Law Enforcement Advisory Board

Arrests for Non-Witnessed Misdemeanor Crimes Against Health Care Workers and Emergency Medical Personnel Pursuant to Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20)

Model Policy

Issued Pursuant to 2011 Act No. 26

DISCLAIMER

This policy is a guide only and shall not be construed as creating any substantive or procedural rights enforceable at law by any party in any civil or criminal matter. This policy shall not be construed as creating a higher legal standard of care with respect to third-party claims.

This information is not legal advice and is not a substitute for the advice of an attorney. If you require legal or other expert advice regarding this topic, you should seek the services of a competent attorney or other professional.

This policy is not intended as a substitute for the specific, statutory language. The actual law is more important than what is in this policy. If a law enforcement officer needs help with a specific situation, law enforcement officers should seek guidance from the agency's attorney.

ABOUT THE MODEL POLICY

This is a model policy adopted by the Law Enforcement Advisory Board pursuant to 2011 Act No. 26, an act relating to assault of a health care worker.

A model policy serves as a guide or starting point for creating actual, working policies within an organization. The purpose of the model policy is to provide a structured and standardized set of guidelines and principles that can be customized and adapted to meet the specific needs and requirements of a particular organization. Model polices can also be useful for training and can serve as a valuable resource for continuing education.

Thus, the model policy provides detailed background and contextual information to help agencies adapt the model policy to their agencies' unique needs.

The Appendix to the model policy includes a sample, working policy.

BACKGROUND

2011 Act No. 26 imposed enhanced penalties for convictions of simple or aggravated assaults against health care workers and emergency medical personnel while the health care workers or emergency medical personnel are performing a lawful duty.

2011 Act. No. 26 also directed the law enforcement advisory board to adopt a model policy to address enforcement of the criminal code as it relates to assaults against health care workers while they are engaged in their official duties providing patient care.

In 2023, the legislature enacted Act 24, an act relating to crimes against heath care workers at hospitals and against emergency medical treatment providers. 2023 Act 24 amended the Vermont Rules of Criminal Procedure, Rule 3 to permit warrantless arrests for three, specific, non-witnessed misdemeanor crimes against health care workers and emergency medical personnel.

This model policy incorporates guidance to law enforcement officers about warrantless arrests for non-witnessed misdemeanor crimes against health care workers, including the procedures for law enforcement officers to follow to arrest and/or remove individuals from hospitals or prehospital scenes without a warrant when there is probable cause to believe such individuals have committed certain, delineated misdemeanor offenses against health care workers in a hospital or emergency medical personnel at a prehospital scene or interfered with the provision of health care services.

VERMONT RULES OF CRIMINAL PROCEDURE, RULE 3

The legislature's amendment of Vermont Rules of Criminal Procedure, Rule 3 expands, rather than narrows, the types of non-witnessed, misdemeanor offenses for which warrantless arrests may be made.

While this model policy incorporates guidance to law enforcement officers about warrantless arrests for non-witnessed misdemeanor crimes against hospital health care workers or emergency medical personnel, it should be noted that Rule 3 may provide other grounds to lawfully arrest a perpetrator for offenses that occur in a hospital or pre-hospital setting.

For example, Rule 3(a) permits arrests without a warrant for felony offenses regardless of whether the law enforcement officer witnessed the commission of the offense if there is probable cause. In addition, Rule 3(b) permits arrests without a warrant for misdemeanor offenses witnessed by law enforcement officers if there is probable cause.

Rule 3 (c) governs arrests for specified misdemeanor offenses that occur outside the presence of a law enforcement officer where probable cause is established through percipient witnesses or other evidence. For example, Rule 3 (c)(8) permits arrests for domestic assault that are not witnessed by law enforcement officers.

The legislature's 2023 amendments to Rule 3 (c) authorize non-witnessed, misdemeanor arrests for the following offenses:

1. Simple assault against a health care worker in a hospital or a person providing emergency medical treatment (Rule 3 (c)(18));

2. Criminal threatening against a health care worker in a hospital or a person providing emergency medical treatment (Rule 3 (c)(19)); and

3. Disorderly conduct for engaging in fighting or in violent, tumultuous, or threatening behavior that interfered with the provision of medically necessary health care services in a hospital or by a person providing emergency medical treatment (Rule 3 (c)(20)).

Conduct that may give rise to a non-witnessed, misdemeanor arrest under the 2023 amendments to Rule 3 (c), may well have been permitted by Rule 3 (c) before the 2023 amendments. Thus, the legislature's amendments to Rule 3 (c) not only provide clarity about non-witnessed, misdemeanor arrests in a hospital or prehospital setting but also reflect the legislature's intent to draw attention to and curtail violence against health care workers.

SPECIAL CONSIDERATIONS REGARDING LAW ENFORCEMENT ENCOUNTERS IN HOSPITALS

Law enforcement encounters in hospitals, particularly in hospital emergency departments, present unique challenges that require special consideration on the part of law enforcement officers.

Hospitals are heavily regulated entities with legal and ethical obligations to patients, violations of which can result in financial penalties, citations for noncompliance, decertification followed by the loss of Medicare or Medicaid reimbursement for services, and/or hospital closure.

For example, pursuant to federal Conditions of Participation, which apply to all hospitals that receive Medicare and Medicaid reimbursement, patients have the right to be free from restraint or seclusion, in any form, imposed as a means of coercion, discipline, convenience or retaliation by hospital staff or at staff's direction. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time. The decision to use restraint or seclusion must be the result of a comprehensive individual patient assessment. While these restrictions do not apply to law enforcement officers, federal regulators consider the use of weapons or restraints by law enforcement officers to protect people or property to be handled as criminal activity and the perpetrator placed in the custody of law enforcement.

Hospitals are also required to protect the privacy and confidentiality of patients' personal health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Hospitals may disclose protected health information only in limited circumstances. However, the layout of and the limited space in emergency departments make it difficult to maintain patient privacy when law enforcement officers are present. This requires law enforcement officers to enter and leave patient areas as soon as they have completed their law enforcement activities and to expect only the limited, protected health information from hospital health care workers that they may legally provide.

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. This is true for patients who are engaging in violent or disruptive behavior. This means that law enforcement may not remove a patient from the emergency department until the person has been medically stabilized.

Emergency department examination rooms also contain instruments that can be used as dangerous weapons (scalpels, needles, etc.), which can put law enforcement officers and others at risk. This requires law enforcement officers to exercise greater care when entering an examination room.

Health care workers in emergency departments are typically engaged in fast-paced, time critical lifesaving work. Law enforcement officers must ensure that their activities do not interfere with essential patient care.

Patients with illness and injury in emergency departments are made more vulnerable and perhaps more unpredictable by pain, adverse effects of medications, and stress from the environment. Law enforcement de-escalation skills will be critical when interacting with patients in these circumstances.

Finally, health care workers are particularly vulnerable to workplace violence. According to the Bureau of Labor Statistics, health care workers are five times more likely[1] to experience workplace violence compared to other industries. This is an increase of 63 percent between 2011 and 2018.

SPECIAL CONSIDERATIONS REGARDING LAW ENFORCEMENT ENCOUNTERS IN PREHOSPITAL SETTINGS

Like law enforcement encounters in hospitals, law enforcement encounters at prehospital emergency scenes present unique challenges that require special consideration on the part of law enforcement officers.

[1] U.S. Bureau of Labor Statistics, Number and rate of nonfatal work injuries in private industries, 2021. Last accessed October 13, 2023. https://www.bls.gov/charts/injuries-and-illnesses/number-and-rate-of-nonfatal-work-injuries-by-industry.htm

Emergency medical services (EMS) personnel provide prehospital emergency medical care. They are a critical link between the public and the health care system. With limited resources, EMS personnel care for patients in acute situations in unpredictable and everchanging environments, such as in the streets, the sides of highways, the homes of victims of violence, and the confined space of an ambulance.

Just like hospital patients, prehospital patients have elevated levels of stress. EMS personnel often care for prehospital patients who may be agitated, combative or violent. They also manage patients in dynamic and sometimes dangerous situations that result not from the patient themselves but from dangerous conditions or violent persons present at the scene.

Because of the unique settings in which emergency medical personnel operate, the restraint techniques and the thresholds for the implementation of restraint techniques differ from those that would be acceptable in a hospital environment. For example, the federal Conditions of Participation that apply to hospitals to limit the application of restraint and seclusion, do not apply at emergency scenes. However, law enforcement officers may have to forgo using some restraint techniques, such as handcuffs, because they may impede the delivery of emergency medical care.

In addition, EMS crews may be staffed by personnel with a variety of licenses and/or credentials with different scopes of practice.[2] In Vermont, there is one level of Vermont EMS certification for emergency medical services personnel and four levels of licensure for emergency medical services personnel.

In Vermont, EMS crews may be staffed by any combination of the following:

Vermont EMS Certification for EMS Personnel	**Vermont EMS Licensure for EMS Personnel**
• Vermont EMS First Responder (VEFR)	• Emergency Medical Responder (EMR) • Emergency Medical Technician (EMT) • Advanced Emergency Medical Technician (A-EMT) • Paramedic

A paramedic has the widest scope of practice and a VEFR, which is an introductory level certification, has the narrowest scope of practice. For example, a VEFR's scope of practice includes bleeding control, basic cardiac arrest management, administration of naloxone and

[2] See Appendix 4 of the **Vermont Statewide EMS Protocols**https://www.healthvermont.gov/ for each level's scope of practice.

assistance with an inhaler or epinephrine auto-injector while only a paramedic may administer sedation under specified circumstances.

The varying scope of practice means that the level or intensity of assistance that emergency medical personnel may require from law enforcement will likely vary based on the license or certification held by the individual members of the EMS crew.

EMS personnel are also subjected to very high levels of workplace violence, with one study finding that EMS personnel have nearly triple the odds of experiencing physical and verbal violence in the workplace. Most of the violence comes from patients, however, EMS personnel also experience violence and aggression from bystanders.

The emergency medical needs of prehospital patients, some of whom may have assaulted the EMS provider, and the transitory nature of the prehospital environment may require law enforcement officers to delay their investigation of criminal conduct until patients are transported to a hospital and/or may require law enforcement officers to accompany the patient and EMS provider in an ambulance for the safety of the patient and the EMS crew.

Because of Vermont's rural nature, the limited availability of law enforcement officers and EMS personnel, at times, the best practice of a law enforcement officer accompanying an assaultive patient and the EMS provider in an ambulance will not be feasible. For example, it may not be feasible for law enforcement officers working alone to leave their cruisers on the side of the road while accompanying a patient and EMS provider in an ambulance. In those instances, the law enforcement officer must choose among the least bad option, always keeping in mind the goal of maximizing the safety of all.

LEGISLATIVE PURPOSE

To address workplace violence against health care workers, the Vermont legislature has stiffened the penalties for crimes against health care workers and made it easier for law enforcement officers to cite, arrest and/or remove violent and disruptive patients and others from hospitals and pre-hospital scenes.

The new legislation is intended to signal to all that violence against health care workers, including emergency medical personnel, is not "part of the job."

To achieve the legislature's objectives, law enforcement officers must cite and arrest perpetrators, and prosecutors must see these cases through the criminal justice system.

SECTION 1. DEFINITIONS

Authorized representative of the hospital means an individual with legal authority to disclose protected health information (PHI) to a law enforcement official, when permitted or required by law, including but not limited to whether the medical condition of a patient subject to detention is stabilized. An authorized representative of the hospital will typically be the administrator on-call, the treating practitioner or a nurse leader.

Emergency medical personnel means persons, including volunteers, licensed by the Department of Health to provide emergency medical treatment on behalf of an affiliated agency whose primary function is the provision of emergency medical treatment. The term does not include duly licensed or registered physicians, dentists, nurses, or physician assistants when practicing in their customary work setting.[3]

Emergency medical treatment means pre-hospital, in-hospital, and interhospital medical treatment rendered by emergency medical personnel given to individuals who have experienced sudden illness or injury to prevent loss of life, the aggravation of the illness or injury, or to alleviate suffering. Emergency medical treatment includes basic emergency medical treatment and advanced emergency medical treatment.[4]

Deadly weapon means any firearm, or other weapon, device, instrument, material, or substance, whether animate or inanimate that in the manner it is used or is intended to be used is known to be capable of producing death or serious bodily injury.[5]

Health care facility means all persons or institutions, including mobile facilities, whether public or private, proprietary or not for profit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any institution operated by religious groups relying solely on spiritual means through prayer for healing, but shall include: (A) hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the State of Vermont, or its subdivisions, or a duly authorized agency thereof; (B) nursing homes, health maintenance organizations, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, or any inpatient or ambulatory surgical, diagnostic, or treatment center.[6]

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[3] 24 VSA §2651(6)

[4] 24 VSA § 2651 (9) and 24 VSA §2651(6)

[5] 13 VSA §1021 (a)(3)

[6] 18 VSA §9432(8)

Health care services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease.

Health care worker in a hospital means an employee of a health care facility or a licensed physician who is on the medical staff of a health care facility who provides direct care to patients or who is part of a team-response to a patient or visitor incident involving real or potential violence.[7]

Health Insurance Portability and Accountability Act of 1996 (HIPAA) means the federal law that protects from disclosure in certain instances individually identifiable health information, called protected health information or PHI, held by most health care providers and health plans and their business associates. HIPAA dictates how and with whom PHI may be shared. HIPAA also gives individuals certain rights regarding their health information, such as the rights to access or request corrections to their information.

Hospital means a place devoted primarily to the maintenance and operation of diagnostic and therapeutic facilities for in-patient medical or surgical care of individuals who have an illness, disease, injury, or physical disability, or for obstetrics. [8]

Law enforcement official for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) means an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to: (1) investigate or conduct an official inquiry into a potential violation of law; or (2) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Medically necessary health care services mean health care services needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Non-patient means individuals at a hospital who have not attempted to gain access to health care services at the hospital to diagnose or treat their own medical or mental health condition.

Person providing emergency medical treatment means emergency medical personnel rendering pre-hospital, in-hospital, and interhospital medical treatment to individuals who have experienced sudden illness or injury to prevent loss of life, the aggravation of illness or injury or to alleviate suffering.[9]

[7] 13 VSA § 1028 (d)(3)
[8] 18 VSA § 1902
[9] 24 VSA §2651(9)

Prehospital means before or during transportation to a hospital. For example, emergency medical personnel provide prehospital emergency care, and transport patients to definitive care (hospital care).

Protected health information (PHI) means all individually identifiable information, including genetic information, and demographic information that is held or transmitted by an entity subject to HIPAA, in any form, whether electronic, paper, or oral that relates to an individual's past, present or future physical or mental health condition, the provision of health care to the individuals, or the past, present or future payment for the provision of health care to the individual that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. PHI includes many common identifiers, such as name, address, birth date, and Social Security Number.

Serious bodily injury means bodily injury that creates any of the following: (i) a substantial risk of death; (ii) a substantial loss or impairment of the function of any bodily member or organ; (iii) a substantial impairment of health; (iv) substantial disfigurement; or strangulation by intentionally impeding normal breathing or circulation of the blood by applying pressure on the throat or neck or by blocking the nose or mouth of another person.[10]

Sexual assault means as described in 13 VSA § 3252.[11]

Stabilized means no material deterioration of the patient's medical condition is likely, within reasonable medical probability, to result from or occur during the transport of the patient from the hospital or the emergency medical treatment scene.[12]

SECTION 2: HOSPITAL AND LAW ENFORCEMENT COORDINATION AND COLLABORATION

Local law enforcement agencies should form and maintain a strong working relationship with hospitals in their service areas. Law enforcement agencies should meet regularly with hospital administrators, including hospital security personnel, to better understand one another's roles during law enforcement encounters in hospitals and to develop protocols to allow law enforcement to respond efficiently and effectively, while ensuring the safety of patients and staff.

Law enforcement officers should be familiar with the layout of hospital facilities and the hospital's emergency operations procedures.

[1010] 13 VSA §1702 (g)(1); 13 VSA § 1021(a)(2)
[11] 13 VSA §1702 (g)(8)
[12] 18 VSA §1883 (c)(4)

SECTION 3: EMERGENCY MEDICAL PERSONNEL AND LAW ENFORCEMENT COORDINATION AND COLLABORATION

Law enforcement restraint protocols tend to be different than **emergency medical personnel** restraint protocols. Thus, collaborative training between **emergency medical personnel** and law enforcement about their respective roles and responsibilities is encouraged.

Joint training sessions between law enforcement and **emergency medical personnel** should include:

a. An understanding of the respective roles and responsibilities of law enforcement officers and **emergency medical personnel** when responding to crimes against **emergency medical personnel** by prehospital patients
b. An understanding of the different restraint practices of law enforcement and **emergency medical personnel**
c. Skills practice with both law enforcement and EMS personnel in which prehospital patients are moved from a prone to supine position, transferred from the ground to the ambulance stretcher, while maintaining adequate control of the restraints necessary to maintain patient and EMS personnel safety.

In addition, law enforcement agencies should form and maintain a strong working relationship with emergency medical services agencies in their areas. Law enforcement agencies should meet regularly with agencies to better understand the capabilities and limitations of the agencies' providers and to better understand one another's roles during law enforcement encounters in the prehospital setting.

Law enforcement officers should be familiar with local emergency medical services procedures for entering and operating in potentially dangerous scenes and work together to develop reasonable expectations for the assistance of law enforcement. Law enforcement agencies should also be familiar with local emergency medical services restraint protocol and procedures and any additional local policies and procedures for managing a violent patient.

SECTION 4: HIPAA AND LAW ENFORCEMENT

A. Disclosures Permitted but Not Required by Health Insurance Portability and Accountability Act (HIPAA)

Under HIPAA, the following are protected health information disclosures that hospital or emergency medical personnel may make to a law enforcement official without obtaining patient authorization. Hospital or emergency medical personnel are not required under HIPAA to make these disclosures.

1. **Serious and imminent threat to health or safety.** A health care provider may disclose protected health information to a law enforcement official or others where the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.[13]

2. **Crime on Premises.** A hospital may disclose to a law enforcement official protected health information that the hospital believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the hospital.[14]

3. **Reporting crime in emergencies.** A health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the health care provider's hospital, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

    a. The commission and nature of a crime;
    b. The location of such crime or of the victim(s) of such crime; and
    c. The identity, description, and location of the perpetrator of such crime.[15]

4. **Disclosures to law enforcement for limited information for identification and location purposes**. Hospital or emergency medical personnel may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that the covered entity may disclose only the following information:

    a. Name and address;
    b. Date and place of birth;
    c. Social security number;

[13] 45 CFR 164.512(j)(i)
[14] 45 CFR § 164.512 (f)(5)
[15] 45 CFR § 164.512 (f)(6)

d. ABO blood type and rh factor;
e. Type of injury;
f. Date and time of treatment;
g. Date and time of death, if applicable; and
h. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.[16]

5. **Victims of a Crime**. In response to a request by a law enforcement official, a hospital may disclose information to the official about a patient who may have been the victim of a crime, if the patient agrees to the disclosure. Such agreement may be oral. If the patient is incapacitated or some other emergency circumstance prevents the hospital from obtaining the individual's agreement, the hospital may disclose information to the law enforcement official only if all the following requirements are met:

    a. **Not to be Used Against Victim**. The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim occurred and such information is not intended to be used against the victim;
    b. **Necessary for Immediate Enforcement Activity.** The law enforcement official represents that immediate law enforcement activity depends upon the disclosure of information and such law enforcement activity would be materially and adversely affected by waiting until the individual is able to agree to the release of information; and
    c. **Best Interests of Individual**. The hospital, in its exercise of professional judgment, believes that the release of information to the law enforcement official is in the best interests of the individual.[17]

B. Disclosures Required by Law

Under HIPAA, hospital or **emergency medical personnel** may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Under Vermont law, when a law enforcement officer responds to an alleged crime committed by a patient at a hospital, an authorized representative of the hospital **shall** disclose to the law enforcement officer the following information before the officer removes the patient from the hospital:

[16] 45 CFR § 164.512 (f)(2)
[17] 45 CFR § 164.512 (f)(3)

1. Information that is sufficient to confirm whether the patient is stabilized, has been evaluated, or is awaiting inpatient care;

2. Any other information that will be necessary for purposes of safely taking custody of the patient.[18]

In addition, under Vermont law, when a law enforcement officer responds to an alleged crime committed by a patient at a prehospital scene, a member of the emergency medical personnel who provided the treatment shall disclose to the law enforcement officer the following information before the officer removes the patient from the emergency medical treatment scene:

1. Information that is sufficient to confirm that the patient is stabilized, has been evaluated, or is awaiting transport for health care; and
2. Any other information that will be necessary for purposes of safely taking custody of the patient.

C. Vermont Bill of Rights for Hospital Patients

Under the Vermont Bill of Rights for Hospital Patients, codified at 18 VSA §1852, a patient at a Vermont hospital "has the right to expect that all communications and records pertaining to his or her care shall be treated as confidential." This provision applies only to a person admitted to a hospital on an inpatient basis.

This provision does not pertain to individuals seeking treatment in hospital emergency departments. In addition, the Vermont Bill of Rights for Hospital Patients does not prohibit an authorized representative of a hospital from disclosing protected health information when reporting a crime on hospital premises, helping to identify or locate a suspect, or reporting information to a law enforcement officer that is sufficient to confirm whether the patient is stabilized, has been evaluated or is awaiting inpatient care.

Vermont law permits hospitals to disclose protected health information anytime disclosure is permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[19]

[18] 18 VSA §1883 (a) and (b)
[19] See 18 VSA §1881

SECTION 5: PREHOSPITAL INCIDENT RESPONSE

A. Before Arrival

During a call for service involving allegations of misdemeanor crimes against **emergency medical personnel**, dispatchers should clarify with the caller whether law enforcement should respond to the prehospital setting or the hospital where the patient is being transported.

Dispatchers should attempt to obtain as much information about the subject of the call as allowed by law to assist law enforcement officers in their response to the call.

Consistent with HIPAA, **emergency medical personnel** may disclose the following information to the dispatcher for the purpose of identifying a suspect:

a. Name and address;
b. Date and place of birth;
c. Social security number;[20]
d. ABO blood type and rh factor;
e. Type of injury;
f. Date and time of treatment;
g. Date and time of death, if applicable; and
h. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

B. Upon Arrival

1. **Prehospital Scene**. Upon arrival to a prehospital emergency scene based on a call involving allegations of crimes against emergency medical personnel, law enforcement officers are encouraged to:

    a. Activate body worn cameras upon exiting their vehicle;
    b. Do what is necessary to make the scene safe;
    c. Confirm whether the subject of call is a patient and/or bystander; and
    d. Contact the crew member leading emergency medical care to obtain additional information about the call for service.

2. **Hospital.** Upon arrival to a hospital based on a call involving allegations of crimes against **emergency medical personnel** that occurred prehospital, law enforcement officers are encouraged to:

[20] While HIPAA allows hospitals to disclose social security numbers in these situations, this model policy recommends against dispatchers requesting social security numbers.

a. Activate body worn cameras upon exiting their vehicles;[21]
b. Do what is necessary to make the scene safe;
c. Locate the emergency medical personnel who alleged criminal conduct to obtain additional information about the call for service;
d. Determine who has custody of the subject patient (i.e., the hospital or the emergency medical personnel). Typically, once the patient arrives at the hospital, the hospital has custody of the patient. Before removing a patient from the hospital when there is probable cause to believe the patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer should inquire of an authorized representative of the hospital whether the patient is stabilized, has been evaluated or is awaiting patient care.

C. Assaultive or Violent Patients

1. Transport of Assaultive Patients

If a patient has assaulted an EMS crew member, the best practice is to call another EMS unit to transport the assaultive patient to the hospital. It is unreasonable to expect an EMS crew member who has been assaulted by a patient to ride in the ambulance with and provide treatment to the patient who has assaulted them.

If another EMS crew is unavailable, law enforcement officers should consider accompanying the patient and EMS crew in the ambulance.

In each situation, law enforcement officers should use their discretion to choose the most feasible option based on the totality of the circumstances and the available resources while prioritizing the safety of all.

2. Restraint of Assaultive or Violent Patients

In some cases, physical control of an assaultive or violent patient may require both EMS and law enforcement officer participation until the patient can be safely deescalated or restrained.

Unlike in a hospital, the law does not prohibit law enforcement officers from restraining prehospital patients for medical reasons. However, EMS personnel are solely responsible for the patient's medical care in a prehospital setting.

[21] Body worn camera recordings of patients not involved in criminal conduct that result when law enforcement officers respond to calls involving violence against emergency medical services personnel are considered incidental uses and disclosures under HIPAA pursuant to 45 CFR 164.502 (a)(1)(iii), and do not require prior patient authorization.

According to the National Association of Emergency Medical Physician's Joint Position Statement on Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners,[22] the primary goals of emergency medical services patient restraint are to protect the patient from injuring themselves and to protect the public and responders from injury. This process is typically a separate purpose from that of law enforcement restraint. Law enforcement officers should never expressly request the administration of chemical sedation nor indirectly pressure paramedics to administer chemical sedation. The use of medications is solely the decision and responsibility of the EMS provider.

Law enforcement officers should work collaboratively with EMS personnel when it is necessary to restrain a patient for purposes of assessment, treatment, and/or sedation for safe transport.

Law enforcement officers should generally remove mechanical restraints when requested by EMS personnel to allow EMS personnel to evaluate patients in a side-lying (lateral recumbent) or supine position without handcuffs and/or to ensure the patient's airway and breathing are not compromised by mechanical restraints or restraint position.

D. Prehospital Investigation

The investigation of an alleged, non-witnessed misdemeanor crime against emergency medical personnel will differ based on the whether the subject of the call is a patient or bystander.

1. **Patient Alleged Perpetrator**. When a patient is the alleged perpetrator, law enforcement officers should generally delay investigation of the alleged crime until the patient has been assessed, treated, and transported to a hospital. Evaluation, assessment, and monitoring of the patient by emergency medical services personnel take precedence over investigation.

2. **Bystander Alleged Perpetrator.** When a bystander is the alleged perpetrator, law enforcement officers may begin their investigation at the prehospital scene if the investigation will not unreasonably delay the assessment, treatment, and transport of a patient. Unreasonable delays are delays that put patient health and/or safety at risk by taking **emergency medical personnel** away from the responsibility of assessing, treating, monitoring, and transporting patients. Unreasonable delays may result in increased morbidity and mortality of patients.

[22] Kupas D, Wydro G, Tan D, et al. (2021). Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners. Prehosp Emerg Care. 25(5):721-723.

E. Probable Cause Determination

Follow the procedures outlined in Section 6, paragraph D, of this policy.

F. Detentions, Seizures, and/or Removal

1. Prehospital Setting

In general, when there is probable cause to believe the prehospital patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), law enforcement officers should not remove the patient from a prehospital setting unless the EMS crew member with the highest licensure:

a. informs the law enforcement officer that the patient is stabilized and does not require transport to a hospital; or

b. Informs the law enforcement officer that the patient has made an informed refusal of medical care.

In either situation, the law enforcement officer should document the name and licensure of the crew member who provided the information.

2. Hospital Setting

Detentions, seizures, arrests and/or removal of patients who allegedly committed crimes against emergency medical services personnel may take many forms. For example, law enforcement officers may detain for purposes of issuing a citation. Law enforcement officers may arrest and remove the alleged perpetrator and after issuing a citation allow the alleged perpetrator to leave the hospital premises. Law enforcement officers may arrest and remove the alleged perpetrator and transport the alleged perpetrator to the station for booking and processing. Law enforcement officers should exercise their discretion to determine what form of detention, arrest, and/or removal is effective to ensure the safety of health care workers and emergency medical services personnel and the effective and efficient delivery of health care services at the hospital.

Before removing a patient from the hospital when there is probable cause to believe the patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer should inquire of an authorized representative of the hospital whether the patient is stabilized, has been evaluated or is awaiting inpatient care.

a. Stabilized patients

Law enforcement officers may remove stabilized patients from the hospital.

Law enforcement officers should document the name and title of the authorized representative of the hospital who disclosed to the law enforcement officer that the patient is stabilized.

Law enforcement officers should specifically request the authorized representative of the hospital to provide any discharge instructions provided to the patient about which the law enforcement officer should be aware to safely remove the patient from the hospital.

1. Non-stabilized patients

A law enforcement officer shall not remove a patient from the hospital if an authorized representative of the hospital informs the officer that the patient is not stabilized, has not yet been evaluated, or is awaiting inpatient care.

2. Not Stabilized and/or Has Not Yet Been Evaluated

A law enforcement officer may place a non-stabilized patient or a patient who has not yet been evaluated under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient or patient not yet evaluated is both a patient and a prisoner.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist health care workers in the provision of health care, including restraint and seclusion.

Law enforcement officers should give health care workers space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

3. Awaiting Inpatient Care

A law enforcement officer may place a patient awaiting inpatient care under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient is both a patient and a prisoner.

Law enforcement officers should maintain continuous custody of a patient awaiting inpatient care.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist health care workers in the provision of health care, including restraint and seclusion.

Law enforcement officers should give health care workers space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

Law enforcement officers should position themselves in a manner that allows them to monitor visually the patient awaiting inpatient care. Law enforcement officers should not leave their post until relieved by another law enforcement officer.

If the patient awaiting patient care is waiting in a room, law enforcement officer should sit outside the room in a position that allows them to monitor the patient visually.

If requested by health care workers, law enforcement officers may accompany the health care worker inside the room during treatment. Law enforcement officers should stand out of the way of the health care worker providing treatment, for example, by standing against a wall away from the patient.

Where the local law enforcement agency does not have the resources to maintain around the clock custody of a patient awaiting inpatient care, the agency should reach out to the local sheriff's department to inquire about splitting the detail.

SECTION 6: HOSPITAL INCIDENT RESPONSE PROTOCOL

A. Before Arrival

1. Telephone Calls for Service

During a call for service involving allegations of misdemeanor crimes against health care workers in a hospital, dispatchers should attempt to obtain as much information about the subject of the call as allowed by law to assist law enforcement officers in their response to the call.

Consistent with HIPAA, hospitals may disclose the following information to the dispatcher for the purpose of identifying a suspect:

a. Name and address;
b. Date and place of birth;
c. Social security number;[23]
d. ABO blood type and rh factor;
e. Type of injury;
f. Date and time of treatment;
g. Date and time of death, if applicable; and

[23] While HIPAA allows hospitals to disclose social security numbers in these situations, this model policy recommends against dispatchers requesting social security numbers.

h. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

2. Panic Button Calls for Service

Some Vermont hospitals have installed hospital panic alarm systems that automatically alert law enforcement to an emergency. When such buttons are pushed, oftentimes the hospital implements a lockdown procedure.

Local law enforcement agencies should coordinate and collaborate with the hospitals in their service areas to familiarize themselves with procedures following the activation of a panic button. At the very least, law enforcement agencies should request hospital floor plans and Master Key/ Access Cards and Codes to enable law enforcement to enter the facility during a lockdown.

B. Upon Arrival

Upon arrival to the hospital based on a call involving allegations of crimes against health care workers in a hospital, law enforcement officers are encouraged to:

3. Activate body worn cameras upon exiting their vehicle;[24]
4. Do what is necessary to make the scene safe; and
5. Contact the authorized representative of the hospital to obtain additional information about the call for service.

C. On Scene Investigation

1. Lifesaving efforts by hospital staff always take precedence over investigative activities.
2. Law enforcement officers should request a room or area to conduct witness interviews. Where a room or space is unavailable, law enforcement officers should consider conducting interviews outside the hospital, when feasible.
3. Law enforcement officers should attempt to interview all involved parties, including the alleged victim, the alleged perpetrator, and witnesses. It may violate the Americans with Disabilities Act to fail to interview alleged perpetrators because of their diagnoses or presumed mental health state.
4. Law enforcement officers should attempt to review any available audio and/or video recordings. If pertinent to the investigation, law enforcement officers should ask the hospital to provide a digital copy of the recording. The person(s) who maintains or monitors or retains custody of video surveillance recordings and who can explain how

[24] Body worn camera recordings of patients not involved in criminal conduct that result when law enforcement officers respond to calls involving violence against health care workers in hospitals are considered incidental uses and disclosures under HIPAA pursuant to 45 CFR 164.502 (a)(1)(iii), and do not require prior patient authorization.

the video surveillance system is maintained should be listed in the police report as a witness and interviewed accordingly, as they may be required to testify at hearings and/or trial.

5. Law enforcement officers should preserve forensic evidence, by photographing and/or collecting and taking custody of the evidence. A law enforcement officer may arrest a person without a warrant if there is probable cause to believe the person has committed or is committing a non-witnessed misdemeanor and the officer has probable cause to believe an arrest is necessary to obtain nontestimonial evidence upon the person or within the reach of the person.[25]

D. Probable Cause Determination

Pursuant to Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer may arrest a person without a warrant for the following non-witnessed, misdemeanor crimes against health care workers, if the officer has probable cause to believe the person has committed:

1. **Simple assault (13 VSA §1023).** A person commits simple assault if they attempt to cause or purposely, knowingly, or recklessly causes bodily injury to another; or negligently causes bodily injury to another with a deadly weapon; or attempts by physical menace to put another in fear of imminent, serious bodily injury.

2. **Criminal threatening (13 VSA 1702).** A person commits criminal threatening against a health care worker in a hospital if the person, by words or conduct, knowingly threatens a health care worker in a hospital or a group of health care workers in a hospital; and as a result of the threat, places the health care worker in a hospital or group of hospital workers in a hospital in reasonable apprehension of death, serious bodily injury or sexual assault. “Threat” and “threaten” do not include constitutionally protected activity.

3. **Disorderly conduct (13 VSA §1026 (a)(1)) and Vermont Rules of Criminal Procedure, Rule 3 (20)).** A person commits disorderly conduct by engaging in fighting or in violent, tumultuous or threatening behavior if they, with intent to cause public inconvenience or annoyance, or recklessly creates a risk thereof that interfered with the provision of medically necessary health care services.

Although the existence of probable cause must be determined with reference to the facts of each case, in general, probable cause to arrest exists when law enforcement officers have knowledge or reasonably trustworthy information of facts and circumstances that are sufficient

[25] Vermont Rules of Criminal Procedure, Rule 3(c)(2).

in themselves to warrant a person of reasonable caution in the belief that (1) an offense has been or is being committed (2) by the person to be arrested."[26]

While probable cause may be based on trustworthy information from a third party in a specific situation, an officer may not blindly defer to third-party information. An officer "is not free to disregard plainly exculpatory evidence." [27] The question is whether the facts known to the arresting officer, at the time of the arrest, objectively provide probable cause to support the arrest.[28]

E. Detentions, Seizures, Arrests and/or Removal

Detentions, seizures, arrests and/or removal may take many forms. For example,

- Law enforcement officers may arrest and temporarily remove the alleged perpetrator from the hospital and after issuing a citation allow the alleged perpetrator to return to the hospital.

- Law enforcement officers may arrest and remove the alleged perpetrator and after issuing a citation allow the alleged perpetrator to leave the hospital premises.

- Law enforcement officers may arrest and remove the alleged perpetrator and transport the alleged perpetrator to the station for booking and processing.

Law enforcement officers should exercise their discretion to determine what form of detention, arrest, and/or removal is effective to ensure the safety of health care workers and the effective and efficient delivery of health care services at the hospital.

Before removing a patient from the hospital when there is probable cause to believe the patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer should inquire of an authorized representative of the hospital whether the patient is stabilized, has been evaluated or is awaiting inpatient care.

1. Stabilized patients

Law enforcement officers may remove stabilized patients from the hospital.

Law enforcement officers should document the name and title of the authorized representative of the hospital who disclosed to the law enforcement officer that the patient is stabilized.

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[26] *United States v. Fisher,* 702 F.2d 372, 375 (2d Cir. 1983)
[27] *Kerman v. City of New York*, 261 F.3d 229, 241 (2d Cir. 2001)
[28] *Gonzalez v. City of N.Y.,* 728 F.3d 149, 155 (2d Cir. 2013)

Law enforcement officers should specifically request the authorized representative of the hospital to provide any discharge instructions provided to the patient about which the law enforcement officer should be aware to safely remove the patient from the hospital.

2. Non-stabilized patients

A law enforcement officer shall not remove a patient from the hospital if an authorized representative of the hospital informs the officer that the patient is not stabilized, has not yet been evaluated, or is awaiting inpatient care.

3. Not Stabilized and/or Has Not Yet Been Evaluated

A law enforcement officer may place a non-stabilized patient or a patient who has not yet been evaluated under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient or patient not yet evaluated is both a patient and a prisoner.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist health care workers in the provision of health care, including restraint and seclusion.

Law enforcement officers should give health care workers space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

4. Awaiting Inpatient Care

A law enforcement officer may place a patient awaiting inpatient care under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient is both a patient and a prisoner.

Law enforcement officers should maintain continuous custody of a patient awaiting inpatient care.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist health care workers in the provision of health care, including restraint and seclusion.

Law enforcement officers should give health care workers space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

Law enforcement officers should position themselves in a manner that allows them to monitor visually the patient awaiting inpatient care. Law enforcement officers should not leave their post until relieved by another law enforcement officer.

If the patient awaiting patient care is waiting in a room, law enforcement officer should sit outside the room in a position that allows them to monitor the patient visually.

If requested by health care workers, law enforcement officers may accompany the health care worker inside the room during treatment. Law enforcement officers should stand out of the way of the health care worker providing treatment, for example, by standing against a wall away from the patient.

Where the local law enforcement agency does not have the resources to maintain around the clock custody of a patient awaiting inpatient care, the agency should reach out to the local sheriff's department to inquire about splitting the detail.

5. Non-patients

Law enforcement officers should confirm with an authorized representative of the hospital that the individual is a non-patient.

After confirming that the individual is a non-patient, in accord with existing policy, law enforcement officers may cite, arrest and/or remove non-patients where there is probable cause to believe they have committed simple assault, criminal threatening against a health care worker at a hospital, engaged in disorderly conduct that interfered with the provision of medically necessary health care services, and/or as otherwise provided by Vermont Rules of Criminal Procedure, Rule 3.

F. Trespass Citation

If for some reason citation and/or arrest for simple assault, criminal threatening and/or disorderly conduct is not possible, a person in lawful possession of hospital property may serve a notice of trespass on the disruptive individual pursuant to 13 VSA §3705.

Individuals subject to a no-trespass order at a hospital may lawfully return to the hospital for emergency medical services.

Should the individual violate the no-trespass order, law enforcement may arrest and cite the individual for violation of the order.

Law enforcement officers may also cite or arrest the person as otherwise provided by Vermont Rules of Criminal Procedure, Rule 3.

SECTION 7: COMMUNICATION WITH WITNESSES AND REPORT WRITING

A. Communication with Victim and Authorized Representative of Hospital

Law enforcement officers should briefly explain to the alleged victim the law enforcement procedures for tasks such as preparing the police report, investigating the crime, and contacting the on-call State's Attorney for a decision on disposition.

At the earliest opportunity, including at the time of the incident or during follow-up, law enforcement officers should inform the alleged victim, and the authorized representative of the hospital of their decisions about arrest, citation, and/or removal, and explain the reasons for them.

If a no-trespass order has been served, the law enforcement officer should explain to the alleged victim and authorized representative of the hospital that the order will not prevent the individual from returning to the hospital for emergency health care services.

B. Communication with Witnesses (including victims)

Law enforcement officers should inform all witnesses that they may be called to testify at trial or other court hearings and that they may receive a subpoena from the State requiring their presence.

Law enforcement officers should provide all witnesses the opportunity to write a sworn statement and provide any other evidence at the time of the incident or any other time.

Law enforcement officers should follow up with each witness as needed to ensure successful prosecution or disposition.

Where it appears to law enforcement officers that an alleged perpetrator's conduct in the hospital may be indicative of similar conduct in the home, if an alleged perpetrator's spouse or domestic partner is present, law enforcement officers should consider inquiring of them outside the presence of the alleged perpetrator whether they feel safe in their home. Law enforcement officers should consider providing the alleged perpetrator's spouse or domestic partner information about community resources that may be able to assist them and provide support or shelter if they do not feel safe in their home.

C. Report Writing

1. In General

Law enforcement should allow victims of crimes against health care worker to use the hospital contact information (hospital address and phone number) rather than personal contact information, when filing a complaint with law enforcement, if they are concerned about their safety.

Law enforcement should allow victims of crimes against **emergency medical personnel** to use their employer's contact information (address and phone number) rather than personal contact information, when filing a complaint with law enforcement, if they are concerned about their safety.

Law enforcement officers should ask hospitals to create a point of contact for law enforcement, prosecutors, and victim witness advocates who need to communicate with victims and witnesses if cases move forward.

2. Use of Force Report

If law enforcement officers use any force beyond compliant handcuffing, the officers should complete a Use of Force Report. Refer to the Statewide Use of Force Policy, Appendix C for minimum requirements.

SECTION 8: BODY WORN CAMERA RECORDINGS

When law enforcement officers activate their body worn cameras upon exiting their vehicles when responding to calls for service at a hospital, the body worn cameras may capture protected health information of patients not involved in criminal conduct. While HIPAA allows incidental disclosures of protected health information without patient authorization,[29] if such body worn camera recordings become the subject of a request under Vermont's Public Records Act, the faces of patients not involved in criminal conduct and any other identifying protected health information should be blurred or redacted before the recording is made publicly available.

[29] 45 CFR 164.502(a)(1)(iii)

SECTION 9: AMERICANS WITH DISABILITIES ACT

Under the Americans with Disabilities Act, individuals are considered to have a "disability" if they have a physical or mental impairment that substantially limits one or more major life activities, have a record of such an impairment, or are regarded as disabled.

Law enforcement officers should err on the side of caution and should consider patients awaiting evaluation, stabilized patients, non-stabilized patients, and patients awaiting inpatient care as persons with a "disability."

When feasible, law enforcement officers should seek to reasonably accommodate individuals with known or apparent disabilities when encountering and interacting with such individuals in hospitals.

Reasonable accommodations are specific to each situation. At a minimum, when feasible, law enforcement officers should speak slowly, simply, and briefly; maintain distance from the individual and respect their comfort zone; and use time to defuse a situation.

An individual does not have to request accommodation if the officer knew or should have known of the disability.

SECTION 10: POST-INCIDENT CRIMINAL DECISIONS

Law enforcement officers should follow existing policy for criminal charging decisions, including the enhanced penalty for assaults against health care workers at 13 VSA §1028 and the enhanced penalty for criminal threatening at 13 VSA § 1702.

If a law enforcement officer has reason to believe that the incident in question constitutes a hate crime incident or qualifies for a hate crime enhancement, the law enforcement officer should directly communicate such information to the State's Attorney Office rather than rely on the State Attorney's Office to discover such evidence on its own in the written statements, police reports or physical evidence.

Incidents at a hospital or in a prehospital setting that involve bias or hate should be reported to the Attorney General's Office for inclusion in the hate crimes database.

SECTION 10: ADDITIONAL RESOURCES

1. Health Insurance Portability and Accountability Act [HIPAA] Privacy Rule: A guide for law enforcement. Accessed October 11, 2023. Available at: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

2. 2023 Act 24, an act relating to crimes against health care workers at hospitals and against emergency medical treatment providers.

3. 2011 Act No. 26, an act relating to assault of a health care worker.

Arrests for Non-Witnessed Misdemeanor Crimes Against Health Care Workers and Emergency Medical Personnel Pursuant to Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20)

Sample Policy

INTRODUCTION

This sample policy addresses arrests for non-witnessed misdemeanor crimes against health care workers and emergency medical personnel pursuant to Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), including the procedures for law enforcement officers to follow to arrest and/or remove individuals from hospitals without a warrant when there is probable cause to believe such individuals have committed the following offenses:

1. Simple assault (13 VSA §1023);
2. Criminal threatening (13 VSA 1702); and
3. Disorderly conduct (13 VSA §1026 (a)(1)) and Vermont Rules of Criminal Procedure, Rule 3 (20).

ORGANIZATION OF THE SAMPLE POLICY

The sample policy includes the following sections:

Section 1: Definitions (Terms that are defined in the policy are **bolded**).

Section 2: Prehospital Incident Response Protocol

Section 3: Hospital Incident Response Protocol

Section 4: Communication with Victim and Report Writing

Section 5: Americans with Disabilities Act

Section 6: Post-Incident Criminal Decisions

SECTION 1: DEFINITIONS

Authorized representative of the hospital means an individual with legal authority to disclose protected health information (PHI) to a law enforcement official, when permitted or required by law, including but not limited to whether the medical condition of a patient subject to detention is stabilized. An authorized representative of the hospital will typically be the administrator on-call, the treating practitioner or a nurse leader.

Emergency medical personnel means persons, including volunteers, licensed by the Department of Health to provide emergency medical treatment on behalf of an affiliated agency whose primary function is the provision of emergency medical treatment. The term does not include duly licensed or registered physicians, dentists, nurses, or physician assistants when practicing in their customary work setting.[30]

Emergency medical treatment means pre-hospital, in-hospital, and interhospital medical treatment rendered by emergency medical personnel given to individuals who have experienced sudden illness or injury to prevent loss of life, the aggravation of the illness or injury, or to alleviate suffering. Emergency medical treatment includes basic emergency medical treatment and advanced emergency medical treatment.[31]

Deadly weapon means any firearm, or other weapon, device, instrument, material, or substance, whether animate or inanimate that in the manner it is used or is intended to be used is known to be capable of producing death or serious bodily injury.[32]

Health care worker in a hospital means an employee of a health care facility or a licensed physician who is on the medical staff of a health care facility who provides direct care to patients or who is part of a team-response to a patient or visitor incident involving real or potential violence.[33]

Health Insurance Portability and Accountability Act of 1996 (HIPAA) means the federal law that protects from disclosure in certain instances individually identifiable health information, called protected health information or PHI, held by most health care providers and health plans and their business associates. HIPAA dictates how and with whom PHI may be shared. HIPAA also gives individuals certain rights regarding their health information, such as the rights to access or request corrections to their information.

[30] 24 VSA §2651(6)
[31] 24 VSA § 2651 (9) and 24 VSA §2651(6)
[32] 13 VSA §1021 (a)(3)
[33] 13 VSA § 1028 (d)(3)

Hospital means a place devoted primarily to the maintenance and operation of diagnostic and therapeutic facilities for in-patient medical or surgical care of individuals who have an illness, disease, injury, or physical disability, or for obstetrics. [34]

Medically necessary health care services mean health care services needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Non-patient means individuals at a hospital who have not attempted to gain access to health care services at the hospital to diagnose or treat their own medical or mental health condition.

Person providing emergency medical treatment means emergency medical personnel rendering pre-hospital, in-hospital, and interhospital medical treatment to individuals who have experienced sudden illness or injury to prevent loss of life, the aggravation of illness or injury or to alleviate suffering.[35]

Prehospital means before or during transportation toa hospital. For example, EMS personnel provide prehospital emergency care and transport patients to definitive care or hospital care.

Serious bodily injury means bodily injury that creates any of the following: (i) a substantial risk of death; (ii) a substantial loss or impairment of the function of any bodily member or organ; (iii) a substantial impairment of health; (iv) substantial disfigurement; or strangulation by intentionally impeding normal breathing or circulation of the blood by applying pressure on the throat or neck or by blocking the nose or mouth of another person.[36]

Sexual assault means as described in 13 VSA § 3252.[37]

Stabilized means no material deterioration of the patient's medical condition is likely, within reasonable medical probability, to result from or occur during the transport of the patient from the hospital or the emergency medical treatment scene. (18 VSA §1883 (c)(4))

[34] 18 VSA § 1902
[35] 24 VSA §2651(9)
[36] 13 VSA §1702 (g)(1); 13 VSA § 1021(a)(2)
[37] 13 VSA §1702 (g)(8)

SECTION 2: PREHOSPITAL INCIDENT RESPONSE PROTOCOL

A. Before Arrival

During a call for service involving allegations of misdemeanor crimes against emergency medical personnel, dispatchers should clarify with the caller whether law enforcement should respond to the prehospital setting or the hospital where the patient is being transported.

Dispatchers should attempt to obtain as much information about the subject of the call as allowed by law to assist law enforcement officers in their response to the call.

Consistent with HIPAA, emergency medical personnel may disclose the following information to the dispatcher for the purpose of identifying a suspect:

a. Name and address;
b. Date and place of birth;
c. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

B. Upon Arrival

1. **Prehospital Scene**. Upon arrival to a prehospital emergency scene based on a call involving allegations of crimes against emergency medical personnel, law enforcement officers are encouraged to:

    a. Activate body worn cameras upon exiting their vehicle;
    b. Do what is necessary to make the scene safe;
    c. Confirm whether the subject of call is a patient and/or bystander; and
    d. Contact the crew member with the highest licensure to obtain additional information about the call for service.

2. **Hospital.** Upon arrival to a hospital based on a call involving allegations of crimes against emergency medical personnel that occurred prehospital, law enforcement officers are encouraged to:

    a. Activate body worn cameras upon exiting their vehicles;[38]
    b. Do what is necessary to make the scene safe;

[38] Body worn camera recordings of patients not involved in criminal conduct that result when law enforcement officers respond to calls involving violence against emergency medical services personnel are considered incidental uses and disclosures under HIPAA pursuant to 45 CFR 164.502 (a)(1)(iii), and do not require prior patient authorization.

c. Locate the emergency medical personnel who alleged criminal conduct to obtain additional information about the call for service;
d. Determine who has custody of the subject patient (i.e., the hospital or the emergency medical personnel). Typically, once the patient arrives at the hospital, the hospital has custody of the patient. Before removing a patient from the hospital when there is probable cause to believe the patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer should inquire of an authorized representative of the hospital whether the patient is stabilized, has been evaluated or is awaiting patient care.

C. Assaultive or Violent Patients

1. Transport of Assaultive Patients

If a patient has assaulted an EMS crew member, the best practice is to call another EMS unit to transport the assaultive patient to the hospital. It is unreasonable to expect an EMS crew member who has been assaulted by a patient to ride in the ambulance with and provide treatment to the patient who has assaulted them.

If another EMS crew is unavailable, law enforcement officers should consider accompanying the patient and EMS in the ambulance.

In each situation, law enforcement officers should use their discretion to choose the most feasible option based on the totality of the circumstances and the available resources while prioritizing the safety of all.

2. Restraint of Assaultive or Violent Patients

In some cases, physical control of an assaultive or violent patient may require both EMS and law enforcement officer participation until the patient can be safely deescalated or restrained.

Unlike in a hospital, the law does not prohibit law enforcement officers from restraining prehospital patients for medical reasons. However, EMS personnel are solely responsible for the patient's medical care in a prehospital setting.

Law enforcement officers should never expressly request the administration of chemical sedation nor indirectly pressure paramedics to administer chemical sedation. The use of medications is solely the decision and responsibility of the EMS provider.

Law enforcement officers should work collaboratively with EMS personnel when it is necessary to restrain a patient for purposes of assessment, treatment, and/or sedation for safe transport.

Law enforcement officers should generally remove mechanical restraints when requested by EMS personnel to allow EMS personnel to evaluate patients in a side-lying or supine position without handcuffs and/or to ensure the patient's airway is not compromised by mechanical restraints or restraint position.

D. Prehospital Investigation

The investigation of an alleged, non-witnessed misdemeanor crime against emergency medical personnel will differ based on the whether the subject of the call is a patient or bystander.

1. **Patient Alleged Perpetrator**. When a patient is the alleged perpetrator, law enforcement officers should generally delay investigation of the alleged crime until the patient has been assessed, treated, and transported to a hospital. Evaluation, assessment, and monitoring of the patient by emergency medical services personnel take precedence over investigation.

2. **Bystander Alleged Perpetrator.** When a bystander is the alleged perpetrator, law enforcement officers may begin their investigation at the prehospital scene if the investigation will not unreasonably delay the assessment, treatment, and transport of a patient. Unreasonable delays are delays that put patient health and/or safety at risk by taking emergency medical services personnel away from the task of assessing, treating, monitoring, and transporting patients. Unreasonable delays may result in increased morbidity and mortality of patients.

E. Probable Cause Determination

Follow the procedures outlined in Section 3, paragraph D, of this policy.

F. Detentions, Seizures, and/or Removal

1. Prehospital Setting

In general, when there is probable cause to believe the prehospital patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), law enforcement officers should not remove the patient from a prehospital setting unless the EMS crew member with the highest licensure:

a. informs the law enforcement officer that the patient is stabilized and does not require transport to a hospital; or

b. Informs the law enforcement officer that the patient has made an informed refusal of medical care.

In either situation, the law enforcement officer should document the name and licensure of the crew member who provided the information.

2. Hospital Setting

Before removing a patient from the hospital when there is probable cause to believe the patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer should inquire of an authorized representative of the hospital whether the patient is stabilized, has been evaluated or is awaiting inpatient care.

a. Stabilized patients

Law enforcement officers may remove stabilized patients from the hospital.

Law enforcement officers should document the name and title of the authorized representative of the hospital who disclosed to the law enforcement officer that the patient is stabilized.

Law enforcement officers should specifically request the authorized representative of the hospital to provide any discharge instructions provided to the patient about which the law enforcement officer should be aware to safely remove the patient from the hospital.

b. Non-stabilized patients

A law enforcement officer shall not remove a patient from the hospital if an authorized representative of the hospital informs the officer that the patient is not stabilized, has not yet been evaluated, or is awaiting inpatient care.

c. Not Stabilized and/or Has Not Yet Been Evaluated

A law enforcement officer may place a non-stabilized patient or a patient who has not yet been evaluated under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient or patient not yet evaluated is both a patient and a prisoner.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist health care workers in the provision of health care, including restraint and seclusion.

Law enforcement officers should give health care workers space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

d. Awaiting Inpatient Care

A law enforcement officer may place a patient awaiting inpatient care under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient is both a patient and a prisoner.

Law enforcement officers should maintain continuous custody of a patient awaiting inpatient care.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist health care workers in the provision of health care, including restraint and seclusion.

Law enforcement officers should give health care workers space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

Law enforcement officers should position themselves in a manner that allows them to monitor visually the patient awaiting inpatient care. Law enforcement officers should not leave their post until relieved by another law enforcement officer.

If the patient awaiting patient care is waiting in a room, law enforcement officer should sit outside the room in a position that allows them to monitor the patient visually.

If requested by health care workers, law enforcement officers may accompany the health care worker inside the room during treatment. Law enforcement officers should stand out of the way of the health care worker providing treatment, for example, by standing against a wall away from the patient.

Where the local law enforcement agency does not have the resources to maintain around the clock custody of a patient awaiting inpatient care, the agency should reach out to the local sheriff's department to inquire about splitting the detail.

SECTION 3: HOSPITAL INCIDENT RESPONSE PROTOCOL

A. Before Arrival

1. Telephone Calls for Service

During a call for service involving allegations of crimes against **health care workers** in a **hospital**, dispatchers should attempt to obtain information about the subject of the call to assist law enforcement officers in their response to the call.

Information to request, which hospitals are permitted to disclose under **HIPAA**, might include:

d. Name and address;
e. Date and place of birth;
f. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

2. Panic Button Calls for Service

Some Vermont **hospitals** have installed hospital panic alarm systems that automatically alert law enforcement to an emergency. When such buttons are pushed, oftentimes the hospital implements a lockdown procedure.

If law enforcement officers have not been provided Master Key/Access Cards and Codes, they should contact the **hospital** en route to request access codes.

B. Upon Arrival

Upon arrival to the **hospital** based on a call involving allegations of crimes against **health care workers** in a hospital, law enforcement officers are encouraged to:

1. Activate body worn cameras upon exiting their vehicle;
2. Do what is necessary to make the scene safe; and
3. Contact the authorized representative of the **hospital** to obtain additional information about the call for service.

C. On Scene Investigation

1. Lifesaving efforts by hospital staff always take precedence over investigative activities.
2. Law enforcement officers should request a room or area to conduct witness interviews. Where a room or space is unavailable, law enforcement officers should consider conducting interviews outside the hospital, when feasible.
3. Law enforcement officers should attempt to interview all involved parties, including the alleged victim, the alleged perpetrator, and witnesses. It may violate the Americans with Disabilities Act to fail to interview alleged perpetrators because of their diagnoses or presumed mental health state.
4. Law enforcement officers should attempt to review any available audio and/or video recordings. If pertinent to the investigation, law enforcement officers should ask the **hospital** to provide a digital copy of the recording. The person(s) who maintains or monitors or retains custody of video surveillance recordings and who can explain how the video surveillance system is maintained should be listed in the police report as a witness and interviewed accordingly, as they may be required to testify at hearings and/or trial.
5. Law enforcement officers should preserve forensic evidence, by photographing and/or collecting and taking custody of the evidence. A law enforcement officer may arrest a person without a warrant if there is probable cause to believe the arrest is necessary to obtain nontestimonial evidence upon the person or within the reach of the person.[39]

D. Probable Cause Determination

Pursuant to Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer may arrest a person without a warrant for the following non-witnessed, misdemeanor crimes against **health care workers**, if the officer has probable cause to believe the person has committed:

1. **Simple assault (13 VSA §1023).** A person commits simple assault if they attempt to cause or purposely, knowingly, or recklessly causes bodily injury to another; or negligently causes bodily injury to another with a **deadly weapon**; or attempts by physical menace to put another in fear of imminent, **serious bodily injury**.

2. **Criminal threatening (13 VSA 1702).** A person commits criminal threatening against a health care worker in a hospital if the person, by words or conduct, knowingly threatens a **health care worker** in a **hospital** or a group of **health care workers** in a **hospita**l; and as a result of the threat, places the **health care worker** in a **hospital** or group of **health care workers** in a **hospital** in reasonable apprehension of death, **serious bodily injury** or **sexual assault**. “Threat” and “threaten” do not include constitutionally protected activity.

[39] Vermont Rules of Criminal Procedure, Rule 3(c)(2).

3. **Disorderly conduct (13 VSA §1026 (a)(1) and Vermont Rules of Criminal Procedure, Rule 3 (20)).** A person commits disorderly conduct by engaging in fighting or in violent, tumultuous or threatening behavior if they, with intent to cause public inconvenience or annoyance, or recklessly creates a risk thereof that interfered with the provision of **medically necessary health care services**.

Although the existence of probable cause must be determined with reference to the facts of each case, in general, probable cause to arrest exists when law enforcement officers have knowledge or reasonably trustworthy information of facts and circumstances that are sufficient in themselves to warrant a person of reasonable caution in the belief that (1) an offense has been or is being committed (2) by the person to be arrested."[40]

While probable cause may be based on trustworthy information from a third party in a specific situation, an officer may not blindly defer to third-party information. An officer "is not free to disregard plainly exculpatory evidence." [41] The question is whether the facts known to the arresting officer, at the time of the arrest, objectively provide probable cause to support the arrest.[42]

E. Detentions, Seizures, Arrests and/or Removal

Before removing a patient from the **hospital** when there is probable cause to believe the patient has committed at least one of the three enumerated crimes in Vermont Rules of Criminal Procedure, Rule 3 (c)(18) – (20), a law enforcement officer should inquire of an **authorized representative of the hospital** whether the patient is **stabilized**, has been evaluated or is awaiting inpatient care.

1. Stabilized patients

Law enforcement officers may remove **stabilized** patients from the **hospital**.

Law enforcement officers should document the name and title of the **authorized representative of the hospital** who disclosed to the law enforcement officer that the patient is stabilized.

Law enforcement officers should specifically request the **authorized representative of the hospital** to provide any discharge instructions provided to the patient about which the law enforcement officer should be aware to safely remove the patient from the **hospital**.

[40] *United States v. Fisher,* 702 F.2d 372, 375 (2d Cir. 1983)
[41] *Kerman v. City of New York*, 261 F.3d 229, 241 (2d Cir. 2001)
[42] *Gonzalez v. City of N.Y.,* 728 F.3d 149, 155 (2d Cir. 2013)

2. Non-stabilized patients

A law enforcement officer shall not remove a patient from the **hospital** if an **authorized representative of the hospital** informs the officer that the patient is not **stabilized**, has not yet been evaluated, or is awaiting inpatient care.

a. Not Stabilized and/or Has Not Yet Been Evaluated

A law enforcement officer may place a non-stabilized patient or a patient who has not yet been evaluated under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient or patient not yet evaluated is both a patient and a prisoner.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist **health care workers** in the provision of health care, including restraint and seclusion.

Law enforcement officers should give **health care workers** space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

b. Awaiting Inpatient Care

A law enforcement officer may place a patient awaiting inpatient care under arrest and maintain custody of the patient. In these circumstances, the non-stabilized patient is both a patient and a prisoner.

Law enforcement officers should maintain continuous custody of a patient awaiting inpatient care.

Any use of force against the patient-prisoner should be employed only for law enforcement purposes. Law enforcement officers should not use force to assist **health care workers** in the provision of health care, including restraint and seclusion.

Law enforcement officers should give **health care workers** space and room to render health care services to the patient-prisoner and not interfere with the delivery of such services.

Law enforcement officers should position themselves in a manner that allows them to monitor visually the patient awaiting inpatient care. Law enforcement officers should not leave their post until relieved by another law enforcement officer.

If the patient awaiting patient care is waiting in a room, law enforcement officer should sit outside the room in a position that allows them to monitor the patient visually.

If requested by the **health care worker**, law enforcement officers may accompany the **health care worker** inside the room during treatment. Law enforcement officers should stand out of

the way of the **health care worker** providing treatment, for example, by standing against a wall away from the patient.

Where the local law enforcement agency does not have the resources to maintain around the clock custody of a patient awaiting inpatient care, the agency should reach out to the local sheriff's department to inquire about splitting the detail.

3. Non-patients

Law enforcement officers should confirm with an **authorized representative of the hospital** that the individual is a **non-patient**.

After confirming that the individual is a **non-patient**, in accord with existing policy, law enforcement officers may cite, arrest and/or remove non-patients where there is probable cause to believe they have committed simple assault, criminal threatening against a **health care worker** at a **hospital**, engaged in disorderly conduct that interfered with the provision of **medically necessary health care services**, and/or as otherwise provided by Vermont Rules of Criminal Procedure, Rule 3.

F. Trespass Citation

If for some reason citation and/or arrest for simple assault, criminal threatening and/or disorderly conduct is not possible, a person in lawful possession of hospital property may serve a notice of trespass on the disruptive individual pursuant to 13 VSA §3705.

Individuals subject to a no-trespass order at a hospital may lawfully return to the hospital for emergency medical services.

Should the individual violate the no-trespass order, law enforcement may arrest and cite the individual for violation of the order.

SECTION 4: COMMUNICATION WITH VICTIM AND REPORT WRITING

A. Communication with Victim and Authorized Representative of Hospital

Law enforcement officers should briefly explain to the alleged victim the law enforcement procedures for tasks such as preparing the police report, investigating the crime, and contacting the on-call State's Attorney for a decision on disposition.

At the earliest opportunity, including at the time of the incident or during follow-up, law enforcement officers should inform the alleged victim and authorized representative of the hospital of their decisions about arrest, citation, and/or removal, and explain the reasons for them.

If a no-trespass order has been issued, the law enforcement officer should explain to the alleged victim and **authorized representative of the hospital** that the order will not prevent the individual from returning to the hospital for emergency health care services.

B. Communication with Witnesses (including victims)

Law enforcement officers should inform all witnesses that they may be called to testify at trial or other court hearings and that they may receive a subpoena from the State requiring their presence.

Law enforcement officers should provide all witnesses the opportunity to write a sworn statement and provide any other evidence at the time of the incident or any other time.

Law enforcement officers should follow up with each witness as needed to ensure successful prosecution or disposition.

C. Report Writing

1. In General

Law enforcement should allow victims of crimes against **health care worker**s to use the hospital contact information (hospital address and phone number) rather than personal contact information, when filing a complaint with law enforcement, if they are concerned about their safety.

Law enforcement should allow victims of crimes against emergency medical personnel to use their employer's contact information (address and phone number) rather than personal contact information, when filing a complaint with law enforcement, if they are concerned about their safety.

Law enforcement officers should ask **hospitals** and **emergency medical personnel** to create a point of contact for law enforcement, prosecutors, and victim witness advocates who need to communicate with victims and witnesses if cases move forward.

2. Use of Force Report

If law enforcement officers use any force beyond compliant handcuffing, the officers should complete a Use of Force Report. Refer to the Statewide Use of Force Policy, Appendix C for minimum requirements.

SECTION 5: AMERICANS WITH DISABILITIES ACT

Law enforcement officers should err on the side of caution and should consider patients awaiting evaluation, **stabilized** patients, non-stabilized patients, and patients awaiting inpatient care as persons with a "disability."

When feasible, law enforcement officers should seek to reasonably accommodate individuals with known or apparent disabilities when encountering and interacting with such individuals in hospitals or prehospital settings.

Reasonable accommodations are specific to each situation. At a minimum, when feasible, law enforcement officers should speak slowly, simply, and briefly; maintain distance from the individual and respect their comfort zone; and use time to defuse a situation.

An individual does not have to request accommodation if the officer knew or should have known of the disability.

SECTION 6: POST-INCIDENT CRIMINAL DECISIONS

Law enforcement officers should follow existing policy for criminal charging decisions, including the enhanced penalty for assaults against health care workers at 13 VSA §1028 and the enhanced penalty for criminal threatening at 13 VSA § 1702.

If a law enforcement officer has reason to believe that the incident in question constitutes a hate crime incident or qualifies for a hate crime enhancement, the law enforcement officer should directly communicate such information to the State's Attorney Office rather than rely on the State Attorney's Office to discover such evidence on its own in the written statements, police reports or physical evidence.

Incidents at a hospital or prehospital setting that involve bias or hate should be reported to the Attorney General's Office for inclusion in the hate crimes database.