# 01-03 Appendix A

## Medical Advisory Notes

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### Member Safety

A. When attending a scene where the risk of contact with blood or body fluids exists, members shall exercise extreme caution and use universal precautions. These include, but are not limited to wearing of disposable examination gloves (nitrile), using waterless antiseptic wash or hand wipes, and using a disposable one–way air valve for mouth to mouth respiration. Hand washing is the most important infection control measure for the prevention of self and cross contamination. (See Procedures 08–06 and 08–07 for further information regarding decontamination.)

B. Where it is suspected or known that a person is a carrier of an air–borne transmitted disease such as tuberculosis, members
   - shall when at a police station, place the person in an area where adequate ventilation exists
   - shall not place a person suspected or known to have tuberculosis or other air–borne transmitted communicable diseases in areas with little or no ventilation, such as interview rooms
   - should wear surgical masks when in close contact with the person and when transporting the person to a police station or other location. Where possible, the infected person should also be asked to wear a surgical mask when in close contact with other individuals. If surgical masks are not available or the infected person refuses to wear a mask, members shall transport the person as the sole occupant of a compartment of a prisoner transport vehicle, or, if not available, with a window of the police vehicle open.

### Persons in Custody Safety

C. During the booking process, the Officer in Charge is required to evaluate the mental and physical condition of the individual. As part of that evaluation, it is incumbent upon the Officer in Charge to be aware of any medication or drug the person in custody has taken prior to arrest (legal, prescription or otherwise). Based on the information received, the Officer in Charge should make further inquiries regarding the type of drug, time and amount taken, whether the individual is a frequent user, and the physical state of the individual. The decision as to whether to send an individual to the hospital should be made based on the Officer in Charge's assessment of the circumstances.

   The Officer in Charge shall inform the person in custody of the risk of not disclosing the consumption of prescribed or non–prescribed substances.

   Where a person in custody appears ill, shows symptoms of distress or adverse reaction, or reports any of these symptoms, as a result of drug use, or for any other reason, further medical advice shall be sought and/or the person in custody shall be transported to the hospital for a medical examination.

➔ *Officers should consider the possibility that an illness may be drug related and be mindful that, under certain circumstances, a prisoner may have unknowingly consumed a drug. [e.g. GHB (Gamma Hydroxybutyrate) slipped in a drink]*

Where a person in custody has, or is suspected of having taken a drug or other controlled substance prior to arrest but shows no outward signs or symptoms of distress or adverse reaction, the Officer in Charge shall make further inquiries in order to determine whether further medical treatment is required.

When considering the need for further medical attention, the Officer in Charge should be cognisant of some circumstances which may impact on the health of the individual

- where a drug that is not designed to be swallowed has been swallowed by an individual (i.e. for the purpose of concealing or transporting), or held in the mouth in such a way that the drug is exposed (e.g. no wrapper, or damaged wrapper)
- where the individual cannot, declines or fails to recall what substances (whether prescribed or non–prescribed), quantity, or when the substances were taken
- where the quantity of drugs taken suggests a possible overdose (i.e. more than prescribed)
- where any drug has been taken in conjunction with alcohol
- where the individual is acting irrationally or aggressively, appears ill, is complaining of pains, nausea, etc., or reports feeling differently than other times when they have taken the same drug
- where cocaine has been used by the person, and the person has had to be physically restrained, or has exerted themself physically (e.g. foot pursuit, struggle, etc.)
- where the prisoner exhibits an unexplained change in behaviour (e.g. becomes aggressive, lethargic, sleepy, etc.)

The following services are available at no cost to assist the Officer in Charge in making a determination as to whether a person in custody is in need of further medical treatment. These services may be used where the Officer in Charge requires further information (e.g. effects of drug interaction) to complete their assessment of the individual

- Telehealth Ontario (1–866–797–0000, TTY 1–866–797–0007) – provides quick easy access to a qualified health professional (registered nurse) who can assess the symptoms of the person in custody and offer advice as to whether the individual is in need of immediate hospital care. Depending on the number of people making use of this service, a representative may have to return your call. When leaving a message, for faster service, ensure you identify yourself as a police officer seeking advice regarding a person in custody who has taken a drug prior to arrest.
- Ontario Regional Poison Information Centre – SickKids Hospital (416–813–5900 or 1–800–268–9017, TTY 416–597–0215 or 1–877–750–2233) – can provide information regarding drug interactions, and potential overdose information. If the concern to be addressed deals only with an interaction or potential overdose, call this service directly; otherwise contact Telehealth Ontario first.

➔ *When there is a delay in receiving the required information from the above mentioned services, the person in custody shall be continuously monitored until the information requested is received and the Officer in Charge has made a final determination whether to accept the individual at the police facility.*

Any person who has or is suspected of having taken a drug prior to being arrested, and is accepted at a police facility shall be monitored more closely, and the results of those checks recorded, until such time as the Officer in Charge is satisfied that the individual is not at risk. Individuals who have taken hard drugs such as cocaine, heroin, etc., shall be monitored more closely for at least 3 hours from the time when the drug was taken.

If at any time, the person in custody's condition changes, or there is a concern regarding the health of the person, members shall notify the Officer in Charge who shall re–evaluate their condition.

D. Individuals with violent or suicidal tendencies shall be lodged in a separate cell whenever practicable and their behaviour closely monitored.

E. Persons in custody housed in divisional cells or lock–ups should be placed opposite each other where possible. This can provide an opportunity for one person in custody to give early warning of illness, suicide, or self–injury involving another person in custody.

F. If a person in custody becomes unconscious, or is in distress from illness, injury, intoxication, or reaction to drugs, the person shall be removed to the nearest hospital for examination and treatment. Under no circumstances will an unconscious person be admitted to a police cell or lock–up.

G. Unexpected deaths of intoxicated individuals may occur as a result of a condition called **obstructive sleep apnea**. The consumption of alcohol or alcohol in combination with central nervous system depressants (e.g. narcotics, barbiturates, etc.) can frequently produce a deep sleep accompanied by loud snoring.

   Snoring is not an indicator of consciousness. It indicates only that a person is breathing. Individuals who are intoxicated or who exhibit very loud or disrupted snoring must be closely monitored and awakened frequently in order to determine if their state of sobriety is improving over time.

H. **Alcohol Withdrawal Syndrome** (AWS) is characterized by physical and mental symptoms that can occur after a person discontinues consuming high doses of alcohol. Symptoms of AWS may appear within 6 – 12 hours after a person's last consumption of alcohol. AWS more commonly affects those with a history of alcoholism and/or those who have experienced problems with alcohol withdrawal in the past.

   Symptoms can depend upon the amount of alcohol consumed, frequency of consumption, and the duration of consumption prior to discontinuance. Determining a "time-stamp" as to a person's last consumption of alcohol is important in assessing the onset of AWS.

   Symptoms can range from mild to severe and include:

   <u>Mild Symptoms</u>
   - tremors (trembling or quivering)
   - anxiety
   - sleep disturbance (insomnia)
   - sweating (diaphoresis)
   - over responsive reflexes (hyperreflexia)
   - nausea/vomiting

   Mild symptoms can occur within 24 hours after discontinuance and should subside within 48 hours.

   <u>Moderate Symptoms</u>
   - intensified Mild Symptoms
   - rapid breathing (tachypnea)
   - racing heart rate (tachycardia)
   - agitation

   Moderate symptoms can occur within 24 – 36 hours after discontinuance and should subside within 48 hrs.

Severe Symptoms

- severely intensified Mild and/or Moderate Symptoms
- hallucinations
- seizures
- disorientation
- abnormally high fever (hyperthermia)

Severe symptoms can occur within 48 hours after discontinuance and/or after a decrease in consumption of alcohol and can cause a person's condition to deteriorate to a very serious condition known as delirium tremens (DTs).

Symptoms of DTs usually occur 48 – 72 hours after discontinuance and include:

- profoundly intensified Mild, Moderate, and/or Severe Symptoms

If left untreated, DTs can result in death.

➔ *The time frames for the onset of AWS symptoms have been generalized. Symptoms occurring outside of the time frames (before and after) must still be considered (e.g. Seizures may present between 12 – 60 hours after a person's last consumption of alcohol).*

The decision as to whether to send a person in custody to the hospital should be based upon the Officer in Charge's assessment of the circumstances and observations made. Where a person in custody displays or reports symptoms of AWS as a result of self–disclosed or suspected alcohol use/abuse, further medical advice shall be sought and/or the person in custody shall be transported to the hospital for a medical examination.

I. Intoxicated individuals who lapse into sleep should be placed lying on their side with the head angled forward (recovery position) whenever possible.

J. Some symptoms make individuals appear as if they are intoxicated when, in fact, they are suffering the negative effects of a medical condition. Members shall arrange for immediate medical attention when this occurs or appears to be occurring.

A diabetic suffering a reaction from low blood sugar will exhibit behaviour normally apparent in an intoxicated person, such as confusion, unsteadiness, profuse perspiration or other unusual behaviour.

In such cases, a diabetic shall be given a soft drink containing sugar, sweetened orange juice, chocolate bar or candy containing sugar. After consuming the item, the diabetic must be immediately transported to the nearest hospital.

K. **Positional Asphyxia** – Members should be aware that certain restraint positions (i.e. stomach down) might compromise heart and lung functions increasing the risk of death. Unless circumstances make it impossible, persons should be restrained in a sitting position while being closely watched. Use of the sitting position permits easier breathing and cardiac function, while affording good positional control over the individual.

L. **Excited delirium** is a condition that can be caused by drug or alcohol intoxication, psychiatric illness or a combination of both. Symptoms displayed by individuals suffering from this condition may include any combination of

- abnormal tolerance to pain
- abnormal tolerance to pepper spray
- unexpected physical strength

- violence towards others
- shouting
- sweating, fever, heat intolerance
- sudden calm after frenzied activity
- bizarre or aggressive behaviour
- impaired thinking
- disorientation
- acute onset of paranoia
- hallucinations
- panic

Individuals exhibiting the symptoms of excited delirium must always be treated as suffering from a medical emergency and once secured, be transported to hospital for examination.

Because of their inclination to violence and extreme exertion, individuals exhibiting the symptoms of excited delirium are often restrained for their own protection and the protection of others.

Members should be cognizant of positional asphyxia when dealing with persons exhibiting the symptoms of excited delirium and, unless circumstances make it impossible, restrain the person in a sitting position as noted in item K.

M. Members shall not inject any medication into a person in custody, and under no circumstances shall a medication container be given to the person in custody. Requests for injectable insulin, transition related hormones and similar medications require treatment by a physician.

➔ *This prohibition does not apply to epinephrine auto-injectors (e.g. EpiPen and Twinject). In accordance with this Procedure, prescription and over the counter medications shall be removed from every person in custody. However, when a person taken into custody has in their possession an epinephrine auto-injector, which has been prescribed for them, and experiences a severe allergic reaction (anaphylaxis), they shall be immediately provided with their epinephrine auto-injector to self-administer. Where a person is unable to self-administer the auto-injector, a member shall administer it to them in accordance with the instructions on the device and/or approved First Aid training. The person shall be transported to the hospital by Toronto Paramedic Services (Paramedics) immediately following the injection.*

*Any member accidentally injected with epinephrine not prescribed for them, shall be immediately transported to a hospital.*

If prescription medication is in pill form, the person in custody may be handed the appropriate dosage in compliance with this Procedure.

N. Methadone is a synthetic opioid used as a replacement therapy for narcotic addiction. Treatment is obtained only by prescription and the prescribed dosage varies between individuals. The short–term (24 – 36 hours) effects of abstinence from methadone by a patient are not life–threatening, although the patient may show signs of anxiety.

Individuals who bring a prescribed dosage of liquid methadone with them into custody (called a ‘carry’) shall <u>not</u> be given the medication. The risk of an adulterated sample being brought into custody presents too great a health danger to allow such dosages to be consumed by persons in custody.

Requests by persons in custody for prescribed methadone in tablet form shall be handled in accordance with items 21, 22 and 23, of Procedure 01–03.

Pregnant persons who require methadone treatment should be treated at hospital regardless of the dispensed form of methadone. The Officer in Charge should make arrangements where possible for the issue of a prescription by the originating physician.

All methadone brought into custody shall be taken from the person in custody's possession. Where lawful authority to possess the methadone is established, a clearly labelled and sealed 'carry' will be refrigerated and returned to the prisoner upon release from custody. Where lawful authority to possess the sample is not established, or the 'carry' is in an unlabelled or unsealed container, it shall be submitted for destruction in compliance with Procedure 09–04.

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