Faculty of Forensic & Legal Medicine

POSITION STATEMENT

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

27 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 assess detainees based on suspicion of COVID-19. Detainees in police custody are entitled to the same standards of care expected in any other healthcare setting. For its part the GMC has made clear that it expects doctors to respond responsibly and reasonably to the circumstances they face, and to be able to explain any decisions they make.

The GMC has also said that if you have pre-existing health conditions that increase your risk of infection, you should discuss this with colleagues and your employer - it may be appropriate to ask another suitably qualified clinician to take over the care of patients who are suspected to have or who have coronavirus. Additionally, it may 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

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

However potential cases of Covid-19 should be treated as high public health risk.

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 at 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 work clothes home to wash, ideally at 60°C)
- Ensure a change of clothes is available so that you do not have to travel in potentially contaminated clothes.

In view of the rapidly changing situation, at the beginning of each shift clinicians should liaise with custody sergeants and detention officers to confirm local arrangements for screening and assessment of detainees suspected of having COVID-19.

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 especially those with substance use disorders.

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:

- New and continuous cough

OR

- Pyrexia of ≥ 37.8°C

Simple cough and/or high temperature is unlikely to need any intervention other than reassurance and advice to self-isolate post release from custody. Clinicians should also be aware of the significant overlap of above criteria with usual illnesses such as tonsillitis.

Particular attention should be paid to detainees in vulnerable groups:

- aged 70 or older (regardless of medical conditions)
- under 70 with an underlying health condition listed below (ie anyone instructed to get a flu jab as an adult each year on medical grounds):
  - chronic respiratory diseases, such as asthma, COPD, emphysema or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease
  - chronic liver disease, such as hepatitis
  - chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), a learning disability or cerebral palsy
  - diabetes
  - problems with your spleen – for example, sickle cell disease or post splenectomy
  - immunocompromised as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets or chemotherapy
  - seriously overweight (BMI of 40 and above
  - those who are pregnant

Version 5 (last updated on 27/3/2020)

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. If a detainee is being recalled to prison it may be useful to liaise with public health locally regarding swabbing prior to transfer.

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.

Resuscitation

If a shockable rhythm 3 shocks may be administered prior to commencing compressions.

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.

Please see the updated ALS algorithm on page 4 and FAQ on page 5 which also clarifies PPE advised for resuscitation.

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.

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				

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.

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

https://www.drugabuse.gov/about-nida/noras-blog/2020/03/covid-19-potential-implications-individuals-substance-use-disorders

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Send any feedback and comments to:
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Resuscitation Council UK

Adult Advanced Life Support for COVID-19 patients

Phase 1

Conversations and decisions on emergency treatment completed and documented

DNACPR

Yes → End of life care

No → Unresponsive and not breathing normally

Call resuscitation team **State COVID-19**

Phase 2 At least Level 2 PPE

Assess rhythm

Shockable (VF/Pulseless VT)

Up to 3 shocks

Don PPE
CPR for 2 min
Minimise interruptions

Return of spontaneous circulation

Immediate post cardiac arrest treatment
- Use ABCDE approach
- Aim for SpO_2 of 94-98%
- Aim for normal $PaCO_2$
- 12-lead ECG
- Treat precipitating cause
- Targeted temperature management
- AGP PPE if AGP interventions

Non-shockable (PEA/Asystole)

Don PPE
CPR for 2 min
Minimise interruptions

Phase 3 AGP PPE

During CPR
- Ensure high quality chest compressions
- Minimise interruptions to compressions
- Give oxygen
- Consider reversible causes 4Hs and 4Ts
- Use waveform capnography
- Continuous compressions when advanced airway in place
- Vascular access (IV or IO)
- Give adrenaline every 3-5 min
- Give amiodarone after 3 shocks

Recommended PPE

Level 2 PPE
- Disposable gloves
- Disposable apron
- Fluid resistant surgical mask
- Disposable eye protection

Level 3 AGP (aerosol generating procedures) PPE
- Disposable gloves
- Disposable gown
- Filtering face piece (FFP3) respirator
- Disposable eye protection

Consider
- Ultrasound imaging
- Mechanical chest compressions to facilitate transfer/treatment
- Coronary angiography and percutaneous coronary intervention
- Extracorporeal CPR

25/03/2020

Resuscitation Council UK

Frequently Asked Questions for doctors, nurses and health care staff re COVID-19 patients and resuscitation procedures.

❶ **What do I do if someone collapses and I have an AED/defibrillator immediately available?**

A: Before chest compressions, immediately turn the device on, apply the pads and deliver shock if VF/pVT. This can be done without PPE and may negate the need for chest compressions. It also allows time for others to begin donning AGP PPE.

❷ **What do I do if aerosol-generating procedure personal protective equipment (AGP PPE) is unavailable?**

A: In the absence of the gold standard of full AGP PPE for undertaking resuscitation procedures, a risk assessment must be taken by a senior clinician who can then decide on the level of protection that must be deployed during resuscitation events.

❸ **Chest compressions are not listed in national guidance as an AGP. Why is RCUK advocating this?**

A: This is a dynamic and changing situation.

B: As with other AGP, there is very limited data, so recommendations are based on expert opinion. One of the few systematic reviews on this topic identifies chest compressions as an AGP (Tran K et al. PloS One 2012;7;e35797).

C: Protecting the workforce was placed as a high priority, balanced against the risks of delaying resuscitation.

D: CPR was defined as an AGP by PHE in previous publications. In the current COVID publication it is neither identified as a causing, or not causing AGP (note it is also not in the list of interventions which do not cause AGP).

E: This is the approach being adopted in other parts of the world.

F: Major international surviving sepsis guidelines just published by the European Society of Intensive Care Medicine and Society of Critical Care Medicine describe CPR as an AGP and recommend full PPE (including FFP3 mask) (Alhazzani W et al. Intensive Care Medicine 2020 online).

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