Protecting Patients' Rights

When Law Enforcement Is Present in the Emergency Department

A Policy Development Toolkit from the HealthCARE Collaborative for Justice

CENTER for INNOVATIONS in COMMUNITY SAFETY

GEORGETOWN LAW

HEALTHCARE COLLABORATIVE FOR JUSTICE (HCCJ)

Policy Development Toolkit

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Letter from the HCCJ

Dear Reader,

We at the HealthCARE Collaborative for Justice (HCCJ) are proud to present this toolkit to you and your communities. We have worked together for the past two years to develop the model policies and forms you'll find here–this process has not always been easy, but it has been essential to creating model hospital policies that address critical issues, are responsive to the priorities of all stakeholders, and prioritize the rights and dignity of victims of violence in Washington, D.C. and around the country.

We decided on our coalition name (HealthCARE Collaborative for Justice) at the end of our first year working together. The CARE in our name refers to our community principles that we collectively agreed upon during our first coalition meeting: Collaboration, Accountability, Respect, and Empathy. We have sought to approach all of our work together with these principles at the forefront.

We want to acknowledge and thank the many people who lent us their time and expertise over the past two years. The work of the HCCJ would not have been possible without all of our hospital, community, and law enforcement partners. Additionally, we would like to extend our gratitude to the following organizations and people who we consulted with us on this work: Neil Singh Bedi and the Stop Shackling Patients Coalition, Heather Warnken, Lydia Watts, Ji Seon Song, members of the US attorneys office in D.C., the D.C. Attorney General's Office, Volare, Civil Rights Corps, ACLU DC, Health Equity and Access for Law Enforcement Involved Patients (HEALIP), Project CHANGE, and many others. Thank you to our partners at CICS for drafting this toolkit, particularly Lucia Mock Muñoz de Luna, Cassandra Ramdath, and Tyler Bates. We are incredibly thankful for the support of the Office of Victims Services and Justice Grants (OVSJG) in D.C. for their support of this initiative over the past two years.

This toolkit and our work together are in the service of all victims and survivors of violence in the District and country, and all of the healthcare and public safety workers who dedicate themselves to helping people heal and rebuild their lives.

Peace,

The HCCJ Steering Committee

Why We Made This Toolkit

Hospitals, trauma bays, and emergency departments should be safe places for care and healing, but for too many victims of violence in Washington, D.C., and across the country, they are also spaces where privacy, dignity, and rights can be violated. In particular, when law enforcement is present in patient care spaces without clear boundaries, it can lead to:

- Breaches of patient confidentiality
- Delays or interference in medical care
- Fear or mistrust of the hospital, especially for overpoliced communities
- Civil and human rights violations

Since 2023, the HealthCARE Collaborative for Justice (HCCJ) has been meeting to identify relevant policy issues and problems of practice, and working collaboratively to develop the model policies, forms, and policy recommendations presented in this toolkit. This policy toolkit aims to provide model policies that hospitals and advocates can adapt to address the following issues that arise in the Emergency Department/Trauma Bay (ED)[1]:

- Law enforcement seizures of personal items (such as cellphones, wallets, and clothing)
- Law enforcement access to patient care areas, including the designation of private vs. public spaces within hospitals
- Familial access to loved ones, familial access to loved ones after they have died, and HIPAA protection(s)

Who Is This Toolkit For?

This toolkit is for those who want to develop and implement hospital policies that protect and uphold the humanity and legal rights of hospital patients, particularly victims of violent crime who interact with law enforcement officials (LEOs) in the Emergency Department, acute patient care areas, and trauma bays. The toolkit contains model policies and forms that can be adapted for use in hospital settings to address specific issues around patient property, law enforcement access to patient care areas, and familial rights. While the policies within were drafted to be directly applicable to D.C. area hospitals, they were written to be broad enough to be applicable (with adaptation) to hospitals around the United States. Specifically, this toolkit is designed by and for:

- Hospital staff and leadership, including nurses, doctors, and administrators
- Hospital Violence Intervention Program (HVIP) staff
- Community members
- Policy and legal partners working in health care spaces

In short, this toolkit is meant to serve as a resource for anyone who wants to make hospital policies work better for patients and caregivers—especially those who are victims of violence.

[1]Because our partner hospitals refer to acute patient care areas differently, we use the terms Emergency Department/Trauma Bay throughout the toolkit to encompass those differences, and use the abbreviation ED as a catchall term.

Who We Are

The toolkit was developed by the HealthCARE Collaborative for Justice (HCCJ), a coalition led by D.C. area medical and public safety professionals alongside community advocates, and convened by Georgetown Law's Center for Innovations in Community Safety (CICS). The HCCJ is funded by a grant from the Office of Victims Services and Justice Grants in D.C. Our membership includes representatives from:

- Children's National Hospital (Youth Violence Intervention Program)
- George Washington University Hospital
- Howard University Hospital
- MedSTAR Washington Hospital Center
- Metropolitan Police Department of Washington, D.C.
- Project CHANGE
- The D.C. community whose lives have been impacted by gun violence
- Community organizations including: Brave Behind the Bullet, the T.R.I.G.G.E.R. Project, and Guns Down Friday

The HCCJ met bimonthly over two years to identify relevant policy issues and concerns regarding law enforcement officials' activities in the hospital and collaborated to develop model policies and forms that address said issues.

Our Process: Participatory Policymaking

Our coalition was built on the understanding that when all partners are meaningfully engaged in decision-making, a sense of ownership and accountability emerges, strengthening trust and enhancing the effectiveness and legitimacy of policies. Furthermore, we believe that participatory policymaking can transform policy writing and implementation by empowering communities to shape the decisions that affect their lives. This process recognizes that the people most directly impacted by a policy are often best equipped to design practical, effective, and just solutions. Ideally, participatory policymaking addresses systemic inequities by breaking down barriers to political access and voice. Too often, underserved communities are excluded from traditional policymaking processes, perpetuating cycles of marginalization and disempowerment. By embracing participatory approaches, we sought to actively work to dismantle these barriers and ensure that these policies reflect the needs and priorities of those most affected.

This process required time and an intentional effort towards building trust and community. This approach to participatory policymaking focused on the following:

1. Sustaining Dialogue – Bimonthly meetings that first focused on building understanding and trust among all partners.
2. Mapping the Gaps & Priorities – Collectively identifying where current laws, law enforcement practices, and hospital policies leave patients vulnerable, and articulating policy priorities for all partners.

3. Drafting Together – Bringing initial drafts of each model policy to the coalition and workshopping through remaining issues and questions as a collective.
4. Responding to Partner Priorities – Building policies, as well as other products - e.g., forms - that the collective identified as most useful.

The theory of change behind the HCCJ's participatory policy creation process is that when policies, practices, and training(s) are informed by the collective wisdom and experiences of all applicable partners, we as a society can better protect victims' rights and improve both patient outcomes and investigative integrity. Concrete policy directives that guide interactions between law enforcement officials and medical staff are essential to protecting patient privacy, dignity, and rights.

Issue Areas

In this toolkit, you will find model policies and forms–alongside legal research and background–that address the following key issue areas that the HCCJ identified as most pressing in law enforcement interactions with victims of violence and hospital staff:

1. LAW ENFORCEMENT ACCESS TO ACUTE PATIENT CARE AREAS

The Issue

When hospitals and healthcare providers give law enforcement unrestricted access to the emergency department, patients' civil rights and privacy interests can be undermined. Whether the concern is about protected patient information being overheard by a third party, or police seizing property, a police presence can compromise patient and medical staff care and safety. Allowing police unrestricted access to clinical spaces can also jeopardize the trust that patients have in their clinical team.

HCCJ Policy Solution

Hospitals should have policies in place that designate the Emergency Department/Trauma Bay as a private space. This designation clarifies expectations, roles, and constitutional protections, and promotes orderly police access to the emergency department/trauma bay when appropriate. Policies create a shared understanding regarding access because if an area of a hospital is closed to the public, it is closed to the police as well, absent specific legal authority allowing police access in particular instances. Designating the Emergency Department/Trauma Bay thus ensures police can only enter with valid cause.

How to Use

Work with your hospital's legal and administrative teams to adopt this model policy. Post clear signage and train staff on what to do if police request access. If possible, communicate with law enforcement agencies to ensure they are aware of the policy. This model policy and related information can be found in Appendix I.

2. LAW ENFORCEMENT SEIZURE OF PATIENT PROPERTY

The Issue

In D.C., victims of violence often report that their personal property, like phones or identification, is seized by police without their knowledge or consent. Once property has been seized, victims are rarely, if ever, given guidance on how, or when, they can get their property back. This reality has made the healing and recovery process complicated, since it can prevent victims from reaching loved ones, accessing services, and rebuilding

stability. Without instruction on how to get their property back, victims lose out on essential items that are needed in day-to-day life.

Our Policy Solution

Require documentation and a clear process when law enforcement seize patient belongings.

How to Use

Implement a "Property Seizure Form" that law enforcement must complete any time patient property is seized and that contains clear information on the property retrieval process. Train staff on implementation and ensuring law enforcement complete the form. This model policy and related information can be found in Appendix II.

3. FAMILY NOTIFICATION AND ACCESS TO VICTIMS OF VIOLENCE

The Issue

Families of victims of violence have reported that law enforcement, at times, denies visitation and access to the victim under the premise that police are engaging in their investigative duties. This denial is not often supported by the law and can violate the moral and ethical obligations that 1) those who work in public safety owe to families and 2) medical professionals owe to their patients. Additionally, law enforcement has at times denied access to a loved one who has passed away, under the same premise.

HCCJ Policy Solution

Create a policy that provides the maximum familial access consistent with legitimate investigative and safety needs.

How to Use

Train security and medical teams/staff to make sure that they are aware of this hospital policy and can explain it to the police when needed. This model policy and related information can be found in Appendix III.

How to Use This Toolkit

FOR HOSPITAL STAFF

1. Convene a multidisciplinary group of key partners that are impacted and have expertise on this issue, including community members and HVIP staff.
   - Assign a facilitator for this group that can set meeting agendas, track progress, and facilitate difficult conversations.
   - The HCCJ chose to include law enforcement in our process because we felt it was critical to the success of both writing the policies and having them be implemented and followed by all parties. However, in bringing law enforcement and others to the table, we also spent a good deal of time building community norms and holding each other accountable to those norms so that all voices were heard and respected.
     - To build trust among all partners we spent the first two meetings outlining and agreeing on community standards that the group would abide by in conversations. These conversations

led to the creation of our four community norms: Compassion, Accountability, Respect, and Empathy.

2. Meet with this group of key partners on a bimonthly basis (or as you decide is appropriate) to identify which issues are most pressing to address, the questions that partners have, and proposed solutions.
3. Review a) current policies within your hospital setting b) local, state, and federal law, and c) your local police department's general orders to better understand if/what policies exist that address these issues, and if they are, whether they need to be changed or if they need to be implemented more consistently.
4. If policies need to be written or changed, determine who in your hospital makes decisions around policies and who you need to talk to (i.e., Who in your hospital typically writes these policies? What does the procedure for writing policies typically look like? What hurdles will you need to overcome?).
5. Review the HCCJ model policies and adapt them for your hospital.
6. Propose new or amended policies to relevant hospital leadership and partners.
7. Once approved, begin the implementation process for these adapted policies within your hospital.
8. Train your team, including security, front-line staff, and HVIP staff on new policies.
9. Share with community partners so they are aware of the policies and can effectively advocate for patients.
10. Evaluate how the policies work in practice, and update policies and practices as needed.

FOR COMMUNITY MEMBERS / ADVOCATES

Building Partnerships

1. Familiarize yourself with local law, police procedure, and hospital policies that are relevant to these issues.
2. Understand which issues in your community are most critical in addressing through hospital policy and/or city and state law.
3. Find out which organizations and programs are already working to support survivors of violence in hospital settings (e.g., Hospital-Based Violence Intervention Programs).
4. Create partnerships with key partners working on these issues and help push and adapt the model policies to fit your community's and hospital's needs.

Advocating with Hospital Leadership and Elected Officials

1. Present this toolkit and proposed policy changes to both hospital officials and local elected officials to advocate for hospital and city and/or state policy level change.
2. Encourage hospital leaders to adapt and adopt these policies through sustained dialogue.

Community Education and Advocacy

1. Adapt this toolkit for community education so that people are aware of their rights if and when they enter the hospital and interact with law enforcement.

> ***If you have any questions or would like to meet with us regarding this toolkit, contact Lucía Mock Muñoz de Luna at lucia.mock@georgetown.edu***

HCCJ Model Policy Toolkit

Appendices and Legal Background

Introduction to Appendices and Legal Background

Hospitals play a vital role in healthcare in the United States for a diverse range of circumstances and conditions. Hospitals provide essential life-saving medical care services, taking care of and treating some of society's most vulnerable and marginalized groups. On top of administering medical care to individual patients, emergency departments provide incomparable value to their communities by opening their doors to people who need care, as well as working in partnership with others to improve and sustain the health of all those in their communities.[2] For hospitals to administer the best care possible to their community, community members must trust their hospital. Individuals must believe that when they enter the hospital, their privacy, humanity, dignity, and legal rights will be respected and upheld.

At times, hospitals throughout the United States struggle to accomplish this goal. The issues and problems plaguing hospitals often mirror those happening on the street. Inequitable access to healthcare, overpolicing of and biases against Black, Hispanic, and Indigenous people and their communities have led to perceptions that some hospital spaces are unsafe.[3] This reality worsens and becomes more problematic within the emergency department/trauma bay (ED), as it holds a unique position at the intersection of health and society.[4] The ED is a frequent law enforcement official (LEO) entry point into healthcare institutions, treating many injuries and illnesses that attract responses from LEOs and the larger criminal legal system.[5] A research brief conducted by the University of Pennsylvania reported that: 1) within an urban ED an officer was present 31% of the time, 2) 1/3 of emergency medicine physicians in a national survey reported seeing at least one officer present in their ED daily, and 3) 8 in 10 trauma surgeons reported officers being present weekly, with 2 in 10 seeing them daily.[6] Unchecked LEO activity in the ED can jeopardize the sanctity of the patient-provider relationship and poses a risk to medical staff.[7] Researchers have consistently found that law enforcement investigations can disrupt medical care.[8] These examples, along with others, have raised the question of what rules apply when law enforcement and healthcare interact in the ED.

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[2] Rick Pollack, *Hospitals Work in Many Ways to Help Create Healthy Communities*, AHA (Aug. 1, 2022), https://www.aha.org/lettercomment/2022-08-01-hospitals-work-many-ways-help-create-healthy-communities.

[3] *Fact Sheet: The Sad Truth About Hospitals, Patient Safety and Racism*, Cent. for Just. & Democracy (July 23, 2021), https://centerjd.org/content/fact-sheet-sad-truth-about-hospitals-patient-safety-and-racism; William J. Hall et. al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, Nat'l Libr. of Med. (Dec. 2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4638275/; Lloy Wylie & Stephanie McConkey, *Insiders' Insight: Discrimination against Indigenous Peoples through the Eyes of Health Care Professionals*, Nat'l Libr. of Med. (May 7, 2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6347580/.

[4] Utsha G. Khatri et. al., *Emergency Physician Observations and Attitudes on Law Enforcement Activities in the Emergency Department*, Nat'l Libr. of Med (Feb. 20, 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10047729/.

[5] Emergency Physician Observations and Attitudes on Law Enforcement Activities in the Emergency Department, https://escholarship.org/uc/item/31w2k9mh

[6] Madison Weiss & Janet Weiner, *To Protect and Serve: Clarifying the Role of Law Enforcement in the Emergency Department*, Penn LDI 3 (July 2023), https://ldi.upenn.edu/wp-content/uploads/2023/07/Penn-LDI-Research-Brief-July-2023_2.pdf

[7] Sally Mahmoud-Werthmann, *Emergency Rooms Need Clear Guidelines About How to Handle Law Enforcement*, STATNEWS (Apr. 3, 2023), https://www.statnews.com/2023/04/03/emergency-rooms-guidelines-law-enforcement/.

[8] *Id*.

Law enforcement activity within hospitals is governed by the United States Constitution, State law, the Health Insurance Portability and Accountability Act (HIPAA), a jurisdiction's police policies, and hospital policies. Together, these give medical staff and patients certain legal rights and privileges when interacting with law enforcement officials. But as a practical matter, medical staff are rarely going to be equipped to understand the complex interactions of these sources of law and policy. Similarly, the LEOs in more than 16,000 local agencies across the country may not understand the boundaries of their authority within specific health care settings either.[9] This is where clear, thoughtful, patient-centered hospital policies and guidelines come into play. Well-designed policies can facilitate interactions between medical staff and LEOs while protecting a patient's rights, privacy, and dignity. Furthermore, ambiguity in the law means that hospital policies and guidelines are necessary to provide protection, clarity, and certainty to patients, staff, and LEOs alike.[10] For example, when an ED nurse at the University of Utah's hospital was arrested for refusing to provide a patient's blood sample results to law enforcement, the hospital issued a policy banning law enforcement activity in patient care areas of its medical center.[11] When hospitals have thoughtful policies and provider education regarding patient and medical staff interactions with LEOs, patient privacy, confidentiality, and autonomy are better protected. Yet most hospitals do not have any policies guiding police interactions,[12]and if there are policies, the policies either do not protect patients' rights to the extent they should, or medical staff are not aware of the policy's existence.[13] The following appendices contain model policies developed by the HealthCARE Collaborative for Justice, a coalition led by D.C. area medical and public safety professionals alongside community advocates, and convened by Georgetown Law's Center for Innovations in Community Safety. *These model policies are intended as guidelines and must be tailored to specific contexts and reviewed by legal professionals before implementation.*

[9] Madison Weiss & Janet Weiner, *To Protect and Serve: Clarifying the Role of Law Enforcement in the Emergency Department*, Penn LDI 3 (July 2023), https://ldi.upenn.edu/wp-content/uploads/2023/07/Penn-LDI-Research-Brief-July-2023_2.pdf

[10] Fred Barbash & Derek Hawkins, *Utah hospital to police: Stay away from our nurses*, Wash. Post (Sept. 5, 2017), https://www.washingtonpost.com/news/morning-mix/wp/2017/09/04/utah-hospital-bars-cops-from-contact-with-nurses-after-appalling-arrest/.

[11] Sara F. Jacoby et. al., *When Health Care and Law Enforcement Intersect in Trauma Care, What Rules Apply?*, Health Affairs (Oct. 1, 2018), https://www.healthaffairs.org/content/forefront/health-care-and-law-enforcement-intersect-trauma-care-rules-apply.

[12] Madison Weiss & Janet Weiner, *To Protect and Serve: Clarifying the Role of Law Enforcement in the Emergency Department*, Penn LDI 3 (July 2023), https://ldi.upenn.edu/wp-content/uploads/2023/07/Penn-LDI-Research-Brief-July-2023_2.pdf

[13] Madison Weiss & Janet Weiner, *To Protect and Serve: Clarifying the Role of Law Enforcement in the Emergency Department*, Penn LDI 3 (July 2023), https://ldi.upenn.edu/wp-content/uploads/2023/07/Penn-LDI-Research-Brief-July-2023_2.pdf

Appendix I: Law Enforcement Access to Acute Patient Care Areas and Mandatory Reporting

In this section, you will find:

1. Why this issue matters
2. Legal Background
3. Background Information on Model Policy and Form
4. Model Policy
5. Model Form

1. Why this issue matters

LEOs arrive at and enter the ED in various ways. They may enter by accompanying individuals who are incarcerated or under arrest and in need of medical care; health systems may call external law enforcement into the ED for security or mandatory reporting purposes; law enforcement officials may enter the ED as part of day-to-day professional practice, and more.[14] When unchecked and unregulated, the activity of law enforcement officials in the ED has been shown to jeopardize patient care and can potentially put medical staff in the middle of complex legal situations as well.[15]

Police may ask for statutorily protected information about patients, improperly document injuries via photography or video, or overhear conversations involving protected patient health information.[16] Medical staff have reported improper seizures of patient property by law enforcement. And the inherent power imbalances between law enforcement and patients and medical staff can make it difficult to know whether an officer is making a request or giving a lawful order. HCCJ members have reported that law enforcement presence in the ED interferes with the medical staff's ability to engage in clinical work in two ways: 1) the unwillingness of patients to communicate information necessary for medical staff to treat patients due to fear or an apprehension of law enforcement overhearing the conversation, and 2) law enforcement hindering medical staff ability to perform the necessary care to the patient by delaying/disrupting time-sensitive medical interventions, increasing patient anxiety/stress, or restricting medical staff's ability to apply treatment.

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[14] Madison Weiss & Janet Weiner, *To Protect and Serve: Clarifying the Role of Law Enforcement in the Emergency Department*, Penn LDI 3 (July 2023), https://ldi.upenn.edu/wp-content/uploads/2023/07/Penn-LDI-Research-Brief-July-2023_2.pdf; *see also* Working Group on Policing and Patient Rights, *Police in the Emergency Department: A Medical Provider Toolkit For Protecting Patient Privacy*, Georgetown Health Justice Alliance 6 (2021), https://www.law.georgetown.edu/health-justice-alliance/wp-content/uploads/sites/16/2021/05/Police-in-the-ED-Medical-Provider-Toolkit.pdf [hereinafter *Working Group*].

[15] Working Group, *supra* note 5; *see* Sara F. Jacoby et. al., *When Health Care and Law Enforcement Intersect in Trauma Care, What Rules Apply?*, Health Affairs (Oct. 1, 2018), https://www.healthaffairs.org/content/forefront/health-care-and-law-enforcement-intersect-trauma-care-rules-apply.

[16] Ji Seon Song, *Policing the Emergency Room*, 134 Harv. L. Rev. 2646, 2661.

To reduce the occurrence of these harms, hospitals should put policies on the books that dictate that the emergency department—and any other acute patient care area—is a private space. Designating the ED as a private space clarifies constitutional protections that police must adhere to in order to gain access when necessary to perform their investigative or public safety duties. To address these concerns, the HCCJ created a model policy addressing law enforcement access to the emergency department, with the goal being to provide guidelines for law enforcement access to the emergency department, creating a straightforward process of communication among all necessary parties.

2. Legal Background

Law enforcement officers do not have a legal right to unrestricted access in the emergency department.[17] An officer's presence in the hospital does not automatically grant them the authority to do whatever they want or be wherever they choose. Police do have access to areas of a hospital that are open to a member of the public.[18] But certain areas of the hospital–especially acute care areas–are not open to the public, and thus should only be accessed by law enforcement in certain limited circumstances. But the hospital must make clear that these areas are private. In hospitals or emergency departments where police officers have routine or largely unrestricted access, it is usually because that facility, either through policy or practice, does not restrict law enforcement access to patient care areas.[19] When hospitals and healthcare providers give law enforcement unrestricted access to the emergency department, patients' rights are undermined.

Patients in the hospital and the ED have expectations of privacy that are rooted in state and federal law. Federal privacy rules are governed by the Health Insurance Portability and Accountability Act (HIPAA), which establishes the confidentiality of protected health information (PHI).[20] Outside of state-mandated reporting laws, a judicial warrant, or a court order, patients have the right to withhold and keep their medical care information confidential from all third parties, including LEOs.[21] A patient's HIPAA protection is compromised when law enforcement is granted unrestricted access within the hospital setting. Officers can and do use passing comments made by medical providers as evidence in legal proceedings.[22] They can also overhear and record conversations involving sensitive or private information and photograph areas, persons, or property. Put simply, any and all information that is gathered by law enforcement within the ED can potentially implicate patients, visitors, hospital staff, or other parties, and absent a valid legal justification, permitting the gathering of this information may be a violation of a patient's civil rights.

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[17] Working Group, *supra* note 5, at 5.

[18] John C. Moskop et. al., From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part II: Challenges in the Emergency Department, 45 Annals of Emergency Med. 60, 60-67 (2005)

[19] Working Group, *supra* note 5, at 5.

[20] *The HIPAA Privacy Rule*, HHS (Sept. 27, 2024), https://www.hhs.gov/hipaa/for-professionals/privacy/index.html.

[21] *Summary of the HIPAA Privacy Rule*, HHS (Mar. 14, 2025), https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#what.

[22] Working Group, *supra* note 5, at 7.

3. Background Information on Model Policy and Form

The ***Law Enforcement Access to Acute Patient Care Areas*** model policy provides guidelines for law enforcement access to acute patient care areas in a hospital setting, establishing a straightforward and clear process of communication between hospital staff and law enforcement. This model policy was created as a tie-in to a hospital's mandatory reporting policies. The rationale behind this decision is that in the District, D.C. Code § 7-2601 requires that medical staff promptly notify law enforcement in writing about incidents arising out of or caused by firearms or dangerous weapons.[23] This process provides a natural opportunity to set clear expectations with law enforcement regarding further communications, including by designating a location for an LEO to wait. By tying access to acute patient care areas to mandatory reporting, hospitals can ensure that timely and accurate communication between medical staff and LEOs is facilitated. This allows law enforcement efficient and effective access to the information they need, while helping to ensure that medical staff is free from obstructions or disturbances caused by unnecessary LEO presence, creating a patient-first care environment.

The ***Hospital Mandatory Reporting Form*** establishes an official record of hospital mandatory reporting to law enforcement for Emergency Department patients with suspected violent injuries caused by firearms or dangerous weapons.

[23] D.C. Code § 7-2601 (2025)

4. Model Policy: Law Enforcement Access to Acute Patient Care Areas

Purpose:

This is a model policy that provides guidelines regarding law enforcement access to acute patient care areas in a hospital setting – such as trauma bays within an Emergency Department– to create a clear process of communication between hospital staff and law enforcement pertaining to the mandatory reporting processes for injuries by firearm or a dangerous weapon as defined by D.C. Code § 7-2601. Ultimately, this model policy serves as a guide for hospital systems seeking to implement policies that restrict law enforcement access to acute patient care areas while also providing recommendations on the mandatory reporting process.

Policy Statement:

Trust is a fundamental cornerstone for both hospital systems and law enforcement agencies. Trust plays a critical role in the effectiveness of hospital workers and law enforcement officers in performing their duties and serving their communities. It enables hospital staff to deliver high-quality care and facilitates law enforcement's ability to gather crucial investigative information. For healthcare providers, patient trust is essential for open communication, adherence to treatment plans, and positive health outcomes. For law enforcement, community trust is vital for effective policing, crime prevention, and public cooperation.

Law enforcement presence in acute patient care areas can potentially interfere with clinical work, particularly during critical phases when patients require immediate and focused medical attention. A delicate balance must be struck between legitimate law enforcement needs and maintaining an environment conducive to healing and patient privacy. Unchecked law enforcement activity and presence in acute patient care areas may compromise patient trust in the medical process, impede the patient-provider relationship, delay or disrupt time-sensitive medical interventions, risk patient physical and mental health, potentially result in bias and discrimination, and increase patient anxiety and stress levels. These factors can significantly impact the quality of care provided and patient outcomes.

This policy aims to address these challenges by providing guidelines that foster an environment maintaining the integrity of both hospital and law enforcement functions while prioritizing patient well-being and public safety.

Stakeholders:
The following stakeholders, where appropriate and applicable, play a role in the process of permitting law enforcement access to acute patient care areas and maintaining clear communication between law enforcement and hospital personnel when abiding by the mandatory reporting guidelines for victims of gun violence or individuals injured by a dangerous weapon: trauma surgeons, registered nurses, hospital safety personnel, hospital-based violence intervention programs staff, hospital administrative personnel, and law enforcement officers.

Application:
This policy applies to all patients receiving care in the Emergency Department who are not in police custody (do note that the mandatory reporting procedures apply to all individuals who enter the Emergency Department with injury due to a firearm or a dangerous weapon pursuant to D.C. Code § 7-2601). It covers individuals who have arrived at the hospital independently or via emergency medical services, including victims of crime and persons of interest in ongoing investigations who are not under arrest. The policy is in effect from the moment a patient enters the Emergency Department until discharge or admission to another unit, encompassing all treatment areas, waiting rooms, and associated corridors within the emergency department. It applies to all hospital staff, security personnel, and law enforcement officers who interact with or attempt to access patients in these areas. This policy does not apply to patients already in police custody upon arrival, those brought for medical clearance prior to booking, or in situations posing an immediate threat to safety. Law enforcement is permitted to maintain a line of vision on individuals who enter an Emergency Department in police custody. However, medical personnel are permitted to request that law enforcement move out of earshot so that medical professionals can discuss sensitive medical information with the patient and their surrogate(s).

Terms and Definitions:

A. Patient: A person under medical or psychiatric care.
B. Surrogate: One appointed to act in the place of another.
C. Medical Staff: Any person who works in, facilitates, and/or administers care to patients in the emergency department, including, but not limited to, registered nurses and trauma surgeons.
D. Emergency Department: An area of a hospital facility that provides unscheduled outpatient services to patients whose condition requires immediate care.
E. Trauma bay: A specific area within an Emergency Department that is designated for resuscitation of a major trauma patient.

F. Acute Patient Care Phase: A type of medical practice that provides short-term and highly intensive care for patients experiencing severe illness or injury.
G. Hospital Designated Point of Contact (HDPOC): A hospital staff member designated to liaise between the hospital care team and law enforcement officials to provide updates on the status, care, and location of the patient, as well as ensuring that the Hospital Mandatory Reporting Form has been filled out and delivered to law enforcement officials.
H. Informed consent: A person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives.

Procedure:

1. When a patient with a suspected firearm injury – or injury by a dangerous weapon – enters an emergency department's trauma bay area, they are immediately considered to be in the acute critical care phase. During this crucial period, medical staff rapidly assess the extent of injuries and the patient's overall condition. The medical team's primary focus is on providing life-saving interventions and stabilizing the patient. To ensure an unobstructed and optimal care environment, the following steps must be followed: (1) ensure that all patient property is secured either by the patient, their surrogate, or hospital security personnel pursuant to the Patient Property and Belongings Model Policy and (2) law enforcement officials will be respectfully escorted by hospital security personnel to a designated waiting area outside the Emergency Department trauma bay. This procedure allows medical professionals to work efficiently without potential distractions or interruptions, prioritizing the patient's immediate medical needs while ensuring that their bodily and property rights are upheld.

2. During the patient stabilization process, appropriate communication channels will be established between the hospital's designated point of contact (HDPOC) and law enforcement to address any necessary law enforcement concerns, in accordance with hospital policy and legal requirements. This communication channel should abide by the following two-step process. First, law enforcement can contact the HDPOC to receive the requisite information, allowing law enforcement to know how to administratively process the investigation. Here, the onus is on law enforcement to reach out to the HDPOC, and the HDPOC, in conjunction with the medical professionals immediately tending to the patient, has discretion in determining when it is appropriate to provide law enforcement with this information pursuant to the patient's status. The second step comes to

fruition when law enforcement expresses a desire to question the patient. Here, the HDPOC serves as the liaison between law enforcement and the patient in communicating law enforcement's request to question the patient. Unless the patient is placed under arrest, the patient does not have to speak with law enforcement, and it is essential that the HDPOC provide the patient with this information. Should the patient provide consent by affirmatively agreeing to speak with law enforcement, the HDPOC will escort the law enforcement officer(s) to the patient. Should the patient elect not to speak with law enforcement, the HDPOC will escort law enforcement out of the Emergency Department area of the hospital to wait for information related to the mandatory reporting process.

3. Once the patient's stabilization process and the acute phase of care are complete, the HDPOC will fill out the mandatory reporting form and provide it to law enforcement officials present at the hospital once all information required for the mandatory reporting form is available.

5. Hospital Mandatory Reporting Form

This form establishes an official record of hospital mandatory reporting to law enforcement for Emergency Department patients with suspected violent injuries caused by firearms or dangerous weapons. In accordance with D.C. Code § 7-2601 (2024), it streamlines the process for healthcare providers to fulfill their legal obligation of promptly notifying law enforcement in writing about such incidents, ensuring timely and accurate communication between medical facilities and authorities.

Patient Information: *(Given at time of arrival)*
1. Name:
2. Date of Birth:
3. Address:
4. Surrogate/Emergency Contact Information:

Patient Status:
_____ Stable _____ Critical _____ Deceased Notes:

Additional Information:

Provider Information:
Staff Name: Date: Time of Update: Signature _____

Law Enforcement Officer Information:
Name: Badge Number: Supervisor Contact Information: Agency: Signature: _____

Appendix II: Law Enforcement Seizure of Patient Property in the Hospital

In this section, you will find:

1. Why this issue matters
2. Legal Background
3. Background Information on Model Policy and Form
4. Model Policy
5. Model Form

1. Why this issue matters

Another significant issue that arises with LEO activity in the hospital is the seizure of patient belongings. When patients enter patient care areas, their property (e.g., phone, wallet, keys, identification) is usually on their person. When care is administered, the patient's property may be moved onto a side table, the floor, into a bag, or into a secure location within the hospital itself. This last option is the ideal, as it protects patients' property to the greatest extent possible. However, most hospitals across the country do not have a policy that protects patient property to that degree, if at all. This lack of policy puts patient property at risk, as LEOs are constitutionally permitted to seize property in areas where the officer is "lawfully present" and, therefore, can seize items that they otherwise would not be able to that are within their "plain view" without a warrant.[24] Once a piece of property has been seized by LEO, it may not be returned for months, or even years. The process for recovering seized property can be lengthy, complicated, and extremely difficult to navigate. Patients sometimes go weeks, months, or years without their phones, identification, and other essential items.[25] In some instances, patient property may be seized without documentation describing the seizure and the process for retrieving the property, leaving patients without the necessary information to initiate the recovery of their property. To address these concerns, the HCCJ created a model policy and form that protects patients' property to the greatest extent possible under the law. The goal of the model policy and form is to provide guidelines regarding law enforcement access to the property of patients receiving care in a hospital system.

2. Legal Background

The Fourth Amendment of the U.S. Constitution states that all persons have the right to be free from unreasonable search and seizure.[26] An officer with a valid court order or warrant may search or seize. Otherwise, patients have the right to withhold their consent to searches and seizures of their person or property. This constitutional protection can be undermined

[24] Plain View Doctrine, Legal Info. Institute, https://www.law.cornell.edu/wex/plain_view_doctrine_0 (last visited Sept. 2, 2025).
[25] Asinor vs. D.C., 111 F.4th 1249 (D.C. Cir. 2024)
[26] U.S. Const. Amend. IV.

due to police presence in the ED primarily in two ways: plain view and the third-party doctrine.

When police are legally within the ED, any objects that have an incriminating nature and that are within the officer's "plain view" can be seized. "Objects" can include but are not limited to clothes, personal identification, and phones. Hospitals that fail to safeguard patients' property by storing it in a secure, inaccessible location jeopardize patients' control over their belongings.

When police ask medical staff for patient property—and medical staff give the police the property —the hospital risks eroding patients' constitutional rights via the third-party doctrine. Some courts have applied this doctrine to remove the warrant requirement that officers need to obtain property belonging to a patient, as the property was given to the officer by a "third-party."[27] By turning patient property over to the police or conducting procedures at the request of police, hospitals risk facilitating this erosion of patients' constitutional rights.[28] Hospitals should be aware that the power imbalance between officers and medical staff, combined with a lack of legal education, could lead to medical staff unknowingly forfeiting patients' rights.

3. Background Information on Model Policy and Form

Much like the ***Law Enforcement Access to Acute Patient Care Areas*** model policy, the ***Patient Property in the Hospital*** model policy relies on the designation of certain patient care areas as private. LEO's should be prohibited from entering private areas unless they have an exigent circumstance, court order, warrant, or the patient's consent. This measure helps ensure that LEO presence within private spaces is justified by legitimate law enforcement need.

The ***Patient Property in the Hospital*** model policy also acts to protect patients' property regardless of whether there is a policy controlling LEO presence. This policy focuses on safeguarding patient property from the moment a patient is admitted into the hospital. The policy gives a conscious patient the autonomy to decide whether their property stays with them or is removed to a secure, inaccessible area. Additionally, if a patient is unconscious, hospital safety personnel immediately handle the property and transport it to a secure, inaccessible area. The property can then only be accessed if: 1) a patient gives consent for a LEO to seize the property, 2) a LEO has a constitutionally permissible justification warranting the release of the property from the secure area (i.e., a legal warrant, court order, exigent circumstances), or 3) a patient requests for the property to be returned to their individual possession. LEOs who inquire about patient property with medical staff are directed to the hospital's designated point of contact, who then handles the proceedings, removing the concern that trauma surgeons, nurses, or anyone else tasked with caring for the patient may potentially giving away patient property and possibly violating their patient's rights.

[27] Song, *supra* note 8, at 2679-80.

[28] Working Group, *supra* note 5, at 8.

This policy allows patients better control of their own property and helps minimize situations where patients or their families are unnecessarily deprived of patient property for lengthy periods of time. It promotes orderly and lawful seizures by LEOs, protects medical staff from implicating a patient's rights, and protects the patient in their time of need.

Coupled with the Model Policy is the ***Law Enforcement Patient Property Seizure Form***. HCCJ members reported that seized patient property was not being properly documented and stored by hospitals. This form addresses the issue of documentation by requiring that any property seized by LEOs be documented and kept within hospital records, thus providing patients with the necessary information to initiate the recovery of their property.

4. Model Policy: Patient Property in the Hospital

Purpose:
This model policy provides guidelines regarding law enforcement access to the property of patients receiving care in a hospital system.

Policy Statement:

Trust is a fundamental cornerstone for both healthcare systems and law enforcement agencies, enabling effective service delivery and community engagement. For healthcare providers, patient trust is essential for open communication, treatment adherence, and positive health outcomes. For law enforcement, community trust is vital for effective policing, crime prevention, and public cooperation.

When patients are unable to maintain control over their property in a hospital setting, the hospital assumes responsibility for the safekeeping of their belongings. Patients and their surrogates expect that property will be returned in the same condition, and the hospital is obligated to account for any items under its care. Hospitals should not consent to the seizure of patient property by law enforcement. The seizure of property by law enforcement during a patient's hospital stay can create a perceived or real breach of trust, potentially impairing patient care and hindering law enforcement's ability to gather necessary information.

This policy aims to address the complex interplay between patient rights, hospital responsibilities, and law enforcement needs, ensuring that all parties can fulfill their roles while maintaining the integrity of patient care and the justice system.

Stakeholders:
The following stakeholders, where appropriate and applicable, play a role in managing patient property and addressing potential law enforcement seizures: trauma surgeons, registered nurses, hospital safety personnel, hospital-based violence intervention programs staff, hospital administrative personnel, and law enforcement officers and detectives.

Application:
This policy applies to all patients receiving care in an Emergency Department and specifically concerns personal property that is not prohibited by existing hospital regulations. It encompasses items that patients bring with them or that are in their possession upon arrival, excluding contraband such as weapons, illegal substances, or other objects deemed hazardous to the safety of either the patient or staff. The policy

governs the handling, safekeeping, and potential law enforcement interaction with patient property throughout the duration of the patient's stay in the emergency department, from admission to discharge or transfer.

Terms and Definitions:

A. Patient: A person under medical or psychiatric care.
B. Surrogate: One appointed to act in the place of another.
C. Property: Any external item over which the rights of possession, use, and enjoyment are exercised. Some examples pertinent to this policy are cell phones, various forms of identification, and clothing.
D. Emergency Department: An area of a hospital facility that provides unscheduled outpatient services to patients whose condition requires immediate care.
E. Informed consent: A person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives.

Procedure:

1. Any items prohibited by hospital policy (like weapons) that are discovered during the evaluation of a patient shall be transferred to law enforcement.

2. When patients enter the emergency department, their personal property shall remain in the custody of the patient or their surrogates.

3. If, for any reason, the patient or their surrogate is unable to maintain custody of their personal property or provide consent for the transfer of property (such as incapacitation or critical health status), the property will be kept with hospital safety personnel until it can be stored.

4. Property stored by the hospital will be kept in a locked compartment in a secure area.

5. Hospital personnel are not permitted to comply with a law enforcement request to seize patient property, as they cannot consent to such seizure on behalf of the patient unless law enforcement presents a warrant for the property or if a warrant exception exists (most likely, if applicable, this will be exigent circumstances). If law enforcement does present a warrant or if there is an applicable warrant exception, the requisite patient property may be seized by law enforcement. Whenever possible, property seizures should be conducted by law enforcement–not by hospital staff. When law enforcement seizes patient property, hospital staff

must provide the Patient Property Seizure Form to law enforcement for completion. This form will document the items and reasons for the seizure and include contact information for retrieval. Hospital staff must also provide patients or their surrogate(s) with a copy of the Patient Property Seizure Form. Hospital staff should review the form with law enforcement to ensure that it is fully and correctly completed and should also request a copy of the warrant (if applicable) for record-keeping purposes.

6. Without a warrant or warrant exception, the only other avenue permitting the hospital to transfer patient property to law enforcement is if the patient provides consent for law enforcement to seize the property. If the patient provides consent, their property may be transferred to the custody of law enforcement. In this situation, the Patient Property Seizure Form must also be completed by law enforcement with a copy of the completed form provided to the patient or their surrogate.

5. Law Enforcement Patient Property Seizure Form

This form seeks to provide patients with information on their property that was seized by law enforcement. Hospital staff providing this form to law enforcement ***DOES NOT*** indicate that they are consenting to the seizure of, or access to, a patient's property.

INFORMATION - TO BE COMPLETED BY LAW ENFORCEMENT REPRESENTATIVE:

Representative
Name:_____

Agency: _____

Badge Number:_____

Assignment:_____

Contact: (Phone) _____ (Email) _____

CCN Number:_____

Name and Contact of Investigator/Detective:_____

Patrol District Phone Number:_____

For MPD property retrieval: inquiries about specific items of property can be made by contacting the investigator at the patrol district phone number above, the MPD Evidence Control Division at 202-727-3230, or by emailing ecb.adminbox@dc.gov.

The Evidence Control Division website with helpful information, links, and numbers is accessible via the QR code.

PROPERTY DESCRIPTION AND RETRIEVAL INFORMATION:

Date:_____ Time:_____

Describe all property seized in detail:

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY HOSPITAL:

A patient's property does not belong to [hospital name]. X Hospital cannot consent to the seizure of a patient's property. By providing this form to, or collecting it from, MPD, the hospital is not consenting to MPD's seizure of, or access to, a patient's property but is complying with law enforcement requests.

Patient Name:_____

Hospital Staff Witnessing Form Completion (Name, Title, and Department):

_____

Date:_____

Appendix III: Family Notification and Access for Victims of Violence

In this section, you will find:

1. Why this issue matters
2. Legal Background
3. Background Information on Model Policy
4. Model Policy

1. Why this issue matters

Picture this scene: You come home from work and receive a phone call from the hospital. The hospital says your adult child has been shot and is in the emergency department. You rush to the hospital to see your child, only to be denied by law enforcement because they say your child is a part of the "investigation." Your child passes away that night, without you by their side; without you even seeing them before they died.

This scenario is the reality for families of victims of violence in hospitals across the nation. At times, law enforcement denies a victim of violence's loved one from seeing them while the police are engaging in their investigative duties. This denial is not grounded in any law and violates the moral and ethical obligations that those who work in public safety owe to families. Additionally, law enforcement has also denied access to a loved one who has passed away for the same reasons.

When hospitals do not have a policy that provides guidelines regarding: 1) communication with the appropriate decision maker of the patient's clinical status, 2) access to victims who are patients in the hospital, and 3) access to the remains of loved ones, the victim and the family suffer. The investigative responsibilities of law enforcement need not supersede the standard of care that medical staff owe to their patient and the patients' families.

2. Legal Background

As of September 2026, CICS has not identified any legal authority permitting law enforcement to restrict visitation to patients who are ***NOT*** *in police custody*. Patients *in police custody* may have their visitation rights restricted by general police orders when police have legal authority to issue such orders. For example, in D.C. Metropolitan Police Department General Order 502.07 — Medical Treatment and Hospitalization of Prisoners — defines persons in custody as "prisoners."[29] "Prisoners" includes any person who has been arrested and is being held, transported, treated, booked, or otherwise detained pending arraignment, release,

[29] Gen. Order 502.07, Medical Treatment and Hospitalization of Prisoners, Metro. Police. Dep't (Apr. 1, 2014), https://go.mpdconline.com/GO/GO_502_07.pdf.

adjudication, transfer to another facility, or is otherwise being processed.[30] The general order asserts that while prisoners are in the hospital, LEOs (or "members" in D.C. general orders) shall not allow prisoners to have visitors without the approval of their watch commander.[31] We encourage you to review your jurisdiction's police general orders, as the regulations outlined may differ from those outlined in D.C.

Your jurisdiction's Office of the Chief Medical Examiner is tasked with the custody of bodies of individuals who have passed away in instances such as violent deaths (i.e., gunshot wounds). Violent deaths are not the only type of deaths that can fall under a Medical Examiner's purview, so in crafting your model policy, it is essential to review your jurisdiction's medical examiner responsibilities.[32] We have not identified legal support for the practice of restricting family members from seeing their loved one who has passed away in the hospital. In D.C., police general order 304-08 describes how LEOs should: 1) use caution to avoid destroying or diminishing the value of any evidence and 2) prevent "unauthorized persons" from affecting physical evidence by "restricting movement, location, and activity while maintaining safety at the scene."[33] "Unauthorized persons" is left undefined in the order, and in conversations with the Metropolitan Police Department and the Office of the Chief Medical Examiner, CICS has concluded that family members are not included under the definition of "unauthorized persons."

3. Background Information on Model Policy

The *Family Notification and Access Policy for Victims of Violence* model policy provides guidelines regarding: 1) communication with the appropriate medical decision maker of the patient's clinical status, including death, 2) access to victims who are patients in the hospital, and 3) access to the remains of loved ones. The model policy was created to balance the investigative responsibilities of police departments and certified medical examiners with the professional standard of care of medical staff, ensuring that ethical and moral obligations to families are met. The core provisions of the model policy make clear that hospital policies allow familial access, permit communication with family members, and stipulate that decedent hospital policies apply to victims of violence. In balancing medical examiner investigations and family members' desire to access their loved ones, the HCCJ advocated that at bare minimum, wherein if there is evidence of a crime, the person should be only partially zipped in a body bag so family members can at least see their loved one's face. This middle ground emerged after discussions with MPD and D.C. OCME. The HCCJ encourages hospitals and advocates to speak with their local police departments and medical examiners in the creation and implementation of policies to ensure family members can have closure in their time of need.

[30] Gen. Order 502.07(II)(7), https://go.mpdconline.com/GO/GO_502_07.pdf.
[31] Gen.Order 502.07(III)(E)(1), https://go.mpdconline.com/GO/GO_502_07.pdf.
[32] D.C. Code § 5-1405 (2025) (Exemplifying the type of deaths that D.C.'s Office of the Chief Medical Examiner investigates)
[33] Gen. Order 304-08(B)(1)(c-d), Crime Scene Response and Evidence Collection, Metro. Police. Dep't (Aug. 28, 2023), https://go.mpdconline.com/GO/GO_304_08.pdf. (B)(1)(c-d)

4. Model Policy:
Family Notification and Access Policy for Victims of Violence

Purpose:
This is a model policy that provides guidelines regarding 1) communication with the appropriate medical decision maker of the patient's clinical status, including death, 2) access to victims who are patients in the hospital, and 3) access to the remains of loved ones. This model policy addresses the gaps in current law and hospital policy by balancing the investigative responsibilities of police departments and certified medical examiners with the professional standard of care of medical staff, ensuring that ethical and moral obligations to families are met. This model policy has been designed to work in conjunction with any existing visitor policy that hospitals already have in place. Ultimately, this model policy serves as a guide for hospital systems seeking to implement policies that address law enforcement restrictions on hospitals' ability to notify next of kin and allow access to loved ones in any capacity.

Policy Statement:
Trust is a fundamental cornerstone for hospital systems and law enforcement agencies. Trust plays a critical role in the effectiveness of hospital workers and law enforcement officers in performing their duties and serving their communities. Trust enables hospital staff to deliver high-quality care and facilitates law enforcement's ability to gather crucial investigative information. For healthcare providers, patient trust is essential for open communication, adherence to treatment plans, and positive health outcomes. For law enforcement, trust is essential for effective policing, crime prevention, and public cooperation. For both healthcare providers and law enforcement, community trust is crucial in maximizing public safety.

Trust in both healthcare providers and law enforcement is eroded when, in a family's time of need, there is conflicting (or a lack of) law and/or hospital policy governing the rights that victims have in the hospital setting. The presence of law enforcement in the hospital interferes with familial notification and access to the victim. Law enforcement officers have a broad range of duties, including the responsibility to enforce laws, investigate crimes, apprehend, detain individuals suspected of criminal offenses, and serve their communities. These duties are prevalent in the hospital setting, particularly in acute patient care areas, when officers need to acquire information to conduct an investigation. But absent a specific constitutional provision or law, the need for law enforcement to conduct an investigation does not usurp 1) the duty that nurses have to provide top-

quality care to patients and 2) the humanitarian principles of family members knowing where their loved one is, their condition, and if applicable, having necessary time for closure.

A delicate balance must be struck between legitimate law enforcement needs and maintaining an environment conducive to healing and patient privacy. The medical standard of care maintains that families of victims of violence are entitled to know where their family member is, their status, and can access their loved one if desired. Absent a binding law, it is the duty of hospital staff to inform families of their loved one's status and facilitate the ability of family members to visit with their loved one in a way that does not compromise law enforcement investigation.

This policy addresses these challenges by providing guidelines that foster an environment that maintains the integrity of both hospital and law enforcement functions while prioritizing patient well-being and public safety.

Stakeholders:

The following stakeholders, where appropriate and applicable, play a role in the process of notifying next of kin, allowing access to victims in the hospital setting, and allowing access to the remains of a victim in the hospital setting: Medical Staff, Hospital Security Staff, Hospital-Based Violence Intervention Programs Staff, Hospital Administrative Personnel, Law Enforcement Officers, and the Office of the Certified Medical Examiner.

Terms and Definitions:

A. Patient: A person under medical or psychiatric care who, in this particular policy, has been a victim of a violent crime.
B. Medical Staff: Any person who works in, facilitates, and/or administers care to patients in the emergency department, including, but not limited to, registered nurses and trauma surgeons.
C. Emergency Department: An area of a hospital facility that provides unscheduled outpatient services to patients whose condition requires immediate care.
D. Law Enforcement Officer: An officer or member of the Metropolitan Police Department of the District of Columbia, or of any other police force operating in the District of Columbia; an investigative officer or agent of the United States; animal control officer employed by the District of Columbia employees of the Office of the Inspector General charged with conducting an investigation of an alleged felony and consistent with the authority granted under § 1-301.115a(f-1); or the Fire Marshal and any member of the Fire and Arson Investigation Unit of the Fire Prevention Bureau of the Fire Department of the District of Columbia, for the

purpose of enforcing arson and the fire safety laws of the District of Columbia, who is so designated in writing by the Fire Chief.

E. Office of the Chief Medical Examiner (OCME): Investigates all deaths that occur in the District of Columbia that occur as the result of violence (injury), as well as those that occur unexpectedly, without medical attention, in custody, or pose a threat to public safety.
F. Medical Decision Maker: An individual legally designated by the patient to make healthcare decisions on behalf of the patient.
G. Next of Kin: Next of kin is defined by existing hospital protocol.

Procedures:

This policy pertains to all patients receiving care who are not in law enforcement custody, including patients who are deceased and their remains. This includes victims of crime and persons of interest in ongoing investigations who are not under arrest. This policy does not apply to "prisoners" as defined in Metropolitan Police Department General Order 502.07, *Medical Treatment and Hospitalization of Prisoners,* or individuals in the custody of the U.S. Marshals Service.[34]

Communication with Appropriate Medical Decision Maker:

1. Per standard medical care, appropriate medical decision makers should be updated on all patient clinical status, including death. Law enforcement does not have the power to prohibit this. Providers may choose not to share some information when they decide that there is a legitimate threat or safety concern. This decision can be made in conjunction with local law enforcement, hospital public safety, hospital administration, and hospital counsel.
    a. If the patient does not have the capacity to assign an individual as an appropriate medical decision maker, hospitals should follow the next of kin procedural outline as defined in **Terms and Definitions** above.

Family Access Procedure:

1. Per hospital policy, family members have the right to visit or see their loved ones while they are in the hospital. Every hospital visitor policy applies to victims of

[34] Custody and Detention, U.S. Marshals Serv., https://www.usmarshals.gov/what-we-do/prisoners/operation/custody-detention (last visited Sept. 2, 2025).

violence who are not in custody. There is no Constitutional provision or law that allows law enforcement to prohibit this visitation.

Access to the Remains of Loved Ones Procedure:

1. Decedent hospital policies apply to victims of violence.
2. If there is evidence of a crime, the following procedure is followed:
    a. The remains of the body should be zipped in a body bag up to the chin.
    b. Law enforcement is allowed within the perimeter to keep the deceased in eyesight.
    c. Visitors should be coached not to disturb the remains.