Faculty of Forensic & Legal Medicine

POSITION STATEMENT

on the management of suspected COVID-19 cases in police custody

23 March 2020

Duty of Care

Healthcare professionals (HCPs) have a duty of care to their patients regardless of the setting they see them in. It should be remembered that detainees in police custody may be particularly vulnerable and have difficulty accessing health advice at other times.

The FFLM is aware that in some cases HCPs have been refusing to see detainees based on suspicion of COVID-19. This is not appropriate, or acceptable, and would fall far below the standards of care expected by regulatory bodies.

Detainees in police custody are entitled to the same standards of care expected in any other healthcare setting.

It may, however, be appropriate to modify usual procedures to accommodate and minimise risk. This might include giving medications at the cell hatch rather than taking patients to the clinical room.

Equally, to reduce cross contamination, it may be prudent to assess suspected cases in the cell rather than the medical room.

Management of acute and chronic illness in the custody suite should not suffer.

Basic Precautions

Providers should ensure that robust infection control policies are both available and adhered to. This should happen anyway but is particularly relevant in the current situation.

Hygiene precautions, although simple, must be done well:

- Regular handwashing, at least 20 seconds using soap and water
- Bare below the elbows
- Wear scrubs to work if possible
- Frequent use of alcohol gel (wherever practical)
- No food or drink in clinical areas
- Avoid wearing uniforms outside of the work environment (consider use of alginate bags to take uniforms home to wash ideally at 60°C)
- Ensure a change of clothes available

Criteria

Clinicians should ensure they keep up to date with latest guidance published via Public Health England.

Be alert to the possibility of atypical presentations in detainees who are immunocompromised.

In view of community transmission, travel history/exposure is unlikely to be relevant and clinicians should be alert to the possibility of COVID-19 infection in detainees presenting with:

- Acute Respiratory Distress Syndrome

OR

- Clinical Pneumonia

OR

- Influenza like illness, temperature ≥ 37.8°C and new onset of at least one of the following:
  - New continuous cough
  - Hoarse voice
  - Nasal discharge or congestion
  - Shortness of breath
  - Sore throat
  - Wheeze
  - Sneezing

Simple cough and/or high temperature is unlikely to need any intervention other than reassurance and advice to stay at home. Clinicians should also be aware of the significant overlap of above criteria with usual illnesses such as tonsillitis.

PPE

Suspected patients should be asked to wear a surgical facemask whilst moving between areas.

As front-line healthcare workers clinicians should seek specific PPE guidance from their employer. However, based on current guidance the following would appear reasonable:

Suspected or confirmed COVID

Fluid repellent surgical mask, visor, plastic apron (ideally with sleeve protection to reduce droplet transmission risk to bare skin or clothes) and gloves

Suspected or confirmed COVID for resuscitation or aerosol generating procedures

FFP3 respirator mask, visors, long sleeved gown and gloves

Clinicians should consult with their employer regarding fit testing for FFP3 respirator masks and be aware that face shape and presence of stubble may mean that masks do not seal adequately to provide protection. Ideally clinicians should also be trained in donning and doffing technique of PPE to minimise risk of contamination.

Diagnostic Swabs

These should only be performed if you have had training and may take days to come back so are unlikely to be of use in the custody setting.

Resuscitation Modifications

Recognition of Cardiac Arrest

Look for absence of signs of life and normal breathing. If competent check for a carotid pulse.

The primary change here is that it is **not** currently recommended to listen or feel by placing ear and cheek close to the patients mouth.

Ensure that PPE is worn as above before commencing compressions.

Mouth to mouth, and pocket mask ventilation is **not recommended**. If you do not have access to a bag valve mask then compression only CPR is recommended.

Intoximeter Usage

Part of the specification for Home Office type approval means that air flow is one way so theoretically, although contaminated air may be blown into the machine it should not be able to come back. This is analogous to previous concerns with HIV and hepatitis.

However, in view of the potential need to deep clean intoximeter rooms where a high risk or confirmed case of COVID-19 has been seen there may be an increase in requests for blood samples from detainees. Clinicians and providers should be aware of this and have contingency plans for this increased demand.

Hospital Transfer/ED Referral

If it is felt clinically necessary to transfer a detainee to hospital, staff must liaise with both nurse-in-charge of the emergency department as well as the local ambulance trust.

It is imperative that if a detainee is suspected of having COVID-19 both the receiving and transporting services are made aware.

It would be prudent for local clinical leads to liaise with clinical leads at their nearest emergency department to ascertain what, if any, changes there are to local protocols. It may be that cases need to be diverted to alternate sites.

Remote Assessments

Providers should explore options for telemedicine within custody suites.

However, it must be recognised that that remote assessments may limit the quality of a clinical assessment. Where a reduced assessment has been carried out due to COVID-19 precautions this should be clearly documented.

Providers should consider utilising clinicians who are self-isolating being provided with resources to support their colleagues with telephone advice.

Apps such as Hospify (which has been approved by the NHS Apps library) may also be useful to support clinician communication where face to face engagement is not possible.

Telephone Consultations

RCGP has some useful guidance on these assessments. They are likely to be of particular use where:

- the diagnosis is fairly clear;

AND

- there are no 'red flags', and the detainee seems in well to custody staff,

AND

- the detainee is willing to accept reassurance and advice.

Face to face consultations are likely to be needed when the diagnosis or severity of the symptoms are unclear or it is difficult to obtain a reliable history from the detainee.

Resilience and Contingency Planning

Providers and police forces must explore contingency planning to take into account the increased probability of rota gaps to cover clinicians who are either recalled to work within NHS settings or who may need to self isolate (see below)

It would be prudent to liaise with organisations providing services to neighbouring forces so that services can be maintained.

Unprecedented challenges such as this are likely to require significantly increased collaboration between organisations which may have previously been in competition.

Clinician Infection

Guidance is continually evolving on this and providers will need to make decisions based on the latest Public Health Guidance as well as internal workforce planning.

At present the consensus is that simple work related exposure to patients with confirmed or suspected COVID-19 with or without PPE allows clinicians to carry on working as normal unless they develop symptoms. Line managers should, however, be informed of any potential exposure via normal incident reporting systems.

Clinicians who develop symptoms consistent with COVID of any degree of severity should self-isolate immediately (usually for 7 days). It may be prudent for providers to liaise with local public health teams to access staff testing in order to allow them to come back to work more quickly.

Self-isolation is only recommended for asymptomatic clinicians if someone in their house is symptomatic.

Symptoms in household members that should prompt clinician self-isolation are:

- New and continuous cough

OR

- Pyrexia of ≥ 37.8°C (in absence of alternative source of infection such as UTI)

Self-isolation would not usually be necessary simply due to a family member sneezing or having a sore throat etc in absence of cough or fever as above.

Day	Person A	Person B	Person C	Person D
1	Symptomatic	Isolate due to others in house being symptomatic	Isolate due to others in house being symptomatic	Isolate due to others in house being symptomatic
2				
3	7 day isolation for self and others living with them			
4				
5				
6			Symptomatic	
7				
8	Isolation ends if symptom free		7 day isolation count starts	
9				
10				
11				Symptomatic
12				
13			Isolation ends if symptom free	7 day isolation count starts
14				
15		Isolation ends if symptom free		
16				
17				
18				
19				Isolation ends if symptom free
20				

Reporting to Public Health

The local health protection team should be informed of any case which occurs in a prison or place of detention. Providers should ensure that procedures are in place to support staff in this duty.

Useful Sources of information

https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance#guidance-for-health-professionals

https://www.england.nhs.uk/coronavirus/

https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/

https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/

https://www.publichealth.hscni.net/news/covid-19-coronavirus

https://www.nhs.uk/conditions/coronavirus-covid-19/

https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/

https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance/covid-19-prisons-and-other-prescribed-places-of-detention-guidance

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