuals who hide illicit drug packages in the rectum or vagina in an unplanned attempt to conceal evidence when on the verge of being arrested

Forensic Medical Examiner (FME) – See FP

FP – Forensic Physician (formally referred to as Forensic Medical Examiners)

HCP – Healthcare Professional

Mules - See ‘Body-Packers’

PACE - Police & Criminal Evidence Act 1984

PER - Person Escort Record - Form that is completed whenever a UKBA detainee is moved, and accompanying them in transit.

SIDT - Suspected Internal Drug Trafficker.

Swallowers - See ‘Body-Packers’

UKBA – UK Border Agency

HMRC – HM Revenue & Customs

Expert Group Membership & Terms of Reference

Dr Anita Donley OBE (Chair)	Consultant Physician, Plymouth Hospitals NHS Trust
Caroline Woolrich	Nursing and Midwifery Council
Dr Richard Preece	Director of Organisational Development, NHS Plus
Dr Friedericke Eben	Royal College of Obstetricians and Gynaecologists
Dr Solomon Almond	Royal College of Physicians
Dr Meng Aw-Yong	Faculty of Forensic and Legal Medicine, Royal College of Physicians, and College of Emergency Medicine
Professor Allister Vale	Royal College of Physicians
Dr Giles Maskell	Royal College of Radiologists
Suzanne Wood	General Medical Council
Dr Kate Adams	Royal College of General Practitioners
David McVittie	Chief Executive, Hillingdon Hospital
Professor John Farnan	Principal Administrative Forensic Medical Officer, University of Ulster
Andrew Alexander	Head of Police Powers Team, Ministry of Justice
Mark Fuchter	Deputy Director Border Policy, UKBA
John Parsons	HMRC/UK Border Agency Custody Officer

Rashmi Barot	UK Border Agency Policy
Matthew Beckingham	UK Border Agency Policy

Terms of Reference

In order to assist HM Revenue and Customs develop clinically sound polices, the expert group on the medical care of suspected internal drug traffickers whilst in custody is asked to:

Produce guidance on the medical care of suspected internal drug traffickers for consideration by the Chief Medical Officer.

In particular, the guidance should cover:

- Identification of individuals in custody at high risk of adverse health events, taking into account any views expressed by HM Coroners

- Stratification of risk and the provision of advice on appropriate care regimes

- Appropriate standards of care for all suspected internal drug traffickers

- Circumstances in which medical opinion should be sought and from whom such advice should be sought

- Circumstances in which HMRC should require advice concerning the admission to hospital of an individual in custody

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