

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER

Date Issued: October 7, 2013 **Order No.:** SO 5-06
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Subject: HOSPITAL AND EMERGENCY MEDICAL SERVICE PROCEDURES
To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To outline hospital and emergency medical service procedures.

<u>Section</u>	<u>Subject</u>
I.	General Procedures
II.	Medical Examiner's Cases
III.	Communicable and Infectious Disease Prevention
IV.	Procedures for Handling Mentally Ill and Alcohol/Drug-Dependent Persons
V.	Crisis Intervention Team (for Handling Mental Health Crisis)
VI.	Handling of Intoxicated Persons and Alcohol/Drug Dependent Persons Posing a Threat of Harm
VII.	Sick and Injury Cases Involving Prisoners in Police Custody
VIII.	Security of Prisoners Confined to Hospital
IX.	Emergency Treatment of Department Personnel Injured While on Duty

By Order of:



D. SAMUEL DOTSON
Colonel
Chief of Police

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METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER

Date Issued: October 7, 2011 **Order No.:** Section I of SO 5-06

Effective Date: October 7, 2011 **Expiration:** Indefinite

Reference:

CALEA Standards:

Cancelled Publications: SO 90-S-13

Subject: GENERAL PROCEDURES

To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To provide procedures concerning (1) the transport of sick and injured patients to medical facilities for treatment; and (2) related police procedures.

A. DEFINITION OF PATIENT (RSMO Section 190.100 (27))

A “patient” is defined by State Statute as “... an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, or dead, excluding deceased individuals being transported from or between private or public institutions, homes or cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance;”.

NOTE: Officers will request the Office of the Medical Examiner to convey the remains of persons declared dead or whose remains are decomposed. See Section II of this Order for full details.

B. STATE STATUTE REQUIREMENTS FOR TRANSPORT OF PATIENTS TO HOSPITAL

1. State Statutes mandate that all patients requiring medical attention be conveyed to the treatment facility in a licensed ambulance staffed with a licensed emergency medical technician and driver, except in the case of a major catastrophe or emergency when the locality has an insufficient number of licensed ambulances and personnel to promptly cope with the incident. **(RSMo. Section 190.105)**

2. Police officers, sheriffs or firefighters may, in emergency situations, transport persons who are seriously sick, injured or otherwise incapacitated.

NOTE: For full details see (1) Paragraph D2 of this Section; and (2) Section IV of SO 5-05, “Transporting Sick or Injured Prisoners in Emergency Situations”.

3. State Statutes do not prohibit the conveying of a sick or injured person in a private vehicle by his/her family or friend.

C. PATROL CAR DISPATCH IN SICK AND INJURY CASES

1. A patrol car will be dispatched on a sick or injury call **ONLY** when one of the following circumstances applies:

a. Serious or life-threatening illness/injury (e.g., heart attack, person not breathing, suicide attempt or threat, etc.);

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- b. Death is apparent or imminent, or Communications believes illness or injury may be serious;
 - c. Crime involved (e.g., assault, cutting, shooting, etc.)^{*};
 - d. Police officer or employee involved;
 - e. Incident occurred on public property or transit;
 - f. Vehicle accident involved;
 - g. Suspicious circumstances involved; or
 - h. Police dispatch requested by EMS.
2. EMS will dispatch an EMS unit according to their protocol in instances where police dispatch is not required.
 3. An officer arriving at the scene of an incident prior to EMS arrival will notify the police dispatcher when the officer determines that (1) EMS is not needed; or (2) the need for EMS is “urgent” (when dispatched as “non-urgent”); or (3) the need for EMS is “non-urgent” (when dispatched as “urgent”). The police dispatcher will advise the EMS dispatcher of any additional information that the officer imparts to him/her concerning the need for EMS.

D. TRANSPORTATION OF SICK/INJURED PERSONS (INCLUDING PRISONERS)

1. Normal Transport by Emergency Medical Service (EMS) Unit
 - a. A sick or injured person in need of medical attention, including prisoners, will normally be conveyed in a Fire Department EMS (Emergency Medical Services) Unit to the point of medical treatment.
 - b. EMS personnel will make the decision as to the medical facility to which the patient will be transported (except in a non-urgent case involving a prisoner):
 - 1) In urgent or life-threatening cases, a patient will be transported by EMS to the closest appropriate hospital. Certain hospitals, such as Barnes-Jewish and St. Louis University Hospitals, are certified and specially- equipped to deal with patients suffering from heart attack, stroke and trauma (see RSMo. Section 190.243).
 - 2) In non-urgent cases, EMS may transport to certain private hospitals outside the city, if requested by the patient or the next-of-kin. A private ambulance may be requested by EMS in such cases.
 - c. Officers will not suggest that a sick or injured person be conveyed by a private ambulance or to a private hospital.

^{*}In rape cases, EMS will be dispatched if there are physical injuries; otherwise, Sex Crimes will convey the victim to the hospital.

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2. Transport of Sick/Injured Person by Police in Emergency Situations

- a. A patient may be transported to the hospital in a police vehicle in an emergency situation when an EMS unit is not immediately available. The Communications Division will notify EMS when a police vehicle is used as a conveyance.
- b. A person requiring emergency medical care will be transported to the nearest hospital with an emergency room, or one that is reasonably near. Consideration should be given to transporting a patient experiencing a heart attack, stroke or trauma to Barnes-Jewish or St. Louis University Hospital, since they are specially-equipped to deal with those emergencies.

NOTE: See Section IV of Special Order 5-05, "Transporting Sick or Injured Persons in Emergency Situations", for full details.

3. Patient with Possible Spinal and Neck Injuries to be Moved by EMS

A patient with possible injury to his/her spine or neck can sustain additional injury if moved. Therefore, such a patient will normally be moved only by EMS personnel to prevent additional injury.

4. Police Escorts for Private Vehicles Carrying Sick/Injured Persons

- a. Department vehicles will not escort non-emergency vehicles transporting a sick or injured person to the hospital. Instead, whenever possible, the patient will be transferred to an EMS unit for the trip to the hospital.
- b. An exception would apply if a person was seriously sick or injured and an EMS unit is not immediately available. In this case, a police vehicle may be used to convey the patient to the hospital.
- c. The driver of the private vehicle may accompany the ill or injured patient in the EMS unit or police vehicle. However, a driver of a non-emergency vehicle will not be permitted to follow an EMS unit or police vehicle transporting a patient to the hospital. Instead, the officer will give directions to the hospital and instruct the driver to follow all traffic regulations.

5. Transport of Prisoners

- a. An EMS unit will be called whenever:
 - 1) a prisoner has an obvious injury;
 - 2) a prisoner complains of illness or injury; or
 - 3) Department procedure requires that a prisoner be taken to the hospital in a specific situation.
- b. In non-urgent cases the officer will designate the hospital to which EMS should take the prisoner, which will normally be the closest hospital with an emergency room.

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EXCEPTION 1: A prisoner with a life-threatening illness or injury will be taken by EMS to Barnes-Jewish or St. Louis University Hospital, since they are specially equipped to deal with those emergencies.

EXCEPTION 2: A juvenile being taken into custody is normally taken to St. Louis Children's Hospital or Cardinal Glennon Children's Hospital.

- c. Two officers will accompany a prisoner-patient to the hospital. At least one officer will accompany the prisoner in the EMS unit; the second officer may follow the EMS unit to the hospital in his/her police vehicle.

6. Transport of Department Personnel

Police Department personnel needing immediate medical attention will normally be conveyed to the hospital in an EMS unit, unless emergency transport in a police vehicle is indicated (see Paragraph C2 of this Order). For full detail concerning the emergency treatment of personnel injured on duty, see Section IX of this Order.

7. Transport of Prisoners/Officers From Hospitals Outside City

An injured prisoner or officer must occasionally be conveyed from a hospital outside the City. If the investigating officer believes that the individual should be conveyed by EMS, he/she will request his/her Supervisor or Watch Commander to contact EMS.

8. Private Ambulances

Private ambulance services will not be notified by the Communications Division. If a patient other than a prisoner desires a private ambulance, he/she or his/her next-of-kin must notify the private ambulance service directly. Officers will not accompany patients in private ambulances. Private ambulances operating in the City must bear a valid City license and are subject to official inspections by EMS officials.

EXCEPTION: EMS will divert calls to private ambulance services when all EMS units are occupied. When this occurs, officers will accompany the patient in the private ambulance only when (1) the patient is a prisoner; or (2) extenuating circumstances exist (e.g., violent OBS case, death imminent, police personnel involved, etc.).

9. Major Disasters

The Communications Division will immediately notify the EMS dispatcher of a major disaster such as a large fire, explosion, airplane crash, etc. EMS will be responsible for all medical-related activities once they arrive. Available police cruisers will be dispatched to supplement EMS units, as needed. Notification to private ambulance companies will be made by EMS Communications.

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E. REFUSAL OF MEDICAL CARE BY ILL/INJURED PERSONS (PRISONERS INCLUDED)

1. General

Officers handling any incident in which a person has sustained (or potentially sustained) illness or injury, will offer medical care to such person. This will apply in both criminal and non-criminal cases (e.g., auto accidents, etc.) This section contains procedures to be followed when the person declines medical attention.

2. Refusal of Medical Care by Prisoner

a. Injury or Illness Apparent/Prisoner Complains of Injury

An EMS unit will be called to the scene whenever a prisoner has an apparent injury or complains of injury or illness, even if he/she refuses medical care. If the prisoner also refuses medical care through EMS and signs an EMS "Refusal of Care" form AND an apparent non-serious injury does not, in the judgment of EMS personnel, require medical care, the officer will (1) convey the prisoner by Department vehicle to the Area Station or Prisoner Processing (at Department of Corrections(DOC)-City Justice Center) for booking; and (2) note the fact that the prisoner refused medical care, along with the EMS medic and trip numbers, in the I-LEADS report. A Department "Refusal of Medical Care" Form GEN-288 (see Attachment 1) is not required.

b. Injury or Not Apparent

If a potentially-injured prisoner has no apparent injuries and refuses medical care, the officer will request the dispatch of a supervisor to the scene to verify the prisoner's condition and willingness to decline medical care. The prisoner will then be asked to sign a Department "Refusal of Medical Care" Form GEN-288 (see Attachment 1, which is available on Department intranet system). Both the officer and the sergeant will endorse the form as witnesses and EMS will not be called. The prisoner will then be conveyed by Department vehicle to the Area Station or Prisoner Processing (at DOC-City Justice Center) for booking. A copy of the "Refusal of Medical Care" form will be scanned into the I-LEADS report.

c. Prisoner Refuses to Sign "Refusal of Care" Form

If a prisoner refuses to sign either an EMS or Department "Refusal of Medical Care" form, refuses treatment by EMS or transport to the hospital AND an apparent non-serious injury does not, in the judgment of EMS personnel, require medical care, the officer will (1) note this information in the I-LEADS report, along with the EMS medic and trip numbers; and (2) convey the prisoner by Department vehicle to the Area Station or Prisoner Processing (at DOC-City Justice Center) for booking.

d. Exception When Prisoner Must be Mandatorily Taken to Hospital

This above procedures will not apply in a situation where there is a mandatory requirement in Department procedures for a prisoner to be taken to a hospital for examination and/or treatment.

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3. Refusal of Medical Care by Person NOT a Prisoner

- a. An EMS unit will be called to the scene when a person other than a prisoner has sustained apparent injuries or illness. EMS will not be called if there are no apparent injuries and the person declines medical attention.
- b. The officer will note in any I-LEADS report prepared that the person declined medical care offered through this Department.

NOTE: A DEPARTMENT "REFUSAL OF MEDICAL CARE" FORM GEN-288 (ATTACHMENT 1) WILL NOT BE COMPLETED IN SITUATIONS WHERE A PERSON WHO IS NOT A PRISONER REFUSES MEDICAL ATTENTION.

F. ACCOMPANYING OF PATIENTS TO HOSPITAL BY POLICE OFFICERS

1. Officers will not accompany sick or injured persons other than prisoners in an EMS unit unless (1) requested by EMS personnel; or (2) when extenuating circumstances exist (e.g., violent observation case, death imminent, police personnel involved, etc.).
2. When an officer assigned to a one-officer car is required to accompany a patient in an EMS unit, he/she will lock the police vehicle and give the keys to any other officer at the scene. If no other officer is present, the officer will retain the keys. He/she will then have the dispatcher notify his/her Supervisor of the vehicle's location and who is in possession of the keys.
3. When an officer is assigned to a two-officer car, one officer will accompany the patient in the EMS unit and the other officer will (1) return to service as a one-officer car; or (2) follow the EMS unit to the hospital (unless two officers are required in the EMS unit).
4. An officer driving a police vehicle will not follow within 300 feet of an EMS vehicle transporting a sick or injured person under emergency conditions.
5. If an incident requires a report, the officer will indicate the EMS medic and trip numbers in the narrative.

G. PERSONAL PROPERTY OF PATIENTS

1. If a patient is conveyed in an EMS Unit, the personal property of the patient is the responsibility of EMS personnel.
2. If the patient is admitted to the hospital, the responsibility for the personal property is assumed by the hospital.

NOTE: If a commissioned officer is admitted to a hospital, the officer handling the assignment will seize all department property (e.g., firearms, badge, etc.) and place it in the district safe until such time as the sick/injured officer is released from the hospital. A firearm personally owned by the sick/injured officer will be seized and either (a) placed in the district safe for safekeeping; or (b) conveyed to the officer's home (at his/her discretion) and turned over to a family member.

3. A prisoner's personal property will remain at the hospital if a "hold order" is placed on the prisoner, or if a police officer is assigned to guard the prisoner. If the prisoner is later

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conveyed to the City Justice Center, his/her possessions will be given to the officer accompanying him/her.

H. POLICE REPORT REQUIREMENT IN SICK AND INJURY CASES

A police report will be required for a dispatch on a sick case, accidental injury or attempted suicide under the following circumstances:

1. Police Department employee involved;
2. Person in custody involved;
3. Death is imminent;
4. Suspicion of a crime;
5. Attempt Suicide case (when firearms or weapon involved); or
6. Accidental Injury case (when public transportation involved).

REFERENCE: Special Order 9-04, "Communications Procedures".

I. MEDICAL CENTER PROCEDURES

1. General Information

Officers will not accompany a patient to the hospital unless suspicious circumstances exist, death may result, it is a violent OBS case, or police personnel are involved. Officers in doubt as to the physical condition of a patient will contact Hospital receiving room personnel at the hospital by phone prior to giving a disposition.

2. Non-Criminal Cases

In non-criminal cases the district officer will return to service after the patient has been taken to the hospital by EMS and no further police action is anticipated. If a report is required, the EMS medic and trip numbers will be included.

3. Suspected Criminal Cases

Medical practitioners are required by law to notify police when a person applies for treatment for an injury caused by a gunshot or knife (Revised St. Louis City Code Section 12.56.010). An officer will be dispatched from the district of occurrence to investigate the incident and prepare any required report.

4. Notification of Next of Kin

The next-of-kin will be notified by the officer if a patient is conveyed to the hospital and the officer definitely knows that the subject is, or will be, admitted. If the officer does not know if the subject will be admitted, the hospital has the responsibility to notify the next of kin.

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5. Operating Room

Officers guarding a prisoner patient will not enter an operating room unless authorized by hospital personnel under conditions that they may impose. However, officers will wait nearby to minimize any opportunity for escape.

6. Interviewing Patients

Patients who are in police custody may be interviewed at any time provided that the attending physician determines that the interview is reasonable considering the medical condition of the patient.

7. Emergency Care for Juveniles

See Section XVII Special Order 5-16, "Juvenile Procedures", for special provisions that apply to medical treatment for juveniles.

DI/frd
251-09-06979

**METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER**

Date Issued: May 27, 2010 **Order No.:** Section II of SO 5-06

Effective Date: May 27, 2010 **Expiration:** Indefinite

Reference:

Cancelled Publications: 91-S-32

Subject: MEDICAL EXAMINER’S CASES

TO: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: The purpose of this Order is to establish guidelines for the handling of deaths which are subject to the jurisdiction of the Medical Examiner’s Office.

A. REPORTABLE DEATHS

The Medical Examiner or his designated assistant shall be notified immediately upon receipt of any death reported to this Department, and investigate the essential facts concerning the medical causes of death.

B. MEDICAL EXAMINER’S INVESTIGATOR (MEI) NOTIFICATION PROCEDURES

1. Whenever an assignment of death is received, and upon the officer’s arrival, if there is the slightest trace of life in the body, an Emergency Medical Service (EMS) Unit will be requested and the person conveyed immediately to a hospital. If upon arrival at the hospital, the officer is advised that the person is deceased, the police officer will immediately notify the Medical Examiner’s Office of the known facts concerning the time, place, and circumstances of death (RSMo 58.720).

NOTE: In cases where the subject is a victim of cold water drowning or hypothermia, the EMS unit shall not be disregarded and the victim shall be taken to a hospital for pronouncement even if no apparent signs of life are observed.

2. The Medical Examiner’s Investigator (MEI) can be contacted by calling 622-4971. If the investigator is out of the office, the requesting officer will contact the SODD dispatcher or the assignment channel dispatcher. The dispatcher will contact the investigator and advise of the type of incident.

NOTE: The Medical Examiner’s Investigator will be responsible for contacting the physician and/or hospital.

3. If an emergency situation develops and it becomes necessary to move the body prior to the M.E. Investigator’s arrival, the officer will immediately inform the dispatcher of the removal of the body, its destination and the reason for the removal, (e.g., traffic hazard, hostile crowd). The M.E. Investigator will be contacted by the dispatcher and advised of this information.
4. The Medical Examiner’s Office will contact a livery service if it is necessary to convey a body from the scene or from the hospital to the morgue. Under no circumstances will an

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officer or the dispatcher directly contact a livery service unless specifically asked to do so by the Medical Examiner's Investigator.

5. Medical Examiner's Investigators are presently able to advise the officer on the scene of the expected ETA of the livery service. The officer should request this information and if advised that the response time will be at least an hour or more, the following options are available:
 - a. Wait for the livery service to make the removal;
 - b. At the discretion of the investigating officer a police cruiser may be used to convey the body. The M.E. Investigator is to be immediately contacted and advised that a police cruiser will be used to convey the body.

NOTE: If the Homicide Section has assumed investigative jurisdiction, the Homicide Crime Scene Supervisor will make the determination as to which option will be used.

C. HOMICIDE AND DISTRICT RESPONSIBILITIES

1. Cases Investigated by the Homicide Section:

- a. The Homicide Section will be responsible for the investigation of the following incidents:
 - 1) Criminal homicide-murder & non-negligent manslaughter;
 - 2) Manslaughter;
 - 3) Aggravated assaults, when death appears imminent or later occurs;
 - 4) Abortions performed by unlicensed person(s) wherein the mother dies;
 - 5) Assisting another in the commission of suicide;
 - 6) All other sudden or violent deaths of a suspicious nature;
 - 7) All incidents where a police officer is shot or when an officer shoots a subject in the performance of duty;
 - 8) All deaths of persons in custody; and
 - 9) Department vehicle accidents which result in critical injuries or death.

NOTE: Manslaughter cases involving a driver suspected of being under the influence and Department vehicle accidents which result in critical injuries or death will be co-investigated with the Accident Reconstruction Team.

- b. If the Homicide Section assumes responsibility for the investigation, it is the duty of the Homicide Crime Scene Supervisor to notify the M.E. Investigator. If responsibility is delegated to the district of occurrence for the investigation, the reporting officer is responsible for notifying the M.E. Investigator.

2. Cases Investigated by Districts:

- a. District officers shall request the Accident Reconstruction Team assigned to the Traffic Safety Division to respond to the scene of all traffic accidents involving critical injuries or fatalities.
- b. In the event the Accident Reconstruction Team is not available, district officers are responsible for the complete investigation of the critical or fatal traffic accident.

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- c. In cases of apparent suicide, the supervisor or watch commander, at the scene shall contact a Homicide Supervisor while the scene is intact and request that he respond to the scene. If the Homicide Supervisor determines that the incident should be handled by the Homicide Section, he will summon a Homicide Crew who will assume responsibility for the investigation.
 - d. In cases of suspected drug overdose, the precinct supervisor or watch commander at the scene shall contact a Homicide Supervisor and request that he/she respond to the scene. The Homicide Supervisor will make the determination to request the on-call narcotics detective to respond to the scene, if necessary. Illicit drugs, drug paraphernalia, or other evidence indicating a drug overdose shall be seized, packaged, and delivered to the Department Laboratory. Photographs of the scene shall be taken by the Precinct Supervisor or investigating Officer/Detective. In all cases of suspicious sudden deaths or suspected drug overdose, a police report will be prepared. This will usually be the responsibility of the District Officer who originally received the assignment. In cases that a narcotics detective responds, Narcotics will conduct any necessary follow up investigation, documenting their investigation in a supplemental report; otherwise Homicide will be responsible for the follow-up investigation.
3. Reporting Deaths Other than a Homicide:
- a. Police reports are required whenever a death is reported that will be brought into the Medical Examiner's Office for further investigation.
 - b. When the cause of death is the result of a previously reported sick case or injury, the information will be embodied in a supplementary report providing an original report was prepared by our Department (i.e., critical traffic-related injury victims who later die require supplemental reports).
 - c. In all cases, the officer at the scene or hospital, will make a visual check of the body for obvious marks or signs of violence, and/or suspicious circumstances and relay this information to the M.E. Investigator. While at the hospital, the officer will also obtain the DOA time and the physician's name.
 - d. The body will not be undressed by the officer but by the hospital staff or attendant at the morgue under the direction of the forensic pathologist.
 - e. Clothing that is removed by hospital staff and has evidentiary value will be seized by the officer and delivered to the Laboratory Division. Clothing that is removed at the morgue and has evidentiary value will be sent to the Laboratory by the investigating Officer/Detective after being viewed by the forensic pathologist.
 - f. The investigating officer will fill out the "Medical Examiner's Report of Death" form as completely as possible. Upon completion, the form will be left with the morgue attendant or investigator.
 - g. In cases of death where a relative of the decedent is not present, the investigating officers should attempt to learn the name and address of a relative for inclusion in the Medical Examiner's Report of Death. If the next of kin is unknown it should be so stated in the report.

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- h. If an officer has left the Medical Examiner's Office and later investigation reveals further information concerning the deceased, (i.e. name of deceased, next of kin, doctor's name, history of previous injury, etc.), the officer will relay this information to the Medical Examiner's Investigator for inclusion in the case file.
- i. If at all possible, a member of the deceased's family shall be notified of the death. The notification by this Department shall be made personally, not by telephone. If the next of kin is a non-resident of St. Louis or St. Louis County, the police agency having jurisdiction where the next-of-kin are located will be requested to make the notification personally. The reporting officer will request verification of this notification.

NOTE: Under no circumstances will an officer release any information as to possible cause or manner of death or that an autopsy will or will not be performed.

- j. In cases where the deceased has lived alone and there are no known immediate relatives in the city to take temporary possession of his home, apartment or room, the officer will secure the premises and notify the Public Administrator of his action. The officer will record in the Police Report the steps taken to secure the residence, the name of the Public Administrator notified, and any statement the Public Administrator makes. The Command Post will maintain a current list of the telephone numbers of the Public Administrators.
- k. Should any additional information relative to the identification, or next of kin, of a body being held at the morgue become available, an M.E. Investigator will immediately notify the desk officer of the concerned district. In turn, the desk officer will cause the information to be embodied in either the original or a supplementary report if district personnel conducted the investigation. As a result of the information learned, a teletype message will be prepared by the investigating unit when necessary to cancel or modify any previous messages.
- l. The officer handling the reported death will obtain a wanted record check on the deceased. If an active wanted card is on file, the originating unit will be notified and will have responsibility for the follow-up investigation and cancellation of record.
- m. If an active St. Louis City warrant is discovered, the Officer handling the assignment will be responsible for contacting TRU to cancel the warrant. This cancellation will be documented in an I/LEADS report.

4. Medical Examiner's Cases Not Requiring a Police Report:

- a. In certain cases, where the M.E. Investigator screens the circumstances of the death, and then releases the body to the next-of-kin or the hospital, no police report will be prepared. The assignment will be classified a "Sudden Death", Code "N".
- b. The officer shall view the body at the scene for obvious marks of violence. If any suspicious marks are noted, the Medical Examiner Investigator will be contacted and informed of this information. If no suspicious marks are noted, the officer will obtain the DOA time, name (first and last) and (DM) driver/medic number of the paramedic who determined the body lifeless. This information will be relayed to the M.E. Investigator by the investigating officer.

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- c. Whenever the M.E. Investigator releases the body to the next-of-kin at the scene, the relative(s) should contact a private funeral director to convey the deceased directly to the funeral home. If the relative is unable to have the body removed the investigating officer will contact the M.E. Investigator for further instructions.

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251-09-06980

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER

Date Issued: October 7, 2013 **Order No.:** Section III of SO 5-06

Effective Date: October 7, 2013 **Expiration:** Indefinite

Reference:

CALEA Standards: Academy 2.2.7

Cancelled Publications: Section III of SO 5-06, issued October 7, 2011

Subject: COMMUNICABLE AND INFECTIOUS DISEASE PROTOCOLS

To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To provide information regarding communicable and infectious disease and outline procedures for exposure prevention during Academy training and when performing essential functions of a Police Officer.

POLICY: To safeguard the health and welfare of the Department employees while maintaining operations in an effective, safe and efficient manner.

A. INTRODUCTION

1. The duties of Police Officers and other Department members may require physical contact with the public, the handling of personal items of those persons and a physical presence in environments that may increase the likelihood of exposure to communicable diseases.
2. The following information includes a communicable disease overview; discussion regarding the use of Standard Precautions to prevent occupational exposure; and a basic understanding of the transmission routes for communicable diseases.

B. BLOODBORNE PATHOGENS

1. HIV/AIDS

a. Facts

Acquired Immune Deficiency Syndrome (AIDS) is caused by a virus known as Human Immunodeficiency Virus (HIV). It is a disease that undermines the human body's immune system, rendering the individual susceptible to a variety of infections, malignancies and other diseases which are not found in persons with normal immune systems. The HIV antibody test does not detect the presence of the HIV infection itself, but indicates the presence of antibodies to the virus, and these antibodies are evidence that the immune system has attempted to fight off an infection. A positive result on a test means that the individual was infected with the HIV virus at some time.

b. Transmission

HIV/AIDS is transmitted through direct exposure to blood, semen, or other body fluids from a person infected with the HIV/AIDS virus entering the body of someone

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who is not infected. This can happen through sexual contact with an infected person or sharing needles, syringes, or other injection drug equipment. HIV/AIDS can also be passed from an infected mother to her baby at birth and during breastfeeding.

c. Treatment

There is no definitive cure for HIV/AIDS, but a variety of drugs can be used in combination to control the virus. Each of the classes of anti-viral HIV drugs blocks the virus in different ways. Post-exposure prophylaxis (PEP) is short-term antiretroviral medication treatment that is prescribed post-exposure to reduce the likelihood of HIV infection after potential exposure

2. HEPATITIS B VIRUS (HBV)

a. Facts

Hepatitis B is a contagious liver disease that results from infection with the Hepatitis B virus (HBV). When first infected, a person can develop an “acute” infection, which can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization. Acute Hepatitis B refers to the first six months after someone is exposed to the Hepatitis B virus. Some people are able to fight the infection and clear the virus. For others, the infection remains and leads to a “chronic,” or lifelong, illness. Chronic Hepatitis B refers to the illness that occurs when the Hepatitis B virus remains in a person’s body. Over time, the infection may cause serious health problems.

b. Transmission

Hepatitis B is usually spread when blood, semen, or other body fluids from a person infected with the Hepatitis B virus enter the body of someone who is not infected through sexual contact, sharing needles, syringes, or other injection drug equipment. Hepatitis B can also be passed from an infected mother to her baby at birth. Hepatitis B is not spread through breastfeeding, sharing eating utensils, hugging, kissing, holding hands, coughing, or sneezing. Unlike some forms of hepatitis, Hepatitis B is also not spread by contaminated food or water.

c. Treatment

There is no definitive cure for Hepatitis B; however a Hepatitis vaccine given as a series of three injections over a period of six months may prevent the disease prior to exposure.

3. HEPATITIS C VIRUS (HCV)

a. Facts

Hepatitis C is a contagious liver disease that results from infection with the Hepatitis C virus. When first infected, a person can develop an “acute” infection, which can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization.

- 1) Acute Hepatitis C is a short-term illness that occurs within the first 6 months after exposure to the Hepatitis C virus. For reasons that are not known, 15% to 25% of people “clear” the virus without treatment. Approximately 75% to 85%

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of people who become infected with the Hepatitis C virus develop “chronic,” or lifelong, infection.

- 2) Chronic Hepatitis C is a long-term illness that occurs when the Hepatitis C virus remains in a person’s body. Over time, it can lead to serious liver problems, including liver damage, cirrhosis, liver failure, or liver cancer.

4. Transmission

Hepatitis C is usually spread when blood from a person infected with the Hepatitis C virus enters the body of someone who is not infected, by blood, sexual contact, and from mother to infant. Today, most people become infected with Hepatitis C by sharing needles or other equipment to inject drugs. Before widespread screening of the blood supply began in 1992, Hepatitis C was also commonly spread through blood transfusions and organ transplants.

5. Treatment

Acute Hepatitis C rarely causes symptoms, and it often goes undiagnosed and therefore untreated. When it is diagnosed, doctors recommend rest, adequate nutrition, fluids, and antiviral medications. People with chronic Hepatitis C should be monitored regularly for signs of liver disease. Even though a person may not have symptoms or feel sick, damage to the liver can still occur. Antiviral medication may be used to treat some people with chronic Hepatitis C, although not everyone needs or can benefit from the anti-viral treatment. However, for many, anti-viral treatment can be successful and result in the virus no longer being detected.

C. STANDARD PRECAUTIONS

The CDC recommendations for Standard Precautions include a group of infection prevention practices that should be used when assisting or working with the public. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible potentially infectious agents.

1. Precautions should be utilized in the presence or anticipation of exposure to:

- a. Blood;
- b. All bodily fluids containing visible blood;
- c. Semen;
- d. Vaginal fluid;
- e. Cerebrospinal Fluid (brain, spine);
- f. Synovial (joint), pleural (lung), peritoneal (abdominal), pericardial (heart), and amniotic (pregnancy) fluids; and
- g. Needles, scalpels and other sharp instruments.

2. Precautions include:

a. Hand-washing

- 1) Washing hands with soap and water is the best way to clean hands.
- 2) If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.
- 3) After touching blood, body fluids, secretions, excretions and contaminated item.
- 4) Immediately after removing gloves.

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NOTE: Hand sanitizers are not effective when hands are visibly dirty.

b. Gloves

- 1) Wear when in contact with blood, body fluids, secretions and contaminated items.
- 2) Wear when in contact with mucous membranes and non-intact skin.

c. Masks, goggles, face masks

- 1) Protect mucous membranes of eyes, nose and mouth from contact with blood and/or body fluids.

d. Gowns

- 1) Protect skin from blood or body fluid contact.
- 2) Prevent soiling of clothing during procedures that may involve contact with blood and/or body fluids.

e. Clothing

- 1) Handle soiled clothing with gloves to prevent touching skin or mucous membranes.
- 2) Remove any soiled clothing as soon as possible and wash skin surfaces after contact with blood or body fluids with soap and water or an antiseptic waterless hand-rub.
- 3) Wash items contaminated with body fluids, such as saliva, blood, urine, feces, nasal secretions, and vomit, following OSHA and CDC Guidelines: Washing clothing with soap or detergent and hot water temperature settings.
- 4) Remove soiled clothing as soon as possible and place the clothing inside a plastic bag to avoid further contact before laundering. As an extra precaution, contaminated clothing should not be laundered with other clothing.

f. Equipment

- 1) Handle soiled equipment in a manner to prevent contact with skin or mucous membranes and to prevent contamination of clothing or the environment.
- 2) Clean reusable equipment with approved biohazard cleaners prior to reuse.

g. Sharps

- 1) Avoid recapping used needles.
- 2) Avoid removing used needles from disposable syringes.
- 3) Avoid handling, bending, breaking or manipulating used needles by hand.
- 4) Place sharps in puncture-resistant evidence containers.

h. Cardio-Pulmonary Resuscitation (CPR)

Use mouthpieces, resuscitation bags or other Department issued ventilation devices to avoid mouth-to mouth resuscitation.

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i. Body Handling/Removal

Utilize gloves and other available protective barriers to avoid body fluid exposure.

3. Post Exposure/Assessment:

If a Department member believes that he/she has been exposed to blood and/or other bodily fluids which may contain blood, the following options are available:

- a. The Department member or Supervisor should contact the BJC/BarnesCare BSE Hotline at (877) 767-8397) / **(877-POSTEXP)** for the trained nurses to provide assessment of the exposure, counseling, arranging of baseline testing; and if necessary, referral to BarnesCare or Barnes Jewish Hospital Emergency Department for post-exposure prophylaxis (PEP).
- b. Seek medical care during business hours at a BarnesCare location.
- c. Contact the after-hours BarnesCare service at **(314) 747-7950**.

4. Statutory Requirement for Testing of Patient with Communicable Disease

- a. Missouri Statute 192.804: states that in the event that an exposure has occurred, source patient testing will be requested and arranged. Law enforcement personnel are entitled to “receive the source patient results if a communicable disease is believed to be present.”
- b. Missouri Statute 192.802 states that “first responders or Good Samaritans are notified if there is reason to believe an exposure has occurred which may present a significant risk of a communicable disease as a result of attending or transporting a patient to a licensed facility.”

D. TUBERCULOSIS

1. Facts

Tuberculosis is also known as “TB”. TB disease is caused by a bacterium called “Mycobacterium tuberculosis”. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. However, not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection and active TB disease.

a. Latent TB Infection

TB bacteria can live in the body without making the person sick. This is called Latent TB infection (LTBI). In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. People with latent TB infection do not feel sick and do not have any symptoms. The only sign of TB infection is a positive reaction to the tuberculin skin test (TST). People with latent TB infection are not infectious and cannot spread TB bacteria to others. However, if TB bacteria become active in the body and multiply, the person will get sick with TB disease.

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b. TB Disease

TB bacteria become active if the immune system can't stop them from growing. When TB bacteria are active (multiplying in the body), this is called TB disease. The symptoms of TB disease are a persistent cough; fever, night sweats, and unexplained weight loss. People with TB disease may spread the bacteria to people they spend time with every day. Many people who have latent TB infection never develop TB disease. Some people develop TB disease soon after becoming infected (within weeks) before their immune system can fight the TB bacteria. Other people may get sick years later, when the immune system becomes weakened for another reason. For persons whose immune systems are weak, especially those with HIV infection, the risk of developing TB disease is much higher than for persons with normal immune systems.

2. Transmission

TB is spread through the air from one person to another. The infectious TB bacteria are expelled into the air when a person with active TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected.

3. Prevention

Early indication and control measures are the keys to reducing the spread of TB. Be alert for signs and symptoms of TB both at work and in the community. Ask people to cover their nose and mouth when coughing. Potential exposures should be reported to your supervisor. The exposure will be assessed and exposed employees will receive follow up testing through BarnesCare.

4. Assessment

All new employees receive a TB test during their pre-employment examination. Department members assigned to work in holdover, who have prolonged contact with detainees, will be tested annually.

5. Treatment

- a. If a Department member feels that he/she has been exposed to Tuberculosis TB, the Department member should contact BarnesCare at **(314) 747-7950** for assessment of the exposure, counseling, baseline testing, and if indicated, treatment of the exposure.
- b. The type and duration of the medication provided to individuals is according to whether the diagnosis is a Latent TB infection or whether the diagnosis is an Acute TB Disease. The treatment process is monitored by the Public Health Department.

E. COMMUNICABLE DISEASE TRANSMISSIONS

1. CONTACT

- a. Examples of Contact infections: Herpes virus, Mononucleosis, Chicken Pox, MRSA, Impetigo (via Staph. or Strep.), Fungal-Tinea (ring-worm); Conjunctivitis; Lice; Scabies

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- b. Direct contact: Infections spread from person to person by either skin-to-skin contact, or skin-to-mucous membrane contact, and mucous membrane to mucous membrane contact.
- c. Indirect contact: Infections spread from a contaminated object to a person.
- d. Prevention includes: Practicing effective hand washing; using Standard Precautions; and covering any non-intact skin, open sores, or lesions with an occlusive dressing.

2. DROPLET

- a. Examples of Droplet infections: Common cold viruses, Human Influenza (flu), Whooping cough, Meningococcal infections.
- b. Infections occur when the germ from an infected person's nose or throat comes into contact with the mucus membranes (the eyes, nose, or mouth) of another person by coughing, sneezing, or spitting.
- c. Such transfers may occur at distances of less than six feet.
- d. Prevention includes: Respiratory hygiene; covering the mouth when coughing or sneezing; effective hand-washing; vaccination when available, and limited exposure.

3. AIRBORNE

- a. Examples of Airborne infections: Tuberculosis, Chickenpox, Measles (Rubella and Rubeola), SARS, Small Pox.
- b. Infections occur when the germ from an infected person becomes suspended in the air and is then inhaled by another person.
- c. Prevention includes: Respiratory hygiene; covering the mouth when coughing or sneezing; effective hand-washing; vaccination when available; and limited exposure.

4. FECAL-ORAL

- a. Examples of Fecal Oral infections: Hepatitis A, Norovirus, Other Diarrheal illnesses, Pinworms.
- b. Infection is spread from the stool or fecal matter of an infected person transferred to another person, usually by contaminated hand-to-mouth contact.
- c. Prevention includes: Effective hand-washing after utilizing the toilet, and before touching the mouth or eating and handling food.

5. SEXUALLY TRANSMITTED

- a. Examples of Sexually Transmitted Infections: HIV, Hepatitis B, Hepatitis C, Gonorrhea, Chlamydia, Herpes-Virus, Genital Warts/HPV (Human Papillomavirus), Syphilis.
- b. Infections are spread from person to person through sexual intercourse via intra-vaginal or intra-anal routes.

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- c. Prevention includes: Latex male condoms, when used consistently and correctly, or abstinence.

F. DEPARTMENT MEMBER WITH A COMMUNICABLE DISEASE

1. Any member of the Department with a communicable disease will have his/her case carefully reviewed by the Department's healthcare provider. The decision to return to work will be made by the employee member's private physician and the Department's health care provider. Members may not return to work while there is the possibility of infecting other members of the Department.
2. Missouri statutes and the American Disabilities Act (ADA) afford all individuals protection against discrimination in the work force. This includes individuals with a known physical or mental disability and if the disability does not interfere with job performance, with or without reasonable accommodation. A fitness for duty examination may be given in order to determine the need for and the extent of the accommodation. The nature of the accommodation, if any, rests within the discretion of the employee without his/her consent. An employee who cannot perform his/her job without accommodation, and declines an offer of reasonable accommodation, subjects him/her to potential discipline, up to and including dismissal.
3. The law does not include protection of individuals who, by reason of such disease or infection, would constitute a direct threat to the safety of other individuals or who are unable to perform the essential physical functions of their employment.

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251-13-00114

**METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER**

Date Issued: October 7, 2011 **Order No.:** Section IV of SO 5-06

Effective Date: October 7, 2011 **Expiration:** Indefinite

Reference:

CALEA Standards: 41.2.7

Cancelled Publications: SO 90-S-13

Subject: **PROCEDURES FOR HANDLING MENTALLY ILL AND
ALCOHOL/DRUG DEPENDENT PERSONS**

To: **ALL BUREAUS, DISTRICTS AND DIVISIONS**

PURPOSE: To outline procedures for handling suspected mentally ill persons, to include persons who, because of mental illness or alcohol/drug abuse, pose a likelihood of serious harm to themselves or others.

A. STATE STATUTE REQUIREMENTS

1. A police officer who reasonably believes that a suspected mentally ill or alcohol/drug dependent person poses an imminent likelihood of serious harm to him/herself or others is authorized to take the person into custody for up to 96 hours for evaluation and treatment **(RSMo. Section 632.305.3); (RSMo. Section 631.120).**
2. The “likelihood of serious harm” is generally defined as a substantial risk that physical harm will be inflicted on self or others because of recent threats, suicide attempts, the infliction of physical harm or the inability to provide basic necessities (e.g., food, clothing, safety, shelter, medical care or mental health care). A pattern of past behavior may also be considered **(RSMo. Section 632.005 (10)).**
3. An officer applying for involuntary detention of a mentally-ill or alcohol/drug dependent person must complete an affidavit for initial detention for evaluation and treatment which outlines the reason for the belief that the person poses an imminent likelihood of harm to self or others **(RSMo. Section 632.305.3); RSMo. Section 631.120.2).**
4. An officer cannot be held civilly liable for detaining or transporting a suspected mentally-ill person, so long as he/she acted in good faith **(RSMo. Section 632.440).**
5. If a suspected mentally-ill person is not accepted for admission to a facility which provides 96 hour evaluation and treatment, any police officer or governmental agency that transported the person to the facility is required to furnish or arrange for transportation of such person to his/her place of residence or other appropriate place **(RSMo. 632.310.3).**
6. Any adult person, including a relative or acquaintance, may file a written application, under oath, to the Probate Division of the Circuit Court stating his/her belief that an individual is suffering from a mental disorder and is likely to harm self or others **(RSMo. 632.305.1).** The Probate Division may, with probable cause, direct the Sheriff’s Office to take the individual into custody and transport him/her to a mental health facility for up to 96 hours

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for evaluation and treatment (**RSMo. 632.305.2**). An Informal Warrant (Detain for Mental Health) will be issued by the Court for this purpose.

NOTE: See Paragraph “I” of this Section for procedures when an officer must execute the Informal Warrant.

B. EVALUATION OF OBSERVATION CALLS BY EMERGENCY MEDICAL SERVICES (E.M.S.)

The Communications Division 911 operator will transfer each observation call to the Emergency Medical Services (EMS) dispatcher for evaluation to determine if the suspected mentally-ill person is a threat to self or others. The 911 operator will remain on the line during the EMS evaluation. Based on the EMS evaluation, the call will be handled as either a non-violent case (Paragraph C below) or as a violent case where a person is a threat to self or others (Paragraph D below).

C. NON-VIOLENT OBS CASES (PERSON NOT A THREAT TO SELF OR OTHERS)

The EMS dispatcher will send an EMS unit to a non-violent OBS case WITHOUT the dispatch of police. Officers will not accompany the suspected mentally-ill person to the hospital, nor will they be required to complete an affidavit.

EXCEPTION: EMS will request immediate police dispatch if they determine upon arrival that the person has become violent or poses a threat of harm to self or others. Communications will immediately contact the Precinct Sergeant for dispatch approval; the sergeant can reach the EMS Supervisor/Lead Dispatcher at (314) 652-9296 for clarification. Any approved request from EMS for police assistance will be considered as urgent.

D. VIOLENT OBS CASES/CASES WHERE PERSON IS THREAT TO SELF OR OTHERS

1. Dispatch of Officers

- a. Whenever police dispatch is requested by EMS in a violent OBS case, the police dispatcher will immediately notify the Precinct Sergeant who will (1) have two officers remain on standby for possible dispatch; and (2) immediately contact the EMS Supervisor/Lead Dispatcher at (314) 652-9296 to verify the necessity for dispatch. EMS will be notified if police dispatch will be made; if so, EMS will wait to approach the scene until officers have the scene under control. Additional assistance may be requested by the assigned officers if necessary.
- b. The primary investigating officer (P.I.O.) will make the determination as to whether a Crisis Intervention (C.I.T.) Officer should be called. If so, Communications will dispatch the closest available same district C.I.T. officer or, if unavailable, an out-of-district C.I.T. officer at the discretion of the district supervisor/Watch Commander. The C.I.T. officer will have primary responsibility at the scene, unless a sergeant is present. However, the P.I.O. will prepare any required I-LEADS report and perform follow-up action related to arrest, booking and information application.

NOTE: See Section V of this Order entitled “Crisis Intervention Team” for full details.

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2. Transport of Mentally-Ill Person to Hospital

- a. At least one officer will accompany the suspected mentally-ill person in the EMS vehicle to the hospital, with the other officer following in a patrol vehicle. A patient not under arrest should be handcuffed if deemed necessary by the accompanying officer(s).
- b. Officers will urge a relative or friend to accompany them to the hospital. If no one is available at the scene to accompany the person, officers will attempt to contact a relative or friend and have them report to the hospital or contact the facility. In the case of a juvenile, officers will require a parent or legal guardian to accompany them to the hospital, if available.
- c. EMS will normally determine the hospital with psychiatric facilities to which a suspected mentally-ill person will be taken. However, an arrested patient 17 and older will be taken by EMS to the hospital designated by the arresting officer (except that a prisoner with life-threatening injuries will be taken at the discretion of EMS to either Barnes-Jewish or St. Louis University Hospital, since they are specially-equipped to deal with those emergencies). A juvenile will normally be taken to St. Louis Children's Hospital or Cardinal Glennon Children's Hospital. If a E.M.S. unit will not be available for an extended period, a suspected mentally-ill person may, in an emergency, be transported in a police vehicle, preferably a cruiser or lock-up car.
- d. The officer will be responsible for the prisoner's property only in those cases where the person is a police prisoner.

3. Completion of Affidavit for Admission of Mentally Ill or Alcohol/Drug Dependent Persons

- a. A Missouri Department of Mental Health Affidavit Form (Attachment 2) will be completed in a single copy at the hospital by the officer stating his/her reasons for believing that the person is a threat to self or others. The form can also be completed by an officer if the person is a juvenile, even when a parent or legal guardian is unavailable, since the Juvenile Court has jurisdiction in such situations.

NOTE: The affidavit is known as the "Affidavit in Support of Application for Detention, Evaluation and Treatment/Rehabilitation – Admission for 96 Hour". The affidavit form is available from the hospital and/or via the Department's intranet system (See Attachment 2).

- b. The Affidavit Form will be presented by the officer to the attending physician at the hospital. In situations where an I-LEADS Report is required, it will be mentioned in the report that an Affidavit was completed and furnished to the hospital.

4. Transport of Mentally-Ill Person Home if Not Accepted for Admission

If a suspected mentally-ill person is NOT accepted for admission, the police officer or governmental agency that transported the person to the facility is required to furnish or arrange for transportation of such person to his/her place of residence or other appropriate place (**RSMo. 632.310-3**).

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E. PROCESSING OF PATIENT AT HOSPITAL

1. Officers escorting a psychiatric patient to the hospital will remain with the patient until he/she is admitted and turned over to hospital personnel.

EXCEPTION: See Section VIII of this Order for security arrangements when a person is a police prisoner.

2. Officers will not normally enter a psychiatric ward or area; however, if this is required in extenuating circumstances, officers will follow any existing hospital regulations for firearms security. Any item of police equipment other than a firearms may be taken into a psychiatric ward.

F. PROCESSING MENTALLY-ILL PERSONS ARRESTED ON BONA FIDE CHARGES

1. Persons 17 Years of Age or Older

The person will be arrested and booked according to the procedures outlined in Special Order 8-01, "Arrest, Booking and Related Procedures". If the prisoner is kept at the hospital for additional psychiatric observation, one of the following actions will be taken based on the seriousness of the charge and the Watch Commander's discretion, per procedures in Section VIII of this Order:

- a. Police officer detail placed;
- b. Prisoner Hold Order, MPD Form GEN-424 placed;
- c. Released on charge (s) pending application for 'at large' warrant.

2. Juveniles

If the juvenile is kept at the hospital for additional psychiatric observation, the apprehending officer will proceed to the Juvenile Court where an affidavit will be prepared. The Deputy Juvenile Officer in the Intake Unit will then decide if a Juvenile Confidential History Form will be prepared.

NOTE: A police officer detail will be placed at the hospital on a juvenile only when there is reason to believe that he/she will make an escape attempt and attempt to harm a victim, witness or another person. See Section XV of SO 5-16, "Juvenile Procedures" for full details.

G. POLICE REPORT REQUIREMENT IN OBSERVATION CASES

A police report will be prepared in an observation case only when one of the following circumstances is involved:

1. Individual was arrested on a bona fide charge;
2. Force was used to subdue the individual;
3. Death is apparent or imminent;
4. Life-threatening illness/injury;
5. Police Department employee involved;
6. Attempted suicide (if firearm or weapon used); or
7. Unusual circumstances.

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H. MISSING PERSONS FROM ST. LOUIS PSYCHIATRIC REHABILITATION CENTER (ST. LOUIS STATE HOSPITAL)

SEE SECTION II (L) OF THE SPECIAL ORDER 9-01 ENTITLED "PROCEDURES FOR THE INCIDENT REPORTING SYSTEM (I-LEADS)" FOR DETAILS CONCERNING THE REPORTING OF MISSING PERSONS FROM ST. LOUIS PSYCHIATRIC REHABILITATION CENTER.

I. INFORMAL WARRANT (DETAIN FOR MENTAL HEALTH)

1. The local Probate Division Judge may issue an Informal Warrant with instructions for the Sheriff or police to deliver the individual to a psychiatric facility.
2. The Sheriff normally serves such warrants; however, an officer may receive a computer 'hit' on a person who was previously unserved.
3. Officers will verify the validity of the Informal Warrant by contacting the Circuit Courts during normal operating hours; during other hours, the Warrant and Fugitive Section may be contacted.
4. Officers will comply with the instructions in a verified Informal Warrant, which requires the delivery of the person to a psychiatric facility without booking.

NOTE: A warrant issued prior to July 15, 2010, may direct that an individual be taken to the Metropolitan St. Louis Psychiatric Center (no longer available). In the event of a 'hit' on such a warrant, the individual should instead be taken to Barnes-Jewish Hospital for evaluation.

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**METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER**

Date Issued: October 7, 2011 **Order No.:** Section V of SO 5-06

Effective Date: October 7, 2011 **Expiration:** Indefinite

Reference:

CALEA Standards: 41.2.7

Cancelled Publications: SO 5-25, issued July 16, 2010

Subject: CRISIS INTERVENTION TEAM (FOR HANDLING MENTAL HEALTH CRISIS)

To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To establish a written policy within the Police Department concerning the functions and responsibilities of the Crisis Intervention Team (CIT).

A. DEFINITIONS

1. CIT Council

A council comprised of law enforcement officials, court officials and mental health advocates, responsible for training and policy concerning the Crisis Intervention Team. The Council also has a review board that meets to discuss individual cases and formulate recommendations.

2. CIT Officer (41.2.7.d)

A non-probationary police officer who has completed 40 hours of specialized Crisis Intervention Team training and who responds to incidents involving a mental health crisis.

3. Consumer (41.2.7.a)

A term commonly used by the mental health community when referring to an individual with a suspected mental illness or who is involved in a perceived mental health crisis and utilizes mental health services.

4. Mental Health Crisis (41.2.7.a)

A situation where an individual's normal coping mechanisms have become overwhelmed causing that individual to pose an immediate and significant risk to self or others (e.g., violent OBS, suicidal subject, etc.).

5. Area Station CIT Coordinator

A Supervisor assigned to an Area Patrol Station who is charged with collecting the CIT forms and distributing them to the CIT Council. Additionally, s/he may be called upon to attend CIT Council meetings. One CIT Coordinator is selected after consultation with District Commanders.

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B. GENERAL (41.2.7.c)

1. The Police Department's Crisis Intervention Team is composed of specially trained Supervisors and officers selected by District Commanders whose functions are to:
 - a. respond to incidents which involve a mental health crisis where the officer's specialized skills may be used to successfully conclude such an incident; and
 - b. provide further assistance, beyond the actual call, for the individual involved (i.e., contacting mental health providers or the Mental Health Court). (41.2.7.b)
2. There are no changes in procedures relative to the transportation of the consumer. If the CIT Officer determines that the consumer is a danger to himself/herself or others, the CIT Officer will have primary responsibility to arrange for transportation via EMS (Emergency Medical Services) to the hospital (see Section IV, Para. D of this Order).
3. The policies contained in this Order do not supersede those outlined in other Orders involving use of force or the notification of specialized units for incidents where the situation dictates such a notification (i.e., notifications to Criminal Investigations, or tactical units, etc.).

C. PROCEDURES (41.2.7.c)

1. Dispatch of Call

- a. WHEN EMS CLASSIFIES A CALL AS A MENTAL HEALTH CRISIS, COMMUNICATIONS WILL, WITH APPROVAL OF THE PRECINCT SERGEANT, DISPATCH AT LEAST TWO DISTRICT OFFICERS TO THE SCENE, PER SECTION IV (PARAGRAPHS B AND D) OF THIS ORDER. IF A C.I.T. OFFICER IS REQUESTED BY EITHER THE CALLER OR THE DISTRICT OFFICERS AT THE SCENE, EVERY EFFORT WILL BE MADE BY THE DISPATCHER TO LOCATE AND DISPATCH A SAME-DISTRICT C.I.T. OFFICER TO THE SCENE.

NOTE: If a same-district CIT Officer is unavailable, it will be at the discretion of the district Supervisor/Watch Commander to request an out-of-district CIT Officer.

- b. If Communications receives a report of a situation that is not immediately recognized as a mental health crisis, but the first arriving officer (Primary Investigation Officer / PIO) determines that a CIT Officer is needed, that officer will immediately request a CIT Officer to respond through Communications.

2. Control of Scene

The on-scene CIT Officer will have primary responsibility of the scene on any mental health crisis-type call, unless a Supervisor is present. In cases where a Supervisor is on the scene along with a CIT Officer, the Supervisor will have primary control of the scene. The CIT Officer will have no further control of the scene beyond the use of his/her specialized skills to successfully conclude the incident.

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3. Responsibilities of the CIT Officer

- a. Upon arrival at the scene of a mental health crisis the CIT Officer will determine the circumstances and will be responsible for the initiation of the appropriate response.
- b. Admission to a treatment facility should be arranged by the CIT Officer. This may include the preparation of required affidavits by (1) a consumer's family member; or (2) any officer with reasonable belief that an individual poses a threat to self or others. **(41.2.7.b)**

NOTE: See Attachment 2 for copy of Affidavit form, which is available on Department intranet system.

- c. If deemed necessary, the CIT Officer will coordinate with Communications to ensure that information concerning a consumer is entered into the CAD Alert File.

4. Reporting Procedures

a. Incident Report Required:

- 1) The PIO will have responsibility in both criminal and non-criminal cases for drawing a complaint number, completing the original incident report and handling all processes related to arrest, booking, and information application.
- 2) The PIO will document in the narrative of his/her incident report if a CIT Officer was requested, purpose of request, and who responded to the scene.
- 3) The responding CIT Officer will complete the Crisis Intervention Team Form (CIT Form) accessible on the Intranet and ensure it is received by the Area Station CIT Coordinator.
- 4) In cases where a CIT Officer was not available during a call involving a mental health crisis, beat officers will complete the original incident report and provide any immediate assistance available to the involved individual in crisis. No CIT Form will be completed.

b. Incident Report NOT Required:

- 1) An appropriate disposition will be given by the officer(s) receiving the original assignment at the conclusion of the call.
- 2) The officer giving the disposition will add an appropriate comment to the CAD call log.

EXAMPLE: "C.I.T. officer requested and responded to scene".

- 3) The responding CIT Officer will complete the CIT Form and ensure that it is received by the appropriate Area Station CIT Coordinator.
- 4) In cases where a CIT Officer was not available during a call involving a mental health crisis, beat officers will provide any immediate assistance available to the involved individual in crisis. No CIT Form will be completed.

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5. Responsibilities of the Supervisors

Monitoring of CIT Officers under a Supervisor's command will include, but is not limited to, ensuring that CIT Officers:

- a. complete and provide to the Area Station CIT Coordinator the Crisis Intervention Team Form when applicable;
- b. conduct follow-up investigations on cases investigated by them; and/or
- c. attend CIT Council-Review Board meetings as requested.

6. Responsibilities of Area Station CIT Coordinators

- a. Coordinate and maintain a central file at their patrol station.
- b. Forward a copy of CIT Forms to the CIT Council for review. Any specific issues found on the forms that may require special attention, will be noted in "Additional Comments."

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**METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER**

Date Issued: October 7, 2011 **Order No.:** Section VI of SO 5-06

Effective Date: October 7, 2011 **Expiration:** Indefinite

Reference:

CALEA Standards:

Cancelled Publications: SO 90-S-13

Subject: **HANDLING OF INTOXICATED PERSONS AND ALCOHOL/DRUG
DEPENDENT PERSONS POSING A THREAT OF HARM**

To: **ALL BUREAUS, DISTRICTS AND DIVISIONS**

PURPOSE: To outline procedures for the handling of (1) intoxicated persons; and (2) alcohol/drug dependent persons posing an imminent threat of serious harm to self or others.

A. INTRODUCTION

1. State law generally provides that “No county or municipality,...may adopt or enforce a law, rule or ordinance which authorizes or requires arrest or punishment for public intoxication or being a common or habitual drunkard or alcoholic” (**RSMo. Section 67.305**).
2. The above Statute does NOT apply to the enactment and enforcement of laws prohibiting:
 - a. drunken driving and driving under the influence of alcohol;
 - b. similar offense involving drinking and the operation of a vehicle, aircraft, boat, machinery, firearms or other equipment;
 - c. the sale, purchase, dispensing, possessing or use of alcoholic beverages at stated times and places or by a particular class of persons; or
 - d. the commission of any other crime while intoxicated or under the influence of alcohol (**RSMo. Section 67.310**).
3. State law also provides that a person with an alcohol and/or drug abuse problem who presents an imminent likelihood of serious harm to self or others may be taken into custody by police and conveyed to an alcohol or drug abuse facility (**RSMo. Section 631.120**).

B. PROCEDURES FOR HANDLING INTOXICATED PERSON NOT BEING ARRESTED

1. An officer observing or receiving an assignment for an intoxicated person who is not subject to arrest under RSMo. Section 67.305 will be handled in one of the following ways, at the discretion of the officer:
 - a. Contact a relative or friend to pick up the intoxicated person;
 - b. Call a taxi for the subject, if he/she has sufficient funds; or

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- c. Contact EMS for transport of the intoxicated person to the hospital ONLY IF HE/SHE IS A DANGER TO SELF OR OTHERS.
2. EMS will always be contacted to convey the intoxicated person to the hospital if he/she has an injury or illness not related to the intoxication.

C. ALCOHOL/DRUG DEPENDENT PERSON LIKELY TO HARM SELF OR OTHERS

1. State Law provides that an officer may take a person with an alcohol/drug abuse problem into custody for up to 96 hours for evaluation and treatment when the officer reasonably believes that the person poses an imminent likelihood of serious harm to self or others (**RSMo. Section 631.120**).
2. The following procedures apply when a person with an alcohol/drug abuse problem poses a threat of serious harm to self or others:
 - a. The officer will call EMS to transport the person to the hospital;
 - b. The officer will report to the hospital and complete a single copy of an “Affidavit in Support of Application for Detention, Evaluation and Treatment/ Rehabilitation – Admission for 96 Hours”. The officer must indicate the reason he/she believes the person poses a threat of injury to self or others.

NOTE: This form is available from the hospital and/or via the Department Intranet system (See Attachment 2).

- c. The Affidavit form will be presented by the officer to the attending physician at the hospital. In situations where an I-LEADS report is required, mention will be made in the report that an Affidavit was completed and furnished to the hospital.

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**METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER**

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Reference:

CALEA Standards:

Cancelled Publications: SO 90-S-13

Subject: SICK AND INJURY CASES INVOLVING PRISONERS IN POLICE CUSTODY

To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To outline procedures to be followed when prisoners become sick and/or injured while in the custody of the Department.

A. PRISONERS CONFINED IN AREA HOLDOVER

1. If a prisoner confined to an Area holdover requires emergency medical attention, an Emergency Medical Service (EMS) unit will be requested to respond to the holdover for medical evaluation and, if necessary, conveyance to the hospital. A police officer will accompany the prisoner in the rear of the vehicle.

NOTE: In the case of an emergency when an EMS unit is not immediately available, a police vehicle may be used to convey the prisoner to the hospital (see Section I of this order).

2. If a prisoner confined to an Area holdover requires non-emergency medical attention, the on-duty nurse at the Department of Corrections (DOC)-City Justice Center will be contacted for guidance.
3. After the prisoner has been treated or released, he/she will be conveyed by police vehicle accompanied by two officers to either the Area Station or Prisoner Processing (at DOC-City Justice Center). A prisoner may be handcuffed with hands in front of his/her body if required by the prisoner's medical condition.
4. Federal prisoners (F.B.I., Secret Service, military, etc.) are the responsibility of the Federal agency that commits them until they are physically placed in the custody of the U.S. Marshal or military authorities. The appropriate Federal agency has responsibility for arranging medical treatment for such prisoners, including transportation. However, EMS will be called when a Federal prisoner requires immediate medical treatment.

NOTE: See Section VI of SO 8-03, "Holdover Operations - Medical and Health Care Services" for full details relating to medical attention for prisoners confined at Patrol Division holdovers.

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B. PRISONERS IN CUSTODY OF PRISONER PROCESSING BEFORE TRANSFER TO DOC-CITY JUSTICE CENTER PERSONNEL

1. When a prisoner in custody of the Prisoner Processing requires treatment at a hospital (e.g., not found 'fit for confinement' by DOC-City Justice Center nurse), the on-duty Prisoner Processing Watch Commander will notify the district/division or Federal agency of arrest.
2. If the injury/illness is not serious, the district/division of arrest or responsible Federal agency will transport the prisoner to and from the hospital in an agency vehicle.

EXCEPTION: In an emergency, EMS will be called to convey the prisoner to the hospital, accompanied by an officer from this Department in an EMS unit, to include a Federal prisoner when an agent is not immediately available.

NOTE: See Section X of SO 8-03, "Holdover Operations – Prisoner Processing Procedures" for full details.

C. PRISONERS IN CUSTODY OF DOC-CITY JUSTICE CENTER

If a prisoner becomes sick AFTER transfer of custody from Prisoner Processing to the DOC-City Justice Center, personnel of that agency have responsibility for transporting the prisoner to and from the hospital.

D. MEDICATION FOR PRISONERS

1. PERSONNEL FROM OUR DEPARTMENT WILL NOT DISPENSE OR ADMINISTER MEDICATION TO PRISONERS IN CUSTODY. This function will be performed by the nurse assigned to the DOC-City Justice Center.
2. If a prisoner is in possession of medication previously prescribed by a physician, the district or division of arrest will enclose the medication in a SEPARATE Property Bag, MPD Form GEN-86/86a, which will be kept unsealed, and forward it with the prisoner to Prisoner Processing.
3. The following disposition will be made of any prescribed medication for a prisoner upon his release from police custody:
 - a. If the prisoner is released from custody BEFORE being turned over to the DOC- City Justice Center, as in the case of an information refusal, the medication will be returned to the prisoner upon release.
 - b. If the prisoner is turned over to the DOC-City Justice Center, as in the case of an information issuance, the medication will accompany the prisoner to the DOC-City Justice Center.
 - c. If a prisoner is turned over to an outside agency, any prescribed medication will be turned over to that agency.

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METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER

Date Issued: October 7, 2011 **Order No.:** Section VIII of SO 5-06

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Reference:

CALEA Standards:

Cancelled Publications: 90-S-13

Subject: SECURITY OF PRISONERS CONFINED TO HOSPITAL

To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To outline procedures for (1) the security of a prisoner confined to any hospital as a result of illness or injury; (2) the placement of a “hold order” on a prisoner confined to a hospital; and (3) release of a prisoner on charge (s) pending application for an ‘at large’ warrant.

A. GENERAL POLICY

1. Responsibility for Prisoner’s Security

- a. The security of a prisoner confined in a hospital is normally the responsibility of the district in which the incident occurred, unless otherwise designated by the Deputy Chief, Bureau of Community Policing or the on-duty Community Policing staff officer.
- b. The Watch Commander or Acting Watch Commander of the responsible district will assign officer(s) to guard a sick or injured prisoner confined in the hospital, until such time as a warrant is issued and custody of the prisoner is relinquished to the Sheriff. In certain situations, a Prisoner Hold Order, MPD Form GEN 424 (see Paragraph B of this Order) may be placed on a prisoner without the need for a police detail; additionally, some prisoners may be released on a Citation/Summons (see Paragraph B below). Additionally, some prisoners confined to the hospital may be released on charge(s) placed pending application for an ‘at large’ warrant (see Paragraph C below).

2. Information Application on Prisoners Confined to Hospital

- a. The Circuit Attorney, upon issuing an information on a prisoner confined in the hospital will file with the Clerk of the Circuit Court either a “complaint” (felony charge) or an “information” (misdemeanor charge).
- b. If a warrant is signed by the judge or clerk acting for the judge, it will be delivered to the Sheriff’s Office, which will assume responsibility for the prisoner at the hospital.
- c. If an information application is refused, a prisoner confined in a hospital will be released on the charge placed against him/her without delay.

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B. PLACEMENT OF HOLD ORDERS ON PRISONERS CONFINED TO HOSPITAL

1. Felony Charges

A police detail will normally be placed on a prisoner who is confined to the hospital on felony charges. However, the District Watch Commander or Acting Watch Commander may, for extenuating circumstances, place a "Prisoner Hold Order", MPD Form GEN 424 (Attachment 3), on a subject charged with a felony crime. This would include the arrest of a person who is extremely aged, vision impaired, a paraplegic, an amputee or a person who, in the opinion of the Watch Commander/Acting Watch Commander, would be easy to locate if he/she left the hospital.

2. Misdemeanor/City Ordinance Charges

In lieu of placing a hospital detail, a prisoner booked on a misdemeanor or City Ordinance violation who is confined to a hospital may, at the discretion of the Watch Commander/Acting Watch Commander, either (1) have a "Prisoner Hold Order", MPD Form GEN 424 (Attachment 3) placed against him/her; or (2) be released on a Uniform Citation form or City Ordinance Summons.

NOTE: Watch Commanders or Acting Watch Commanders will closely evaluate the nature of the incident, as well as the subject's prior arrest record and convictions before having a Prisoner Hold Order placed or releasing him/her on a Citation/Summons.

3. Completion of Prisoner Hold Order, MPD Form GEN-424

- a. The "Prisoner Hold Order", MPD Form GEN-424 (Attachment 3), which is available on the Department intranet system, will be completed in an original and one copy by the arresting officer, after verbal authorization from the Watch Commander. The form will be completed in two copies: (1) an original copy which is presented to the hospital representative receiving the order, who will be required to sign as receiving the form; and (2) a copy which is attached to the "district" copy of the Arrest Register.
- b. The appropriate on-duty Watch Commander of the District in which the hospital is located will be notified by the arresting officer that a hold order has been placed on the prisoner. The Watch Commander will then have the precinct sergeant responsible for detail inspections check on the status of each prisoner with a hold order.

4. Prisoner Released From Hold Order

If the hold order on the prisoner is no longer in effect, the District Watch Commander of the arresting officer(s) will have an officer personally report to the hospital and sign the "Hold Order Released by" column of the Prisoner Hold Order Form. This information will also be indicated on the "district copy" of the Arrest Register.

5. Prisoner with "Hold Order" Leaves Hospital Without Authorization

If a prisoner-patient with a hold order against him/her leaves the hospital without authorization, an officer from the district of arrest will place a wanted on the subject and prepare a supplementary report.

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C. RELEASE OF PRISONERS PENDING APPLICATION FOR 'AT LARGE' WARRANT

At the discretion of the District Watch Commander/Acting Watch Commander, a prisoner confined to the hospital may be released on felony or misdemeanor charge(s) placed against him/her pending application for an 'at large' warrant. This option will only be employed when, in the opinion of the Watch Commander, the prisoner does not pose a threat of injury to anyone and would be easy to locate at a later date if the warrant is issued.

D. HOSPITAL CONFINEMENT PROCEDURES

1. Arresting Officer's Responsibility

- a. Arresting officers will immediately inform their immediate supervisor whenever a prisoner is admitted to any hospital as a patient. The officers will also inform the attending physician of the nature of the arrest and charges.
- b. TWO officers will accompany the prisoner at all times unless the attending physician indicates that the officers' presence is not permitted (i.e., prisoner in surgery). The officers will, however, remain in close proximity to prevent any escape attempts as well as to safeguard hospital personnel and other patients.

NOTE: A probationary officer on field training will not be included as one of the accompanying officers.

- c. If the prisoner is being x-rayed, the officers will keep the prisoner in view at all times by standing behind the protective wall provided for the x-ray technician and observing the prisoner through the glass partition in the wall.
- d. Arresting officers will insure that the prisoner is secured to the hospital bed unless otherwise directed by the physician, and will remain with the prisoner until such time as the hospital guard detail is established by the district of arrest.

2. Assignment of Officer Guard at Hospital

- a. The district of arrest precinct sergeant will (1) make the initial decision for assigning officers to guard a confined prisoner; and (2) lend needed assistance (i.e., securing leg irons, etc.).
- b. Each Area Station has sets of leg irons for use when a prisoner is confined to the hospital with a police guard. Additional leg irons are available from Prisoner Processing (after conclusion of the hospital detail, the disposition of the leg irons will be indicated in the Hospital Detail Activity Log, MPD Form OPP-27 – Attachment 5.)
- c. The Watch Commander or Acting Watch Commander of the district of arrest will normally assign TWO officers from that district (excluding a probationary officer on field training) to assume guard duty at the hospital to relieve the arresting officers, unless exigent circumstances such as serious staffing problems require that only one officer be assigned. However, special efforts will be made to assign two officers on prisoners being held on felony charges.

NOTE: If the prisoner is a female, the Watch Commander or Acting Watch Commander of the district of arrest will determine if female officers are available to assume detail responsibility. If female officers are unavailable, or until they are

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available, male officers will be assigned to the hospital detail; however, the male officers will comply with all reasonable requests from hospital personnel to respect the modesty of the prisoner and other female patients. Prisoner security, however, will always remain the overriding consideration.

d. The Watch Commander or Acting Watch Commander of the district of arrest will have a file folder prepared for each prisoner confined to a hospital with a police guard. The 11 3/4 x 9 1/2 manila file folder will be prepared as follows:

- 1) The exposed tab will contain the prisoner's pedigree, the charge(s), the Arrest Register number, and his/her hospital location. (For example, Bryson, Wendell, W, M, 29, Ark. - 4210 Blaine, Robbery, A.R. 3-719, Barnes-Jewish Hospital - Div. 10).
- 2) A copy of a completed "Hospitalized Prisoner History," MPD Form OPP-26 (see Attachment 4) will be stapled to the left interior side of the folder. The right interior side of the folder will be equipped with a paper fastener to which three (3) copies of the Hospital Detail Activity Log, MPD Form OPP-27 (see Attachment 5), will be initially attached.

NOTE: Both forms are available on the Department intranet system.

- 3) A Department EPIC photo, if available, should be made a part of the file folder as soon as possible.

NOTE: The prisoner's file folder will be given to the guarding officer(s).

3. The district of arrest precinct sergeant responsible for the detail will discuss at length with the hospital detail officers the hazards and responsibilities for guarding a prisoner. It is especially important to notify new officers of possible methods a prisoner might employ to escape custody, as well as the ways in which weapons can be smuggled to the prisoner. Watch commanders should give consideration to alternating officers assigned to a hospital detail on the Night Watch, since it is difficult to remain alert while inactive.
4. When a prisoner is confined to a private hospital, the district wherein the hospital is located will be notified so that the precinct sergeant can be made aware of the situation and periodically inspect the detail.
5. Watch commanders of both the district of arrest and the district in which the hospital is located will insure that all information concerning a confined prisoner (e.g., Prisoner Hold Order Form GEN-424 completed, progress reports, "release" information, etc.) is recorded in the district desk book. The desk personnel of the district in which the hospital is located will notify the oncoming precinct sergeant of all pertinent information concerning hospital details for which he/she is responsible (i.e., periodically inspecting the prisoner detail and arranging relief for guarding officers, etc.).

E. SECURITY PRECAUTIONS

1. Upon assuming charge of a prisoner-patient confined to a hospital ward, hospital detail officers will adhere to guidelines in this paragraph, and may use additional security precautions considered necessary for prisoner security.

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2. The prisoner and his/her immediate surroundings will be searched to insure the absence of weapons, alcoholic beverages, and unauthorized drugs. The condition of leg irons should be checked. These measures should be undertaken after every detail change in the presence of the assigned officer(s) and the relieving officer(s).
3. A completed Hospital Detail Activity Log, MPD Form OPP-27 (Attachment 5), will be maintained by the guarding officer(s) containing all pertinent information concerning the prisoner (e.g., off-ward treatment, visitors, detail reliefs, sergeants' inspections, unusual occurrences which may affect prisoner security, etc.).
4. If detail officers must guard two prisoners, adjoining beds will be used for this purpose. If necessary to remove one of the prisoners to another ward for any reason, the officers will call the district wherein the hospital is located for assistance. If one of the prisoners is to be permanently moved to another location, the district of arrest will be notified to furnish officers for the detail.

F. VISITATION OF PRISONERS AT HOSPITAL

1. Officers must exercise care and good judgment when allowing a prisoner to have visitors. Both the attending physician and district of arrest command personnel must concur in permitting the prisoner to receive visitors.
2. The visitor must be a member of the prisoner's immediate family (i.e., wife, husband, parents, children above the age limit established by the hospital, and other persons certified as members of the prisoner's immediate family, such as brother or sister, aunt or uncle, spouse equivalents). Friends will not be admitted.

EXCEPTION: Prisoners are allowed to have visits from counsel.

3. Only one visit will be admitted at a time.
4. AN OFFICER MUST BE IN ATTENDANCE AT EACH PRISONER VISIT.
5. Visits will be limited to twenty (20) minutes for each visitor, and only during the hospital's regular visiting hours unless otherwise advised by the attending physician.
6. The visitor will be required to complete the Hospital Detail Activity Log, MPD Form OPP-27 (Attachment 5), by entering his/her signature, address and relationship to the prisoner.
7. Prior to admittance, the prisoner will be searched if, in the opinion of the officers, this action is necessary for prisoner security. Male officers will limit a search of a female visitor to her handbag and/or other items she is carrying. In addition, packages intended for the prisoner containing food, clothing or reading material will be inspected by the guarding officers before being given to the prisoner.
8. Visitors will not be allowed to congregate in the hallway outside the prisoner's room or ward.
9. The guarding officers may refuse admittance to a visitor if a potential or real security hazard exists. The name of the visitor and reason for refusal will be included on the Hospital Detail Activity Log, MPD Form OPP-27 (Attachment 5), by the guarding officers.

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G. SAFEGUARDING OF MATERIAL WITNESSES

It may be occasionally necessary to safeguard material witnesses who are hospitalized. In such cases, security procedures will be the same as those in effect for prisoners; however, extra security precautions must be taken to protect the witness from persons who may attempt to harm him/her to prevent testimony.

H. PROCESSING FELONS CONFINED IN HOSPITAL

1. Violent felons who are confined to hospitals prior to being processed at the City Justice Center Processing may be occasionally photographed and fingerprinted by the Identification Section and/or Evidence Technician Unit.
2. After the hospital staff physician or private physician has granted permission to process a prisoner, the district of arrest Watch Commander will contact the Commander of the Laboratory/Identification Division or, if unavailable, a Division supervisor, to have the processing performed. Hospital prisoners will normally be processed only on the day watch.
3. When the prisoner is released from the hospital and confined to the holdover, a new photo and prints will be taken. The hospital prints and photographs will remain in the subject's L.B. jacket.

I. DISPOSITION OF PRISONER'S FILE

1. When the detail is terminated (e.g., prisoner makes bond, Sheriff's Office assumes responsibility, etc.), the prisoner's file folder will be taken back to the district of arrest by the last officer having charge of the detail. The district of arrest will, in turn, notify the district wherein the hospital is located and the hospital administrator, that the prisoner detail has been terminated. The disposition of leg irons will be included on the Hospital Detail Activity Log, MPD Form OPP-27 (Attachment 5) in the folder.
2. Upon receipt of the Hospital Prisoner File from the guarding officer, district of arrest desk personnel will note the original complaint number on the upper left exterior of the folder and file same in a special file. Such folders will be filed for not less than thirteen (13) months.
3. District of arrest desk personnel will also staple a 3" x 5" card note on the district file copy of the I-LEADS stating "Hospital Confinement Folder on File".

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**METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER**

Date Issued: October 7, 2011 **Order No.:** Section IX of SO 5-06

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Reference:

CALEA Standards:

Cancelled Publications: 90-S-13

Subject: EMERGENCY TREATMENT OF DEPARTMENT PERSONNEL
INJURED WHILE ON DUTY

To: ALL BUREAUS, DISTRICTS AND DIVISIONS

PURPOSE: To outline the procedures for the emergency treatment of Department employees injured while on duty.

A. TRANSPORTATION FOR MEDICAL TREATMENT

1. Life-Threatening Emergencies

In life-threatening emergencies, an injured employee will normally be taken to the nearest hospital with full emergency facilities, namely:

- a. Barnes-Jewish Hospital, 216 S. Kingshighway Blvd. (Emergency Room); or
- b. St. Louis University Hospital, 3635 Vista Avenue (Emergency Room).

2. Non Life-Threatening Emergencies

If an injured employee requires emergency medical treatment for a non-life threatening emergency, he/she will be transported to the emergency room of the hospital recommended by the current “contracted medical provider” (CMP).

3. Method of Transportation

An employee injured while on duty who requires emergency treatment at a Hospital will normally be conveyed in an Emergency Medical Services (EMS) unit.

EXCEPTION: An employee may be transported to the hospital in a police vehicle in urgent or life-threatening situations when an EMS unit is not immediately available and life may be endangered by a delay. The employee should, whenever possible, be transported to the nearest hospital with full emergency facilities (e.g., Barnes/Jewish Hospital and/or St. Louis University Hospital).

B. NOTIFICATION TO COMMAND POST

In case of a serious or life-threatening injury to a Department employee, the first superior officer with knowledge of the incident will notify the Command Post as soon as possible. The Command

SO 5-06

Post will immediately notify appropriate command officers, as well as the Director of Human Resources, the Manager of Compensation and Benefits and the Third Party Administrator.

C. TRANSPORT OF DEPARTMENT EMPLOYEE FROM OUTSIDE HOSPITAL

If an injured Department employee must be conveyed from a hospital outside the City, the investigating officer will contact his supervisor/Watch Commander, who will contact the current medical provider (CMP). The CMP will then contact the physician in charge of treating the employee in the outside hospital regarding the mode of transportation and location for medical treatment within the City.

D. DEPARTMENT PROPERTY

If a commissioned officer is admitted to a hospital, the officer handling the assignment will seize all Department property (e.g., firearms, badges, etc.) and place it in the district safe until such time as the sick/injured officer is released from the hospital. A firearm personally owned by the sick/injured officer will be seized and either (1) placed in the district safe for safekeeping; or (2) conveyed to the officer's home (at his/her discretion) and turned over to a family member.

DI/frd
251-09-06979



METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
REFUSAL OF MEDICAL CARE
(POLICE PRISONER)



Complaint Number # _____

Arrest Register # _____

I hereby voluntarily acknowledge and state that I have been advised that I have been offered the opportunity to receive medical care, to be administered by members of the Emergency Medical Service of the City of St. Louis and / or to be transported to a hospital for medical care. I hereby voluntarily refuse to receive or accept such medical care and / or transportation and I do hereby for my heirs, executors, administrators and assigns forever release and fully discharge the St. Louis Metropolitan Police Department, as well as their agents, servants and employees, the City of St. Louis, from any and all liability arising from my aforesaid refusal to receive or accept medical care or, transportation for the purpose of medical care.

Signature of Person Refusing Medical Care *Date*

Signature of Officer Offering Medical Care *Date*

Signature of Supervisor as Witness *Date*

**COMPLETION OF FORM NOT REQUIRED WHEN PERSON
OTHER THAN A PRISONER REFUSES MEDICAL CARE**



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
**AFFIDAVIT IN SUPPORT OF APPLICATION FOR DETENTION, EVALUATION
 AND TREATMENT/REHABILITATION - ADMISSION FOR 96 HOURS**

IN THE MATTER OF _____, RESPONDENT,
 A PERSON ALLEGED TO BE MENTALLY DISORDERED.

_____, HEREBY AFFIRMS AN OATH AS FOLLOWS:
 (Describe the behavior which respondent exhibits which supports the conclusion that respondent is mentally disordered or
 an alcohol or drug abuser and presents a likelihood of serious harm to himself or others.)

SAMPLE

NAME (SIGNATURE)			
STREET ADDRESS			
CITY	STATE	ZIP CODE	TELEPHONE
NOTARY PUBLIC (EMBOSSER OR BLACK INK RUBBER STAMP SEAL)	STATE OF		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		



METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS



PRISONER HOLD ORDER

Name of Hospital _____

THE PATIENT-PRISONER IDENTIFIED BELOW IS BEING HELD AS A POLICE PRISONER ON THE CHARGE(S) INDICATED. SUCH PERSON IS NOT TO BE RELEASED FROM THE HOSPITAL UNTIL THE RESPONSIBLE DISTRICT IS NOTIFIED TO TAKE CUSTODY OF THE PRISONER AT THE HOSPITAL. YOU WILL BE NOTIFIED IN PERSON IF CHARGES ARE NO LONGER PENDING.

Patient-Prisoner Name: _____

Arrest Register No.: _____

Arresting Officer(s): _____

Charge(s) Pending: _____

Hold Order Placed by: _____

Rank	Signature	District	Date	Time

Name of Watch Commander Authorizing Hold Order: _____

Hospital Representative Receiving Hold Order: _____

Title	Signature	Department	Date	Time

Hold Order Released by: _____

Rank	Signature	District	Date	Time

DISTRICT PHONE NUMBERS:

- South Patrol Area (Districts 1 & 2) 444-0100
- Central Patrol Area (Districts 3 & 4) 444-2500
- North Patrol Area (Districts 5 & 6) 444-0001

Original – Hospital
Copy – District Arrest Register Copy

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS

HOSPITALIZED PRISONER HISTORY



Complaint Number: _____

L.B. # _____

Prisoner: _____
NAME RACE SEX AGE A.R. #

Home Address: _____

Arresting Officer(s): _____
NAME DSN ASG.
NAME DSN ASG.

Charge(s): 1. _____
2. _____
3. _____
4. _____

Leg Irons: _____

Hospital: _____ Ward/Room _____

Reason for Confinement: _____

Attending Physician: _____

Attorney: _____
NAME ADDRESS TELEPHONE

Visitors Allowed? _____ If Not, What Authority? _____
(MEDICAL, POLICE, ETC.)

Immediate Family:
1. _____
NAME ADDRESS TELEPHONE
2. _____
NAME ADDRESS TELEPHONE
3. _____
NAME ADDRESS TELEPHONE
4. _____
NAME ADDRESS TELEPHONE
5. _____
NAME ADDRESS TELEPHONE

District Watch Commander: _____

