SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Management of Patients Suspected of Concealing Drugs Internally transferred to St George and Prince of Wales Hospital by the Australian Federal Police Force from Customs.
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/361
DATE OF PUBLICATION	July 2024
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards – Standard 1: Clinical Governance Standard 4: Medication Safety Standard 8: Recognising and Responding to Acute Deterioration
REVIEW DATE	July 2027
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Executive Director Operations
AUTHORS	SESLHD Emergency Clinical Nurse Consultants and Nurse Educators Working Group.
POSITION RESPONSIBLE FOR THE DOCUMENT	Critical Care Stream Manager Suzanne.schacht@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Critical Care and Emergency Medicine
KEY TERMS	Concealment, Internal Search, Australian Federal Police (AFP)
SUMMARY	This procedure instructs clinicians on the appropriate management of patients who are brought to St George and Prince of Wales Hospital's Emergency Department by the Australian Federal Police Force from Customs suspected of internal drug concealment.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Management of Patients Suspected of Concealing Drugs Internally transferred to St George and Prince of Wales Hospital by the Australian Federal Police Force from Customs

SESLHDPR/361

1. POLICY STATEMENT

South Eastern Sydney Local Health District (SESLHD) has identified the need of developing a procedure for managing patients brought to Prince of Wales Hospital and St George Hospital Emergency Departments (ED) suspected of concealing illicit substances internally. Therefore, this procedure ensures the provision of high quality health care and appropriate triage, bed allocation, early diagnosis and management of these patients in line with the following NSW Ministry of Health Policy Directives and NSW Legislation:

- NSW Ministry of Health Policy Directive PD2017_032 - Clinical Procedure Safety
- NSW Ministry of Health Information Bulletin IB2020_010 - Consent to Medical and Healthcare Treatment Manual
- Customs Act 1901

2. BACKGROUND

Patients are usually brought in by the Australian Federal Police (AFP) from the airport. They are suspected of concealing drugs internally, most often cocaine or heroin. Concealment is usually by swallowing packets of drugs or inserting same into a body cavity i.e. rectum / vagina.

Whilst in hospital they are hospital patients under police guard. No procedure can be carried out on these patients against their will. The AFP cannot require a staff member to perform any procedure or examination without the patient's informed consent.

3. RESPONSIBILITIES

3.1 Australian Federal Police (AFP) will:

The AFP will provide the patient with a *"Patient Information Sheet – CT Scan Abdomen"* (Appendix 1) prior to arrival in the ED.

Obtain informed written consent under the Customs Act 1901 from the patient prior to their arrival to the ED (Appendix 2).

The consent must be sighted by the triage nurse, treating nurse or Medical Officer prior to fast tracking / ordering of an abdominal CT.

3.2 Employees will:

All employees of SESLHD will act in accordance with this procedure.

3.3 Line Managers will:

Ensure this procedure is followed by relevant staff.

3.4 District Managers/ Service Managers will:

Provide support to staff in the implementation of this procedure as required.

3.5 Medical staff will:

All medical officers working in emergency departments and hospital wards will comply with this procedure.

3.6 Nursing Staff will:

All nursing staff working in emergency departments and hospital wards will comply with this procedure.

4. PROCEDURE

4.1 Triage / Clinical Initiatives Nurse (CIN) Assessment

- Assess the patient for any signs and symptoms of drug intoxication. The rupture of a concealed package is a life threatening situation.
- Signs of **heroin** intoxication include miosis (pinpoint pupils), drowsiness, respiratory depression, sweating, vomiting and hypothermia.
- Signs of **cocaine** intoxication include dilated pupils, dry mouth, cardiac arrhythmias, chest pain, myocardial infarction, tachycardia, hypertension (may cause intra-cranial haemorrhage), seizures, hyperactivity, anxiety and respiratory failure.
- Triage documentation should be clear and concise, noting all subjective and objective data.
- Ensure a full set of vital signs are attended i.e. heart rate, blood pressure, respiratory rate, temperature, oxygen saturation and BGL prior to transfer to radiology.

4.2 Triage Category and Location

- If clinically well and asymptomatic and deny ingesting any packages, patients should be triaged as ATS Category 3 and fast tracked for a non-contrast abdominal CT *(refer to section 4.3).*
- If the patient has admitted to ingesting packages they should be moved to an appropriate and available single room with the modified plumbing connection *(if available)* and **SHOULD NOT** be fast tracked for an abdominal CT *(refer to section 4.6 management).*
- If the patient shows any signs of drug intoxication or rupture and/or their observations are outside normal limits, the patient should be given appropriate triage category as according to the Australasian Triage Scale (ATS) Guidelines (G24)
- The patient suspected of concealing drugs should be allocated to either a resuscitation room or an acute bed as clinically indicated.
- These patients must all be flagged to the ED Team Coordinator (TC) and Staff Specialist (SS) / Senior Medical Officer (SMO) on shift when they arrive in the ED, so they are able to coordinate immediate ongoing care and management of these patients in a timely manner.

4.3 Consent for Abdominal CT

- No investigations can be undertaken without the patient's informed consent or Court Order. The AFP officers will obtain written consent from the patient prior to their arrival to the ED. If an interpreter has been used this must be handed over to ensure valid consent. *(Appendix 2).*
- The consent must be sighted by the nurse/medical officer ordering the abdominal CT. If the patient *does not* consent, the procedure cannot be ordered or carried out. These patients should be immediately referred to the ED SS or SMO on shift who will seek confirmation from the AFP officers as to whether they are seeking Court Order.
- If the patient admits to ingesting packages an abdominal CT **SHOULD NOT** be ordered *(refer to section 4.6).* These patients should be referred to the ED SS or SMO for further management.
- Do not order a CT on any female who may be pregnant. A urine or serum ßHCG test must be confirmed negative prior to ordering the abdominal CT *(refer to section 4.7).* Hospital personnel are not to be used as witnesses for passing of urine, it is the responsibility of the AFP officers.
- Once patient consent has been sighted, a non-contrast abdominal CT may be ordered. The Extended Practice Nurse (EPN) or Clinical Initiatives Nurse (CIN) can order a non-contrast abdominal CT as per emergency standing orders *(Appendix 3).*
- If fast tracking a patient from the ED waiting room, communicate with CT through the following contact numbers and send the patient with AFP escort to radiology:
  - **St George Hospital:** 9113 4678 (ext 34678)
  - **Prince of Wales:** 938 20333 (ext: 20333) for the registrar via CT reception, and after hours contact the radiology registrar via switch.
- For patients who require transfer by orderly to radiology, nursing staff must correctly complete the Medical Imaging *Patient Transport and ID Form*. This is to comply with NSW Ministry of Health Policy Directive PD2017_032 - Clinical Procedure Safety.

4.4 Management of Carriers with Negative CT Scan

- If the CT scan is reported to be negative and the patient is clinically well, he /she may be discharged into the care of the AFP officers after senior ED medical officer review.
- CT scans **MUST** be reported by a radiology registrar (interim report) / consultant (authorised report) prior to discharging the patient. All CT scans should be viewed using both standard 'abdominal windows' and 'lung windows'.
- The CT scan report and the disposition of patients must be clearly documented in the ED medical record.

- The AFP must be provided with a documented letter confirming the negative CT report and the reporting doctor. The treating medical officer must provide this letter prior to discharge.
- If there is a high index of suspicion and the CT findings are equivocal, the patient should be admitted for observation (refer to section 4.5) and ongoing management.

4.5 Management of Carriers with Positive Reported CT Scan

- Refer immediately to the ED SS or SMO on shift.
- Obtain an estimate of the number of packages from the radiologist reporting the CT.
- If the patient is haemodynamically stable admit under Gastroenterology. Stable patients can be managed in a normal ward bed (single room).
- After patient consent give up to 3 litres of **Macrogol 3350 - electrolyte bowel cleansing preparation (for example Glycoprep®)** to accelerate evacuation. Dissolve 1 sachet in 3L of water, give 250-500ml every 15-20 minutes until fecal discharge clear. Recommended intake 1.2-1.8L/hr. Suppositories and enemas **SHOULD NOT** be used because of the risk of package perforation.
- If Glycoprep® is refused the patient should be admitted and observed until all packages are passed. It is the responsibility of the AFP officers to check all motions for packages. Hospital personnel are not to be used as witnesses for passing of bowel motions.
- Once the patient has passed packages approximating the estimated number **AND** has had 5 consecutive clear bowel motions, a non-contrast abdominal CT should be ordered to confirm the absence of further packages.
- If on the second CT there are packets still present, the patient is to continue observation for further passage of the remaining packets.
- If the CT demonstrates 10 or fewer packets, once these are all accounted for **NO FURTHER CT** is required.
- If the CT demonstrates greater than 10 packets, once the patient has passed packages approximating the estimated number **AND** has had 5 consecutive clear bowel motions a non-contrast abdominal CT should be ordered to confirm absence of further packages.
- All patients admitted for drug concealment must be kept under constant AFP supervision.
- All patients are discharged to AFP custody once their medical treatment is completed.

4.6 Management of Patients Admitting to Ingestion

- If the patient admits to ingesting packages a CT scan **SHOULD NOT** be ordered initially.

- If the patient is haemodynamically stable admit under Gastroenterology.
- After patient consent, give up to 5 litres of Glycoprep® to accelerate evacuation.
- Once the patient has passed packages approximating the number reported by the patient **AND** has had 5 consecutive clear bowel motions a non-contrast abdominal CT should be ordered to confirm absence of further packages.
- Refer to section 4.5 for ongoing management of these patients.

4.7 Management of Concealment in Pregnancy

- **DO NOT** order an abdominal CT on any females who may be pregnant. A urine or serum ßHCG test must be confirmed negative prior to ordering the abdominal CT.
- Glycoprep® should not be used routinely in pregnant 'body packers'. The risk of Glycoprep® on the foetus is unknown. This potential risk must be balanced against the risk to the mother and foetus if a drug packet ruptured.
- It should be noted that rupture of drug packets is very uncommon, with no cases occurring at St George Hospital between 2008 and 2013. If considering using Glycoprep®, the potential risks and benefits should be discussed with the patient.
- If Glycoprep® is refused the patient should be admitted and observed until all packages are passed. It is the responsibility of the AFP officers to check all motions for packages.
- Suppositories and enemas should not be used because of the risk of package perforation.

5. DOCUMENTATION

Nursing / Medical Documentation

Thorough and complete documentation of nursing and medical assessment, standing orders and ongoing patient management must be entered into the ED medical record and at a minimum must include:

- Patient history and presentation at triage
- Assessment / physical examination
- Written consent obtained by AFP and sighted for abdominal CT
- Radiology registrar / consultant reporting CT
- CT scan results *i.e. negative / positive or equivocal*
- Disposition of patient *i.e. federal police custody / admission*

6. AUDIT

Emergency Departments will undertake random 12 monthly audit of patients presenting with suspected drug concealment i.e. clinical medical records and CT reports to ensure this procedure is complied with.

7. REFERENCES

- NSW Ministry of Health Policy Directive PD2017_032 - Clinical Procedure Safety
- NSW Ministry of Health Information Bulletin IB2020_010 - Consent to Medical and Healthcare Treatment Manual
- Australian College of Emergency Medicine- Australasian Triage Scale (ATS) Guidelines (G24)

External References

- Gill JR, Graham SM. Ten years of 'body packers' in New York City: 50 deaths. J Forensic Sci 2002;47:843-6.
- Wetli CV, Rao A, Rao VJ. Fatal heroin body packing. Am J Forensic Med Pathol 1997;18:312-8.
- Hassanian-Moghaddam H, Abolmasoumi Z. Consequence of body packing of illicit drugs. Arch Iran Med 2007;10:20-3.
- Wetli CV, Mittleman RE. The 'body packer syndrome' - toxicity following ingestion of illicit drugs packaged for transportation. J Forensic Sci 1981;26:492-500.
- Asha S, Curtis KA, Grant N, et al. Comparison of radiation exposure of trauma patients from diagnostic radiology procedures before and after the introduction of a panscan protocol. Emerg Med Australas 2012 24:43-51.
- Asha SE, Higham M, Child P. Sensitivity and specificity of CT scanning for determining the number of internally concealed packages in 'body-packers'. *Emergency medicine journal*. 2015; 32(5):387-91
- Asha SE, Cooke A. Sensitivity and specificity of emergency physicians and trainees for identifying internally concealed drug packages on abdominal CT scan: do lung windows improve accuracy? Journal of Emergency Medicine. 2015; 49(3):268-73
- Berrington de Gonzalez A, Mahesh M, Kim K-P, et al. Projected cancer risks from computed tomographic scans performed in the United States in 2007. Arch Intern Med 2009;169:2071-7.
- Brenner DJ, Hall EJ. Computed tomography-an increasing source of radiation exposure. N Engl J Med 2007;357:2277-84.
- Smith-Bindman R, Lipson J, Marcus R, et al. Radiation dose associated with common computed tomography examinations and the associated lifetime attributable risk of cancer. Arch Intern Med 2009;169:2078-86.

- Radiation Protection Series Publication No. 8. Exposure of humans to ionizing radiation for research purposes. Australian radiation protection and nuclear safety agency; 2005:13-4.
- Hartoko TJ, Demey HE, De Schepper AM, Beaucourt LE, Bossaert LL. The body packer syndrome-cocaine smuggling in the gastro-intestinal tract. Klin Wochenschr 1988 66:1116-20.
- Kersschot EA, Beaucourt LE, Degryse HR, De Schepper AM. Roentgenographical detection of cocaine smuggling in the alimentary tract. ROFO Fortschr Geb Rontgenstr Nuklearmed 1985 142:295-8.
- Flach PM, Ross SG, Ampanozi G, et al. “Drug mules” as a radiological challenge: Sensitivity and specificity in identifying internal cocaine in body packers, body pushers and body stuffers by computed tomography, plain radiography and Lodox. Eur J Radiol 2012 81:2518-26.
- Taheri MS, Hassanian-Moghaddam H, Birang S, et al. Swallowed opium packets: CT diagnosis. Abdom Imaging 2008;33:262-6.
- Yang RM, Li L, Feng J, et al. Heroin body packing: clearly discerning drug packets using CT. South Med J 2009 102:470-5.
- Hahn IH, Hoffman RS, Nelson LS. Contrast CT scan fails to detect the last heroin packet. J Emerg Med 2004;27:279-83.
- Schmidt S, Hugli O, Rizzo E, et al. Detection of ingested cocaine-filled packets-diagnostic value of unenhanced CT. Eur J Radiol 2008;67:133-8.
- Maurer MH, Niehues SM, Schnapauff D, et al. Low-dose computed tomography to detect body-packing in an animal model. Eur J Radiol 2011;78:302-6.
- Mandava N, Chang RS, Wang JH, et al. Establishment of a definitive protocol for the diagnosis and management of body packers (drug mules). Emerg Med J 2011 28:98-101.
- Traub SJ, Hoffman RS, Nelson LS. Body packing-the internal concealment of illicit drugs. N Engl J Med 2003 349:2519-26.

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
January 2012	1	Drafted by Kelly Drew, CNS Emergency Department St George; Leanne Horvat, CNC Emergency Department St George
August 2013	2	Revised by Bernadine Romero, CNC Emergency Department; Dr Stephen Asha, Staff Specialist, Emergency Department, St George Hospital; Leanne Horvat, Clinical Stream Nurse Manager, Medicine, Critical Care & Emergency.
October 2013	3	Converted to procedure and re-formatted by Scarlette Acevedo, District Policy Officer
February 2014	4	Revised by Leanne Horvat, Clinical Stream Nurse Manager, Medicine, Critical Care &

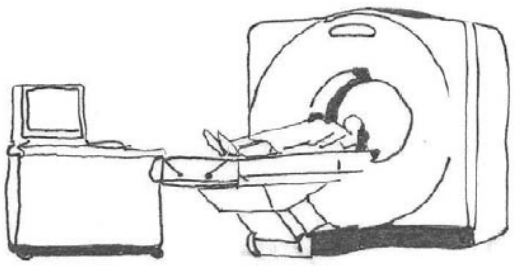
		Emergency. Policy approved at SESLHD Emergency Clinical Stream Committee meeting on 20 February 2014
July 2014	5	Endorsed by: Ministry of Health Legal and Regulatory Services; Australian Federal Police and Customs 24 July 2014.
August 2014	6	Endorsed by: District Drug and Quality Use Medicines Committee
October 2014	6	Endorsed by Clinical and Quality Council SESLHD
December 2015	7	Document revised – minor changes to links and references. Content endorsed by Executive Sponsor and published. Review date December 2017.
April 2018	8	Document reviewed – no changes aside from removing a link that is no longer relevant.
July 2018	8	Endorsed by Executive Sponsor Endorsed by SESLHD Quality Use of Medicine Committee.
March 2021	9	Minor review. Links updated. Clarifying consent when using an interpreter and adding in a BGL test. Approved by Executive Sponsor. To be tabled at Quality Use of Medicines Committee.
April 2021	9	Approved at March Quality Use of Medicines Committee and published. Executive Sponsor amended to Executive Director Operations.
16 July 2024	9.1	Minor review. SGH Radiology phone number updated. Changes to volume of water required to dissolve macrogol. Approved at SESLHD Drug and Therapeutics Committee.

Appendix 1: Patient Information Sheet – CT Scan of Abdomen

Health
South Eastern Sydney
Local Health District

PATIENT INFORMATION SHEET – CT SCAN OF ABDOMEN

You are being requested to have a CT scan of your abdomen. This is a painless test. You will lie down on a bed, and the bed moves through a large ring-shaped machine. This is done in a big open room. You will not feel anything and the test takes about 5 minutes.



There are some possible risks associated with this test. The CT scan uses x-rays to create pictures of the inside of your body, and X-rays are a type of radiation. People are exposed to radiation from natural sources all the time. All x-rays involve a small extra dose of radiation. The dose of radiation used for CT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. However, all radiation exposure is linked with a slightly higher risk of developing cancer. The size of any increased risk depends on the age of the patient and the total amount of radiation received. The risk from any one scan is very small.

Once the scan is complete there will be a delay while experts look at the pictures, and then tell the police and you the result. Sometimes other things are seen on the scan such as cysts or gallstones. You will be told if other things are found on the scan and should you be discharged from the police, your local medical doctor will be able to obtain a formal report in a few days.

If you require further information or have any questions about the scan, please ask the hospital staff on your arrival to the Emergency Department.

If you need an interpreter to explain this information sheet to you, please ask for assistance from the hospital staff or federal police officer in charge of your case.

Patient Information Sheet _ CT Scan Abdomen provided by South Eastern Sydney Local Health District

Endorsed by: NSW Ministry of Health Legal and Regulatory Services & The Australian Federal Police
24th July 2014.

Appendix 2: Consent for Internal Medical Search – Customs Act 1901

ENGLISH — *CUSTOMS ACT 1901* — *If ENGLISH is not your first language, you can ask for an INTERPRETER.*

CONSENT FOR INTERNAL MEDICAL SEARCH

I, (Full Name) _____ agree to:

- a doctor examining me to find out if there is anything hidden inside my body;

AND

- the doctor or a nurse using their skills and procedures to remove anything found there (BUT not through a surgical operation).

I understand that:

- I am being searched because a Customs and Border Protection officer or Police officer thinks that I may be hiding an unlawful amount of drugs inside my body;

AND

- the internal search may include an X-ray OR ultra sound OR CT Scan OR physical examination of my body.

I am satisfied that I have been advised of my rights under the *Customs Act 1901*.

Signed _____ Date / /

Witness _____ Date / /

Interpreter (If present) _____ Date / /

Appendix 3: ADVANCED STANDING ORDER:

FOR PATIENTS SUSPECTED OF CONCEALING DRUGS INTERNALLY

This procedure is to be implemented for adult patients who present suspected of concealing drugs internally.

All mandatory markers are necessary to implement this standing order.

MANDATORY MARKERS

The Australian Federal Police presents with a person under arrest for suspicion of internal drug concealment

Written consent obtained by Australian Federal Police and sighted by nurse commencing standing order

OPTIONAL MARKERS

All females must have a negative urine HCG prior to arranging abdominal CT.

ESCALATION

Refer all patients in escalation criteria to ED Senior Medical Officer

- If symptoms of toxicity present triage to acute / resuscitation rooms
- If patient refuses consent for abdominal CT
- If patient admits to ingesting packages
- Haemodynamically unstable (PACE / BTF criteria)
- Altered level of consciousness and/or GCS < 15
- Pin point or Unequal pupils
- Pregnancy (confirm with urine ßHCG)
- Paediatric patients < 15 years

	ASSESSMENT	INTERVENTION
Airway	▪ Assess patency	Maintain airway patency
Breathing	▪ Colour ▪ Respiratory rate & effort ▪ SpO_2	Apply O_2 to maintain SpO_2 > 95%
Circulation	▪ External bleeding ▪ Pulse rate, rhythm & strength ▪ Skin colour and temperature ▪ Capillary refill < 2 seconds	*If circulation / neurovascular status is inadequate or compromised immediate MO review*
Disability	▪ Glasgow Coma Score (GCS)	Monitor level of consciousness *If GCS < 15 for immediate MO review.*

	ASSESSMENT	INTERVENTION
Measure & Test	▪ Focused history of concealment ▪ Medication history ▪ Allergies	 *If patient meets any exclusion criteria, refer onto ED SS / Registrar for ongoing management*
	▪ Pain history and score	▪ Visual acuity score (VAS) *or* numerical score *If requiring analgesia for pain immediately refer to MO or NP for ongoing management*
	▪ Abdominal examination	▪ Sight written consent obtained by Federal Police for procedure ▪ Fast track non-contrast Abdominal CT
	▪ Pathology (if toxicity present)	▪ Cannulation (large bore) ▪ FBC, UEC, drug screen
Specific Treatment	▪ Abdominal CT reported Negative *CT must be reported by either Radiology Consultant / Registrar*	▪ Notify ED MO to review patient ▪ ED MO to provide documenting letter for Police ▪ Discharge to care of Federal Police
	▪ Abdominal CT reported Positive *CT must be reported by either Radiology Consultant / Registrar*	▪ Immediately notify ED SS / Registrar ▪ Ongoing care and management coordinated by ED SS / Registrar ▪ Consent for up to 5 litres of Macrogol 3350 - electrolyte bowel cleansing preparation (for example Glycoprep®) to accelerate evacuation.