# Management Guidelines for Persons Suspected of Having Drugs Concealed Internally

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# 1. Status

1.1 These guidelines apply to Scotland.

1.2 These guidelines describe the immediate assessment of persons in police custody suspected of having substances concealed internally.

1.3 They describe individual roles and responsibilities and the process to be followed, up to and including the process for discharge from hospital.

1.4 Based on the *Best Practice Guidelines – Caring for Adult Patients Suspected of Having Concealed Drugs* produced by the College of Emergency Medicine in June 2014, they have been developed by a multi-agency, multi-professional short life working group, including NHS professionals in Emergency Medicine, Toxicology, Forensic Physicians and Nurses and Police Scotland.

1.5 These guidelines are not intended to cover the process for people not in police custody who present to Emergency Departments with drugs concealed internally. In these cases, healthcare professionals should consult relevant General Medical Council (GMC) Guidance about disclosing information.

# 2. Introduction

2.1 This document has been developed to provide guidance to healthcare professionals and Police Scotland on the management of individuals detained in police custody who are suspected of having drugs concealed internally and represent best practice at the time of writing.

2.2 Concealed Drugs may be hidden internally in three broad categories:

- **Body 'packers'** or '**Mules**' are those who deliberately hide large quantities of drugs internally in order to smuggle those drugs across borders or into prisons. Generally the packaging is more resilient and specifically planned, chosen or manufactured for the purpose, thus risk of rupture has decreased in recent years. The quantities carried tend to be large, so if they do leak there is a high risk of severe or fatal toxicity.

- **Body 'stuffers'** or **'body pushers'** generally have much lower quantities of drugs concealed however the hiding of the drugs is not planned, but undertaken to avoid detection by the police e.g. 'stuffed' into the mouth and subsequently swallowed or 'stuffed' or 'pushed' into another body cavity such as the rectum or vagina. The packaging in this hasty concealment is generally not resilient, not designed for the purpose and presents a choking, leakage and rupture risk. Drugs may also be 'stuffed' in quantities greater than normally taken and present an overdose risk.

- **'Parachuting'** is intentional ingestion of drugs that are wrapped in a covering expected to dissolve in order to release the drug for later absorption. These patients should be treated as body stuffers.

2.3 **The vast majority of individuals in police custody concealing illicit drugs fall into the body stuffing or body pushing category with risk presented because of the hasty nature of concealment.** Drug packers tend to come to attention through UK Border Force or Prison authorities.

## 3. Response to Police Suspicion and Pre-hospital Care / Assessment

3.1 The safety of the patient remains the priority at all times and where there is doubt, it is advisable to err on the side of caution.

3.2 **If the person in police custody is showing any signs of drug intoxication with suspicion of having drugs internally concealed then the police shall treat this as a medical emergency and immediately call for an emergency ambulance**. Two police officers should remain with the person in custody if they need to be taken to hospital.

3.3 Suspicion of internal concealment of drugs may be as a result of police intelligence, witnessed swallowing or insertion or because the detainee has admitted to the police or healthcare professional that they have drugs concealed.

3.4 Where the police have reasonable belief that drugs may be hidden internally in a detainee, they will treat that person as 'in need of medical attention' and refer to the duty custody healthcare professional.

3.5 The fitness to be detained at the police office must be assessed by the Custody Sergeant in consultation with the duty custody healthcare professional as appropriate. An individual with suspected internally concealed drugs will be initially deemed not to be fit for detention in the police custody suite.

3.6 The police or healthcare professional will contact the Emergency Department and inform the nurse in charge of the transfer.

3.7 Consideration should be given as to how the person in custody should be transported to hospital. This process should include an appropriately conducted and recorded risk assessment. If clinically appropriate, particularly in remote and rural areas, consideration should be given to the use of ambulance vehicles. The patient will be accompanied at all times by two police officers.

3.8 In the event that a patient refuses to go to hospital, a healthcare professional should assess the patient and explain the risks of not going to hospital. The healthcare professional will discuss the case with Police staff who will put in place appropriate observations.

## 4. Role of the Healthcare Professionals working in police custody

4.1 The healthcare professional is responsible for any healthcare and forensic medical elements of the examination of a person in custody. This includes advising on medical aspects relating to custody, such as fitness to be detained.

4.2 The Forensic Physician is responsible for any intimate examination to be carried out to confirm the presence of suspected drug packages.

4.3 The Forensic Physician should make it clear to the patient that absolute confidentiality similar to the solicitor / client relationship does not exist within the doctor / patient relationship. There will be certain circumstance where a doctor will be compelled to produce material or answer questions if required to do so by the presiding officer of a court.

## 5. Immediate Assessment in the Emergency Department

5.1 On arrival at the Emergency Department the patient should be triaged appropriately according to local processes. The healthcare professional in charge should direct the patient to an appropriate area.

5.2 Best Practice Guidelines - *Caring for Adult Patients Suspected of Having Concealed Drugs* (June 2014)[1] has been produced by the College of Emergency Medicine to be used in conjunction with TOXBASE advice and as an aid to clinical assessment and management. These should be referred to as required.

## 6. Intimate Examinations

The Forensic Physician is responsible for any intimate examination to be carried out to confirm the presence of suspected drug packages. Intimate examination must only be conducted with the person's full informed consent and co-operation. For further information on informed consent, please refer to Faculty of Forensic and Legal Medicine (FFLM) and British Medical Association (2010) *Recommendations for healthcare professionals asked to perform intimate body searches*[2].

6.1 A Sheriff's Warrant, whilst making an examination lawful, does not permit a doctor to proceed without consent but failure to comply with the Warrant may result in aggravation of any offence committed.

6.2 Intimate examination must only take place in a facility with **full** resuscitation capabilities, i.e. Hospital; and never at a police office.

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[1] College of Emergency Medicine (2014) *Best Practice Guidelines - Caring for Adult Patients Suspected of Having Concealed Drugs*, available from the College of Emergency Medicine website. Note - Police and Criminal Evidence Act 1984 (PACE) does not apply in Scotland.
[2] Faculty of Forensic and Legal Medicine (FFLM) and British Medical Association (2010) *Recommendations for healthcare professionals asked to perform intimate body searches.*

6.3 The only time that hospital staff may be asked to get involved in an intimate examination is if it is suspected that a package has ruptured and the reason to perform an intimate examination is to retrieve the leaking package in order to save the patient's life. In this instance, hospital staff would be protected by common law if it were not possible to obtain consent due to the patient's decreased level of consciousness, for example. In line with BMA and FFLM guidance, an intimate search without consent is justified where the life of the patient is at risk.

## 7. Continuing Hospital Care

7.1 The senior clinician in charge within the Emergency Department is responsible for any decisions relating to the clinical management plan, not the Forensic Physician.

7.2 While in hospital it should be noted that the person still remains in police custody.

7.2.1 Where confidentiality and privacy is required, **and the dynamic risk assessment allows**, it may be possible for Police to be out of earshot for privacy reasons, at the door or behind a curtain for examinations, but in close proximity at all times.

7.2.2 There may be circumstances where risk assessment does not allow this and discussion between NHS staff and police will be required to come to an arrangement that is mutually acceptable and safe.

7.2.3 It is the responsibility of the police to monitor relevant and egested packages for collection of evidence. In order to appropriately protect Police Officers, Health Protection Scotland's National Infection Prevention and Control Manual should be followed[3].

7.2.4 The hospital staff must not partake in this task as it may interfere with the chain of evidence and hence be detrimental to the police case.

7.2.5 Hospital staff should alert the Police to any suspicious items. It is not appropriate for hospital staff to try and dispose of suspected drugs in these instances. Staff may be committing a criminal offence if they attempt to do so.

## 8. Discharge from Hospital

8.1 The patient must not be discharged from hospital until the senior clinician in charge of their care is fully satisfied that no concealed packages remain, or the risk of adverse events is sufficiently minimal.

8.2 In making the decision, the senior clinician should weigh up all of the available evidence and base their decision on the likelihood of there being concealed drugs and the possibility of an overdose caused by rupture of a concealed package and the risk of patient death. This includes taking cognisance of police intelligence.

[3] Health Protection Scotland (2015) *National Infection Prevention and Control Manual*, available from the Health Protection Scotland website

8.3 Once the senior clinician in charge has advised that the person is fit for discharge, the person is fit for discharge irrespective of whether they are returning to police custody.

8.4 As is the case with any patient being discharged from the Emergency Department, it is good practice that a discharge letter be prepared and should accompany the patient back to police custody if appropriate. This should be placed in a sealed envelope marked ‘medical confidential’.

8.5 This information should be supplemented by telephone before the patient is discharged, so that the custody healthcare professional can discuss any contentious issues with the Emergency Department team.

8.6 All patients who have capacity may discharge themselves from the hospital even though they are under arrest. In this instance the senior clinician in charge should document fully what the patient has been told about the risks. It is recommended that the patient is given a copy of the documentation.

## 9. Detention in Police Custody following Discharge from Hospital

9.1 In the event of a person in custody being discharged from hospital, the fitness to be detained at the police office must be assessed in person by the Custody Sergeant and the duty custody healthcare professional as they arrive at the police office. The level of risk and responsibility requires the involvement of a healthcare professional in person. This should be done in consultation with the on duty Forensic Physician.

9.2 Before accepting a person to return to police custody, custody healthcare staff must fully discuss the individual with the attending police officers. This is in addition to the healthcare professional to healthcare professional information sharing outlined in section 8.4

9.3 People in custody may still have drug packages in their bodies as hospital tests and observation will not always detect them. The person in custody may continue to be at risk of deterioration, which may be either slow or sudden.

9.4 If the patient has self-discharged then there may be reason for further observation while in police custody. A robust risk management custody welfare plan will be agreed upon by the duty custody healthcare professional and instigated by Police Scotland.

9.5 Custody staff should have a low threshold for contacting the custody healthcare professional if there is any cause for concern about the person. For example increasing or unusual drowsiness may indicate on-going opiate absorption, agitation could indicate developing cocaine or amphetamine toxicity.

9.6 In the event of a person in custody who has been discharged from hospital being fit for detention but who subsequently deteriorates whilst in custody, the custody officer will deem this a medical emergency and call for an ambulance immediately.

# 10. References

British Medical Association and Faculty of Forensic and Legal Medicine (2007) *Guidance for doctors asked to perform intimate body searches*.

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## Appendix A - High level flow diagram