Denver Police Department
Infectious Disease Control
Resource Manual

INFECTIOUS DISEASE CONTROL

DENVER POLICE DEPARTMENT

Speculative Implications of Infectious Diseases

STATEMENT OF INTENT:

Public Safety Personnel routinely come into contact with the public. At some point in time, they will predictably interact with a person who has an infectious disease. The focus of this communication is intended to make known to those professionals, the available information which will allow them to perform their duties with minimum risk to themselves and others. While AIDS is the central topic of communication, hepatitus, tuberculosis and other infectious diseases should be considered.

CONCEPT STATEMENT:

AIDS is a rapidly growing epidemic, however, prudent precautions can reduce the spread of the virus.

BEHAVIORAL OBJECTIVE:

In performance of their duties, public safety personnel should demonstrate an increased understanding of possible implications when they contact a person who has been infected with AIDS. Also, they should commence taking precautions to prevent the spread of infectious diseases in total.

FOOTNOTE:

Please be informed that the training and lesson plan outlines and other enclosures contained in this resource book require presentations by a trained instructor, so that accurate interpretations can be made.

TABLE OF CONTENTS

Denver Police Department
Infectious Disease Management

Chronicle of Program Development

February, 1987: District One Commander Aristedes Zavaras (Presently Chief of Police) directed Sgt. Wayne Dudley to research the subject of Aids and determine if it had an impact on police officers and the activities they undertake in the line of duty.

March, 1987: Sergeant Dudley contacted local and national resource persons and agencies and compiled an information pool of clinical data. Continuing, a job task analysis was completed and correspondence was forwarded to Captain Zavaras imparting suggestions for preliminary risk reduction methods and training.

April, 1987: Meetings with D/C Operations R. Phannenstiel (Presently retired Chief Of Police)resulted in approval to expand research and training and develop guidelines for the Denver Police Department.

May, 1987: Formation of a Coordinating Committee consisting of sixteen members from respective sections of the Denver Police Department and a representative from The Office of Citizen Response. Focus: Problem Solving.

Chronicle of Program Development (continued)

June, 1987: Objectives were determined and D/C Training Michael T. O'Neill advanced the program past the conceptual stage to Procurement of Supplies, Written Departmental Directives and Development of Training Programs.

July, 1987: Implementation of Training Program: Presented to staff from the Service Center, Garage and Custodial Sections. Focus: Imparting information regarding infectious diseases and Disinfection Methods and Procedures. Duration: 8 hr. Training Program.

Seminar presented to (40) Officers. Focus: Developing Trainers who would disseminate information regarding risk reduction measures to personnel throughout the Denver Police Dept.

August, 1987: Nine-8 hour Conferences attended by Command and Supervisory Personnel to discuss Infectious Disease Information, Departmental Policies and Legal Issues.

September-
October 1987: Retraining to clarify misinterpretations and provide updates. Continued research and development. First Aid Decontamination Room becomes operational.

SECTION ONE

TRAINING OUTLINES AND INSTRUCTIONAL MATERIALS

MICRO-ORGANISMS

OUTLINE	NOTES

BEHAVIORAL OBJECTIVE:

In the performance of their duties, public safety personnel should demonstrate an increased understanding of possible implications when contacting persons who have any infectious diseases. They should take precautions to prevent the spread of any infectious disease.

CONCEPT STATEMENT:

Prudent precautions can prevent the spread of infectious disease.

*** Center for Disease Control estimates that 80,000 people die per year from hand to mouth transmission of infection. An additional 20,000 people a year die in hospitals.

I. Types

- A. Virus
- B. Bacteria
- C. Spores

II. Methods of Transmission

- A. Direct personal contact
- B. Contact with contaminated objects and surfaces

III. Methods of Control

- A. Chemicals
  - 1. Considerations
    - a) shelf life
    - b) kill time
    - c) requirement of water catalyst
    - d) effects of hot and cold water mixtures

OUTLINE	NOTES

e) toxicity

1) ingestion

2) inhalation

3) skin absorption

2. EPA Categories

a) disinfectants-kill bacteria, not spores

b) sanitizers-kill 99.9% bacteria, out of 1 million treated, 1 thousand remain alive.

c) antiseptics-retard growth, may not kill all bacteria

d) virucides-kills virus and some spores

e) fungicides-(sterilant) kills all virus, bacteria, and spores

f) deodorizers-minimizes odor only.

3. types

a) alcohol-partially virucidal

b) chlorine-short shelf life, kills some spores

c) quatenary agents- neutralizes solution

B. Personal hygiene

1. home environment

a) remove uniform

b) remove shoes- carry meningitis , pidgeon dropping

c) vacuum carpeting

2. washing

a) fingernail polish

b) rings, watches

c) hair- pillows

II. Procedural Recommendations.

A. Officers should wear disposable rubber gloves to eliminate their exposure to blood and other body fluids. An adequate supply of rubber gloves will be made available by supervisory personnel.

B. When a subject is suspected of infectious disease, officers, at their discretion, may initiate use of an ambulance, detoxification van or scout car for transport to the proper facility. These individuals will be transported separately from other subjects.

C. Arrested persons shall be taken directly to Headquarters and placed in the designated holding area prior to processing.

D. Recommended disinfection procedures are as follows:

1. Affected areas shall be immediately designated by the posting of an "Infectious Disease Contamination" sign.

2. Protective rubber gloves will be worn during all phases of disinfection.

3. Spills of blood or other body fluids should be cleaned with soap and water and the contaminated cleaning item discarded in provided plastic bags.

4. The disinfection solution must be freshly prepared, utilizing a 1:10 concentration of sodium hypochlorite (household bleach) to water. (One part bleach to 10 parts water.)

5. The affected area shall be sprayed with the bleach solution and allowed to air dry.

E. Disinfection procedures shall be effected when a transport vehicle has been contaminated by blood or other body fluids.

F. Replacement of contaminated personal or departmentally issued property can be effected by adherence to Operations Manual Section 111.09(2).

G. Contaminated evidence shall be placed in labeled double plastic bags and delivered to the Property Section in accordance with Operations Manual Section 106.02(1)a.1.

H. Officers exposed to infectious disease contaminates in the line of duty shall notify their supervisor and the required forms outlined in Operations Manual Section 505.10 will be completed.

I. Officers will be evaluated clinically and serologically for evidence of infection as soon as possible after the exposure. This will be done through DGH or by referral to the officer's private physician.

"AIDS/Management and The Issues"

OUTLINE

Behavioral Objective:

Command and Supervisory Officers should demonstrate an increased awareness of AIDS and The Issues, and consequently forecast problems which may occur in the workplace.

Concept Statement:

The AIDS epidemic is of such magnitude and the dimensions of its effects so sobering, that it will require command and supervisory officers to make many difficult decisions.

Activities:

I. Presentation (45minutes)

A. Mayor's AIDS Task Force
   1. C.D.C. Guidelines Followed
   2. D.P.D.: "Special Circumstances"
      a. individual policy & procedure statements
   3. Discrimination Platform
      a. policy statement/RE: Supervisors

B. Legal Redress Resources
   1. Department of Health & Human Services
      a. Federal Rehabilitation Act
      b. Office For Civil Rights
   2. Lamda Legal Defense & Educational Fund
   3. National Gay Rights Advocates
   4. Gay & Lesbian Advocates & Defenders

C. Colorado Civil Rights Commission
   1. Advocates AIDS as a Handicap
      a. Nassau Cnty. v Arline (T.B. is a handicap therefore protected under Vocational Rehabilitation Act of 1973.

      b. Florida Department of Health Regulation: "PCP" & "KS" qualify as "physical impairments" therefore "AIDS" is a handicap.

   2. Federal Rehabilitation Act of 1973: cannot terminate or refuse to hire because person has a "medical condition", but may "restructure"

OUTLINE	NOTES

3. 14,000 AIDS patients have qualified for Social Security Disability Benefits as of August 1987. Maximum benefits are $769.00 a month.

4. Human Rights Act of 1977: "May not discriminate against handicap by termination of employment." "Protected Class"

5. $30 million Fund set up to pay for the purchase of AZT by The Public Health Service through Health Resources and Services Administration." (Signed by President Reagan July 11, 1987. Eligibility grant for states range from $30,000 to $8.5 million. (AZT per patient=9,000 to $12,000)

6. Illinois State Chamber of Commerce lobbying against routine testing of hospital inpatients because cost would range from $17-$43 million.

7. British United Provident Association(largest private medical insurance company) "We will not pay benefits to patients needing treatment for AIDS for anyone joining after July 1987.

8. Insurance companies advocating State Sponsered Catastrophic Illness Coverage for AIDS patients.

9.. Lincoln National Corporation reported 1 individual claim paid out on a death benefit for $1 million.

General Reassurance Company received 17 AIDS death claims totaling $3.6 million

10. "Open Enrollments"
"Uniform Individual Accident and Sickness Policy Provisions Law" (2yrs-misstatements incontestable)
"Model State Insurance Pool Bill" (mechanism used for setting rates)

11. Perceived Actions by Insurance Companies:
    1. Denial of Coverage
    2. Required Tests
    3. Increasing Insurance Rates

OUTLINE	NOTES

D. Duty To Warn:

Tarasoff v. Regents of The University of California

(Psychotherapist had a legal duty to exercise reasonable care to protect the "foreseeable victim" from that danger)

Mavroudis v. Superior Court-County of San Mateo

(A foreseeable victim need not be specifically named to be identifiable for the purpose of giving warning)

Hedlund v. Superior Court of Orange County

(Since attack on mother was "foreseeable" the psychologists could be found liable for their failure to warn)

Bellah v. Greenson

(Duty to warn is limited to situations where patient creates a danger of injury to another person. It does not apply where the risk is of self-inflicted harm or mere property damage)

E. Deadly Force:

"Certainty of Results"

"All other means of apprehension and control exhausted"

"Lesser degree of Force Inadequate"

"Justified in Acting on Appearances"

"Remedy for Public Safety Personnel" (Assault to a Police Officer)

OUTLINE	NOTES
F. Workplace Hazardous to Health and Safety American Federation of State, County and Municipal Employees Union and The State of Minnesota Department of Corrections Julie Bernales v. City & County of SanFrancisco Dept. of Public Health (The concern of the nurse was reasonable in view of the uncertainties expressed in the medical community) G. Section 1256: California Unemployment Insurance Code (Claimant had good cause to voluntarily leave his employment. Accordingly, the claimant was not disqualified from receiving unemployment benefits)	

Local resource persons who have made significant contributions to the Department's Infectious Disease Control Program are acknowledged with sincere appreciation. They are:

Dr. Douglas J. McCluskie
Environmental Health
Denver Department of Health and Hospitals

Peter Ralin, Director
AIDS Information Service
Denver Department of Health and Hospitals

Ellen Reath, Attorney
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City and County of Denver

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Denver Department of Health and Hospitals

Francis Jarasitis
(Contaminated Item Disposal)

Manny Chavez, Captain
Denver Fire Department

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Huntington Laboratories

Patti Wells, Deputy City Attorney
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****

Participating Infectious Disease Control Committee Members:

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Sgt. Raymond J. Libonati
Sgt. Mark R. Olin
Sgt. Michael J. Phelan
Det. John Schnittgrund
Det. Harry E. Straight
Tech. Norma K. Davidson
Tech. Bobbet L. Hines
Patwm. Donna M. Ryan

*Special Acknowledgement to Chief A.W. Zavaras, Former Chief R. Phannenstiel and D/C Training M.T. O'Neill for their far-sighted posture and commitment to the safety and welfare of the citizenry and officers of the City & County of Denver.

3705 E COLFAX #301
DENVER, COLORADO 80206
303/321-4657

****Police Officer Special: $30.00

PATIENT	AGE	SEX	REFERRED BY	PAGE
8024		F	DR. DENVER POLICE DEPT	1

PATIENT NAME :

DOE, JANE

PROCESSING DATE : 07/07/87 DATE OF SERVICE : 07/09/87

TEST	RESULTS Abnormal	RESULTS Normal	REFERENCE RANGE	UNITS	TIME DRAWN	SERV DATE	TECH INIT
HTLV III		NEGATIVE				07/07/87	

HTLV-III NEGATIVE SEE BELOW

\TIVE INTERPRETATION: FOLLOW UP TESTING MAY BE ADVISED IF CLINICAL FINDINGS ARE DISCORDANT WITH RESULT. VIREMIA WITHOUT DETECTABLE ANTIBODIES IS POSSIBLE. TESTS MAY NOT DETECT ANTIBODIES IN RECENTLY INFECTED PERSONS OR PATIENTS IN LATE STAGES OF AIDS.

POSITIVE INTERPRETATION: POSITIVE RESULTS ARE NOT DIAGNOSTIC OF AIDS (ONLY OF POSSIBLE EXPOSURE) AND MAY NOT MEAN PERSON IS INFECTED; HOWEVER, ASSOCIATION IS HIGH BETWEEN STRONG SEROPOSITIVITY AND ABILITY TO ISOLATE VIRUS.

FALSE POSITIVES: OCCUR AT LOW FREQUENCIES. WITH LOW INFECTION RISK. FALSE POSITIVE PROBABILITY HIGHER--REPEAT TESTING AND/OR CONFIRMATION SUGGESTED. IF HIGH INFECTION RISK, THEN PREDICTIVE VALUE OF POSITIVE IS HIGH. ASSAY SENSITIVITY = NEARLY 100 %; SPECIFICITY = 99.8 %.

PHYSICIAN OR TRAINED PERSONNEL SHOULD COUNSEL THE PATIENT AS TO SIGNIFICANCE OF A FINAL RESULT. PATIENT IDENTITY AND RESULTS SHOULD BE TREATED WITH STRICT CONFIDENTIALITY. CEA LAB IS NOT LIABLE FOR CONFIDENTIALITY IF SPECIMEN IS GIVEN WITH PATIENT NAME INSTEAD OF CODED NAME DESIGNATION. HTLV-III'S THAT ARE ORDERED ALONG WITH WESTERN BLOTS ARE PERFORMED BY THE PUBLIC HEALTH DEPT OF COLORADO.

*** FINAL REPORT *** FINAL REPORT *** FINAL REPORT ***

TRAINING OUTLINE

I. Roll Call Presentation

A. "A.I.D.S. and Your Job" - video tape developed for public safety personnel. U.S. Public Health Service.

B. Presentation and Discussion of the Speculative Implications of Infectious Diseases/A.I.D.S.

1. Development of Virus.

a) Africa - green rhesus monkey.

b) Haiti - French educators/Cuban Soldiers.

c) New York City/Immigrants/Travel bans lifted.

2. Definitions/Stages of Development.

a) Bloodborne:

Term applied to a virus which is transmitted and sustained by blood and living tissue.

b) H.I.V. Positive:

A.I.D.S. virus has entered and contaminated the blood. Lifelong infection.

c) A.R.C. (A.I.D.S. Related Complex):

The term given to the symptoms exhibited by an infected person, indicating a more advanced stage of HIV infection. This is a precursor to AIDS.

d) ELISA:

A test to determine the presence of antibodies to HIV in the blood (HTLV-III).

e) Western Blot:

A test used to eliminate false positive readings or confirm true positive readings from ELISA test. Eliminates doubt.

3. Identification of High Risk groups:

a) Homosexual males.

b) I.V. drug users.

c) Hemophiliacs.

d) Asiatics (Hepatitis B).

4. Signs/Symptoms.

   a) Severe "flu-like" symptoms.

   b) Profound fatigue accompanied by light headedness and/or headache.

   c) Marked, rapid weight loss - 10 pounds in 2 months.

   d) Lymph node enlargement for 3 months in two different locations.

   e) Skin rashes/lumps.

   f) Unexplained bruising - ankle, leg, mouth, nose, anus, eyelids.

   g) Persistent, dry, heavy cough with shortness of breath.

   h) Sore throat - "thrush".

   i) Neurological disorders (Dementia - memory loss).

5. Considerations.

   a) Open sores/lacerations.

      (1) Protective coverings.

   b) Handling and arrest of A.I.D.S. subjects.

      (1) Statistical identification.

      (2) Rubber gloves.

      (3) Posture/Frisk and Search.

   c) Potential Exposures.

      (1) Subject.

         (a) Biting.

         (b) Scratching.

         (c) Urinating.

         (d) Spitting.

      (2) Officer.

         (a) Evidence gathering.

         (b) Fingernail biting.

(c) Equipment

i) Flashlight.

ii) Baton.

iii) Handcuffs.

iv) Pen.

d) Transport of infected subjects.

(1) Scout Car.

(2) Ambulance.

(3) Detox Van.

(4) Police Car.

e) Confinement of infected subjects.

(1) Separation from others.

(2) Location easily disinfected.

f) Emergency lifesaving responses.

(1) Bleeding.

(2) Cardio/Respiratory arrest.

g) Eating establishments.

(1) Officer anxiety.

h) Workplace and the H.I.V. positive employee.

(1) Fear, suspicion, confidentiality.

(2) Injuries to co-worker.

(3) Public response.

(4) Inter-agency cooperative efforts.

(5) Duty status.

i) Testing.

(1) Advantages.

(a) Physician/Treatments.

(b) Dentist.

(c) Sex partner.

(2) Disadvantages.

(a) Anxiety.

(b) Insurance.

(c) Credit.

6. "A.I.D.S. Facts and Unknown Quantities" handout.

ABBREVIATED SUGGESTIONS FOR

IMPROVING INSTRUCTIONAL TECHNIQUES:

"INFECTIOUS DISEASE MANAGEMENT"

Enclosures:

1. Preparing Yourself.
2. Why Are You Sharing This Information?
3. Giving the Presentation.
4. Instruction Strategies and Techniques.

PREPARING YOURSELF:

1. Read completely through your material.
2. Break it down into three (3) parts:
   a. Why this is important!
      i.e.: - Up to 3 million people may be HIV Positive
            - You can keep from being one of the walking dead.
   b. Origin and Progression
      i.e.: - Began in Africa and progressed initially by I.V. Drug Users and Homosexual males, etc.
   c. Precautions and Procedures
      i.e.: - What are the things we can do to prevent becoming HIV Positive?
3. Learn each part before going to the next. Learn Part One before you go to Part 2, etc.
4. Practice the entire presentation by putting all of the parts together.

WHY ARE YOU SHARING THIS INFORMATION?

1. Give officers the facts and clarify the "unknowns".
2. Help officers set their mental channels so that they can deal with the problems that occur.
3. Cause offices to adjust their behaviors and create a safer working environment.

GIVING THE PRESENTATION:

I. Give an Overview:

1. How AIDS affects us as officers.
2. What can happen if we do not adopt procedures and precautions.
3. How we can cope with the problems that AIDS causes.

4. What problems will the solutions cause?

   a. Interaction between line and staff personnel.

   b. I.I.I.B. complaints.

II. Presenting the Information:

1. Follow the lesson plan.

III. Reteach Parts if Some Are Confused.

IV. Feedback:

1. "I'll be available if you want to talk "private"."

V. Closing Remarks:

1. The information you have, plus the supplies you use, and the precautions you take will keep yourself and others from becoming negatively affected by AIDS or the controversial problems it creates.

INSTRUCTION STRATEGIES AND TECHNIQUES:

1. Time:

   a. After 30 minutes, you have saved all the sinners you are going to save!

2. Humor:

   a. Do not start with it. (Listeners adjusting to your voice and style.)

3. Visuals:

   a. One picture is worth a thousand words.

   b. Do not talk to the chalkboard, flip chart, etc.

   c. Display at proper level (seating arrangements).

4. Delivery:

   a. Do not read your presentation.

   b. Do not hold items in your hand.

c. Begin your first ten seconds with the person in the back.

d. Talk loudly.

e. Hold eye contact with one person at a time until the end of your sentence or theme.

f. Do not be afraid to pause.

g. Beverage approach (hot or cold).

h. Participants names/corners.

i. Chaining.

5. Posture:

a. Do not make love to the podium. Walk 1' - 2' in each direction away from the podium.

6. Questions:

a. Do not be afraid to admit if a question is outside your expertise.

7. Gimmicks:

a. Inspect hands.

b. Disinfect desk.

c. Visual (blank).

d. Participants write down questions **"before"** presentation.

HIV

SELF-AUDIT

RISK ASSESSMENT

Points

In the past 10 years I have had:

___ (1) One sex partner.

___ (2) Two to four partners.

___ (3) Five to nine partners.

___ (6) Ten or more partners.

Most of my sexual contacts during the past three years were:

___ (1) A steady relationship which I believe is monogamous.

___ (2) I have been monogamous, but my partner may have not been.

___ (5) Multiple relationships with persons fairly well known to me.

___ (10) Multiple relationships with persons I don't know well.

My sexual activities during the past three years include: (check all that may apply)

___ (4) Unprotected (no condom) vaginal or anal sex with a partner whose AIDS risk I know nothing of.

___ (3) Vaginal or anal intercourse using condoms.

___ (2) Unprotected vaginal or anal sex with a long term monogamous partner.

___ (1) Oral sex.

During the past three years:

___ (25) My partner has an AIDS risk.

___ (20) I suspect my partner has an AIDS risk, but we haven't discussed it.

___ (4) My partner has no evident risks, but I haven't looked into the past.

___ (1) I have discussed AIDS with my current and past partners and am not aware of any risks.

Drug Use:

____ (25) I have injected drugs in the past 5 years.

____ (20) I gave up injecting drugs ten years ago.

____ (6) My use of alcohol or non-injected drugs has led me to sexual contacts.

My current attitude towards AIDS is:

____ (4) I don't think I could get it.

____ (3) Anyone can get it from sex or injected drugs, but I'm not concerned.

____ (2) I have a fear of AIDS and don't discuss it with anyone.

____ (1) I am learning about risk behaviors and discuss the subject openly.

Most of my sexual encounters during the past five years were with persons from areas of:

____ (3) New York, Northern New Jersey, Wilmington, Baltimore, Washington, D.C., Chicago, Las Vegas, San Francisco, Los Angeles, Houston-Dallas, Southern Florida, Puerto Rico.

____ (2) Other large urban areas (Atlanta, Boston, Denver, Seattle, Philadelphia, etc.)

____ (1) Small towns, rural areas, central farm states.

My Race or Ethnic Group is:

____ (3) Black or Hispanic.

____ (2) White.

____ (1) Oriental or other.

My age is:

____ (2) Under 35.

____ (1) 35 or older.

During the last ten years:

____ (2) I have had blood transfusions.

During the last ten years:

____ (1) I have had blood splattered on an open sore or wound or into a mucous membrane.

____ TOTAL POINTS

KEY:

35 or more	=	High Risk (obtain HIV Test)
28 to 34	=	Medium Risk (obtain HIV Test)
24 to 27	=	Moderate Risk (consider changing your sexual behaviors)
23 or less	=	Low Risk (keep informed of AIDS risk behaviors and minimize your risks)

(This assessment is partly based on a system used by the American College Health Association.)

TRUE	FALSE		
____	____	1.	The Aids Virus is a non-aggressive, frail virus.
____	____	2.	A person who has the virus, but is not manifesting any symptoms, is infectious.
____	____	3.	Condoms, when used in sexual intercourse, provide adequate protection against AIDS.
____	____	4.	AIDS cannot be transmitted through kissing.
____	____	5.	The AIDS virus on inanimate surfaces can be successfully neutralized through the use of disinfectants.
____	____	6.	The AIDS virus can be isolated in a blood sample.
____	____	7.	Demented behavior, and seizures with no other symptoms of AIDS can be an indicator that the person has the AIDS virus in his/her system.
____	____	8.	The medication AZT, when taken every 4 to 6 hours, successfully controls the virus.
____	____	9.	It is virtually impossible for a female in a heterosexual relationship with an infected male to contract AIDS.
____	____	10.	It is possible to be infected with the virus for long periods of time without advancing to the ARC or end stages of AIDS.
____	____	11.	All donated blood is tested for AIDS, and if the virus is not discovered in the blood, it is impossible to contract AIDS from that donated blood.
____	____	12.	If your blood test shows no signs of AIDS, you need not worry any further about having AIDS.
____	____	13.	Oral-genital or oral-anal sex is "safe" sex.
____	____	14.	Urine and saliva are not transmitters of AIDS.
____	____	15.	The mortality rate from AIDS seems to be leveling off, therefore it can be said that the number of AIDS cases is dropping.

DENVER POLICE TRAINING ACADEMY

INSTRUCTOR EVALUATION

Date: _____

Instructor: _____ Subject: _____

Rating Scale: 5 - Outstanding

4 - Good

3 - Average

2 - Inadequate

1 - Poor

ASPECTS OF INSTRUCTION	RATING	COMMENTS
- Introduction to Subject :	_____	_____
- Organization & Presentation of Material :	_____	_____
- Knowledge of Subject :	_____	_____
- Enthusiastic Interest in Material :	_____	_____
- Encourage Questions and Discussion :	_____	_____
- Use of Training Aids :	_____	_____
- Review & Emphasis on Key Points :	_____	_____
- Relationship with Students :	_____	_____
OVERALL PRESENTATION :	_____	_____

Further Comments _____

(Rev. 03-18-87/mll)

INFECTIOUS DISEASE MANAGEMENT

FOR

PUBLIC SAFETY PERSONNEL

KNOWLEDGE and COMMUNICATION

THE MOST EFFECTIVE DEFENSE

"I'd like you to meet Dr. Modell, who's sending messages into space;
Dr. Kimbell, who's talking to dolphins;
and Dr. Klien, my husband, who's trying to communicate with me."

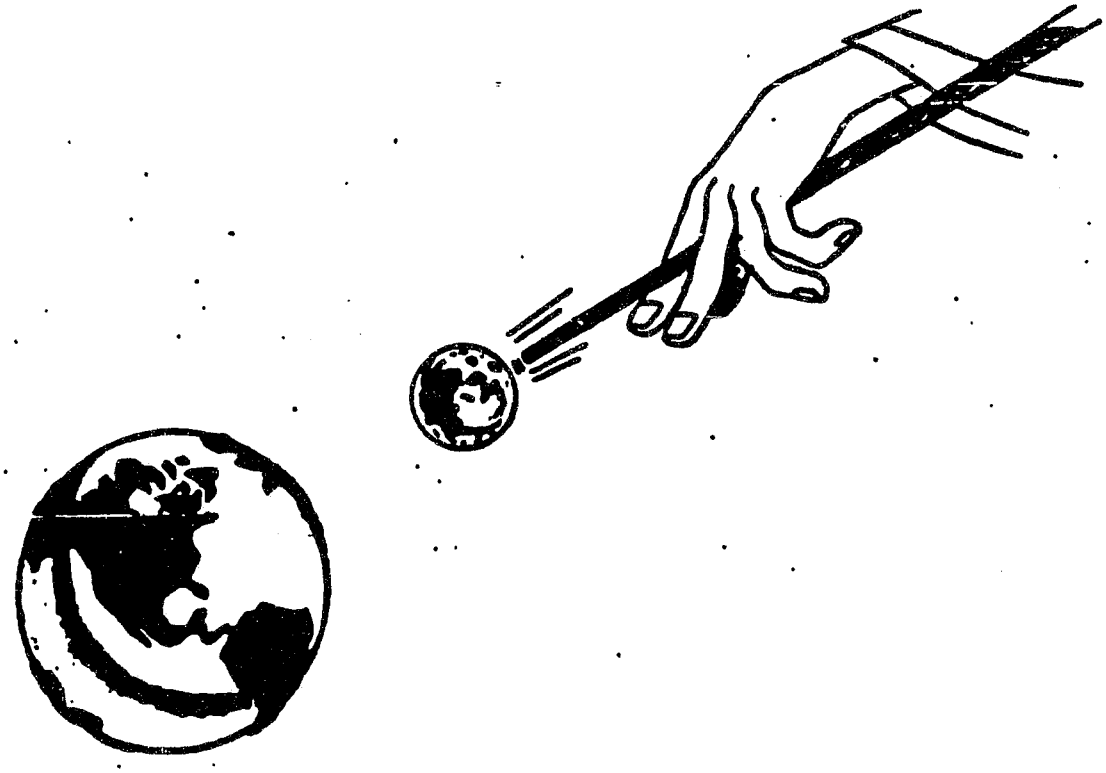
THE SPREAD OF A.I.D.S. :

AFRICA : GREEN SPIDER MONKEY

HAITI &ZAIRE: CULTURAL EXCHANGE

CUBANS / ANGOLA

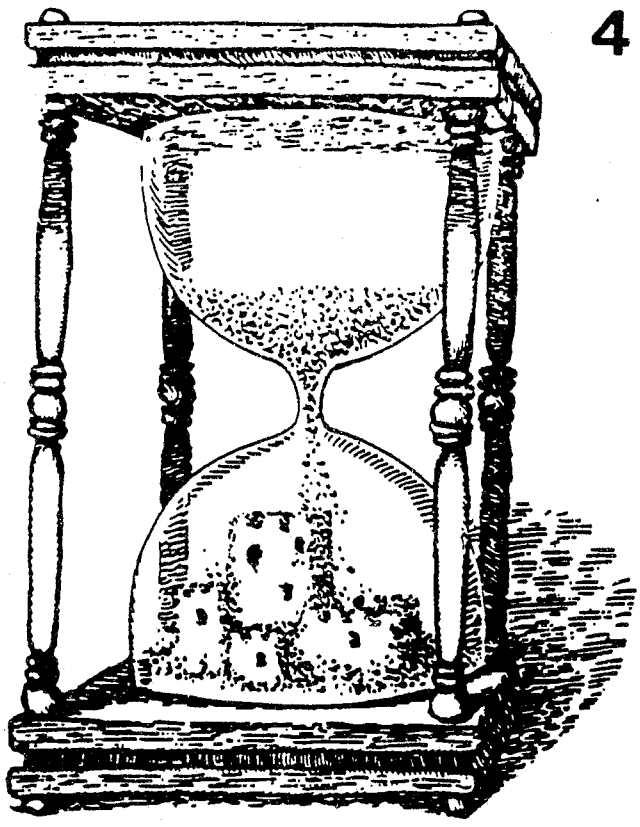
NEW YORK-MIAMI



In a time of drastic change, it is the learners who inherit the future. The learned usually find themselves equipped to live in a world that no longer exists.

UNREASONABLE FEAR CAN BE AS CRIPPLING AS THE DISEASE ITSELF

THE DIAGNOSTIC WINDOW OF A.I.D.S.:



4WEEKS ? 8MONTHS ?

ELISA ?

WESTERN BLOT ?

"Well, I'd like still another opinion, Doctor."

STAGES OF DEVELOPMENT :

HIV Infection through sexual contact, exposure to: blood, secretions or contaminated needles . . .

Immune system affected

HIV Positive

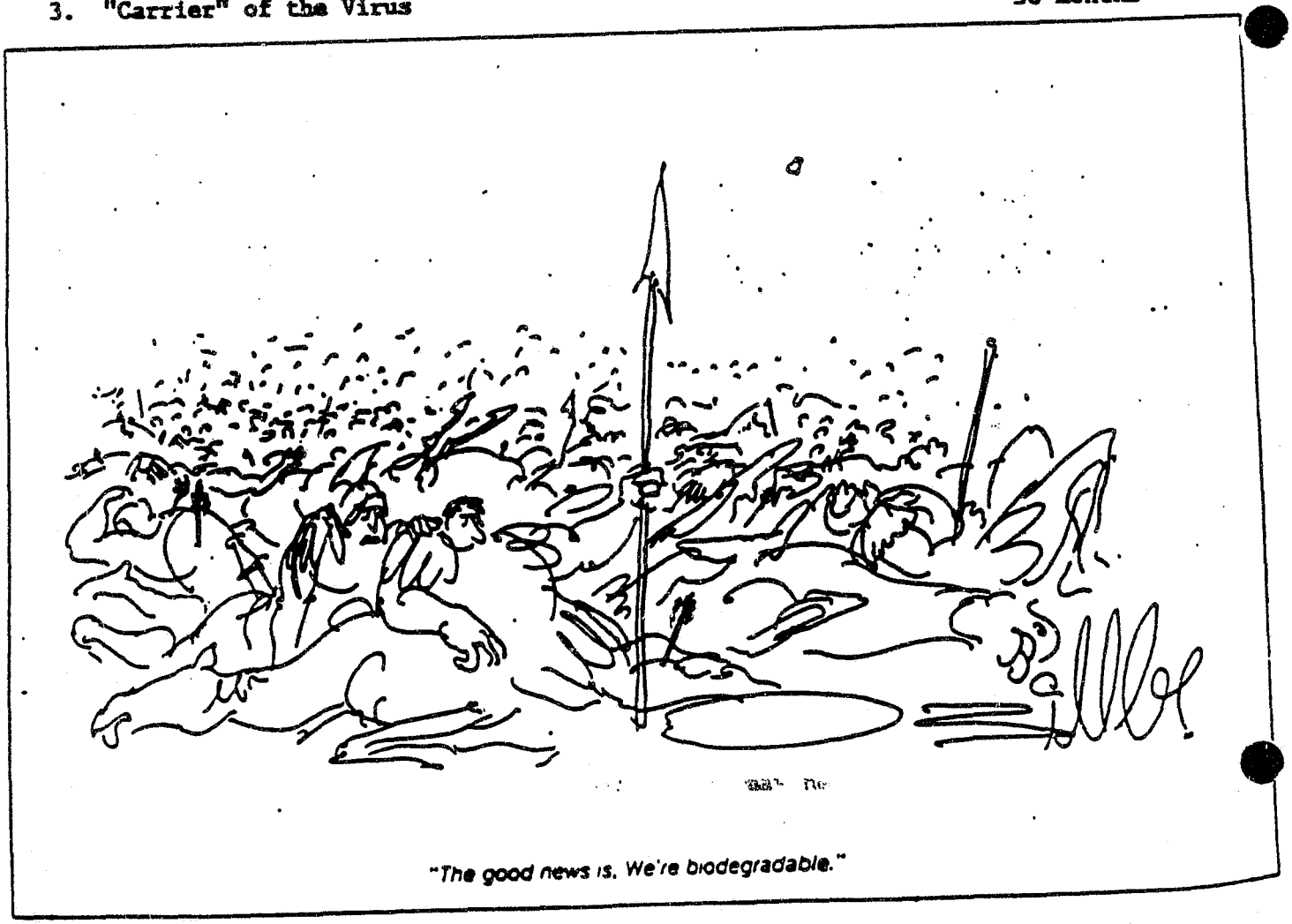
1. No Symptoms
2. No Disease
3. "Carrier" of the Virus

AIDS-Related Complex (ARC)

1. Symptoms
2. Can be Fatal

Acquired Immune Deficiency Syndrome (AIDS)

1. Infections
2. Fatal within 36 months



"The good news is, We're biodegradable."

SIGNS & SYMPTOMS :

a) Severe "flu-like" symptoms.

b) Profound fatigue accompanied by light headedness and/or headache.

c) Marked, rapid weight loss - 10 pounds in 2 months.

d) Lymph node enlargement for 3 months in two different locations.

e) Skin rashes/lumps.

f) Unexplained bruising - ankle, leg, mouth, nose, anus, eyelids.

g) Persistent, dry, heavy cough with shortness of breath.

h) Sore throat - "thrush".

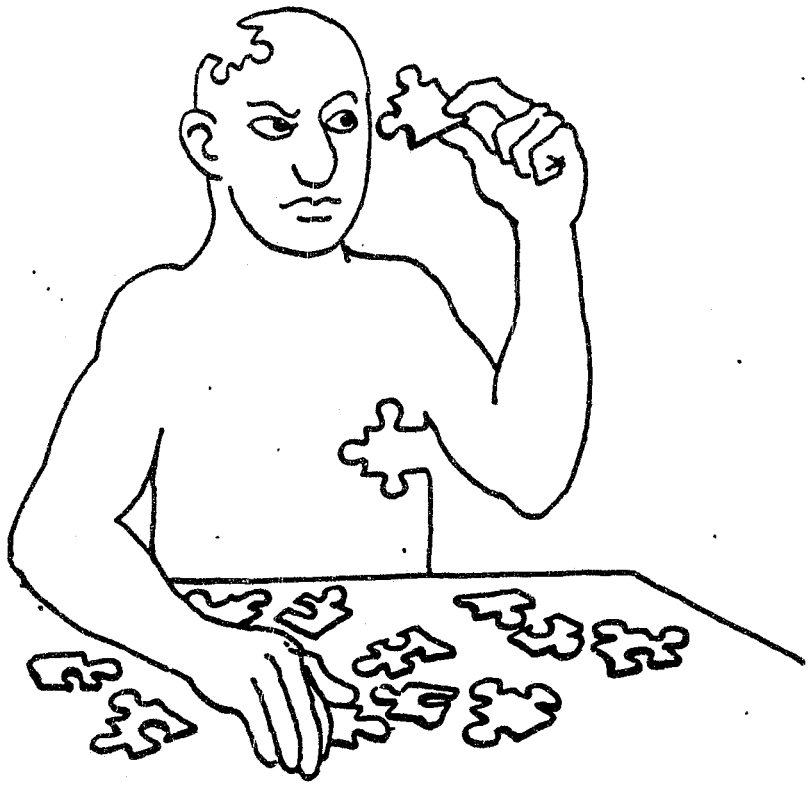
i) Neurological disorders (Dementia - memory loss).

CALLS FOR SERVICE

and increased frequency of

NEUROLOGICAL DISORDERS

DEMENTIA



Two things worry most people these days: one, that things may never get back to normal; and the other, that they have already.

POLICIES WHICH BENEFIT THE

HEALTH &WELFARE OF ALL CITIZENS :

Transport of contaminated subjects.

(1) Scout Car.

(2) Ambulance.

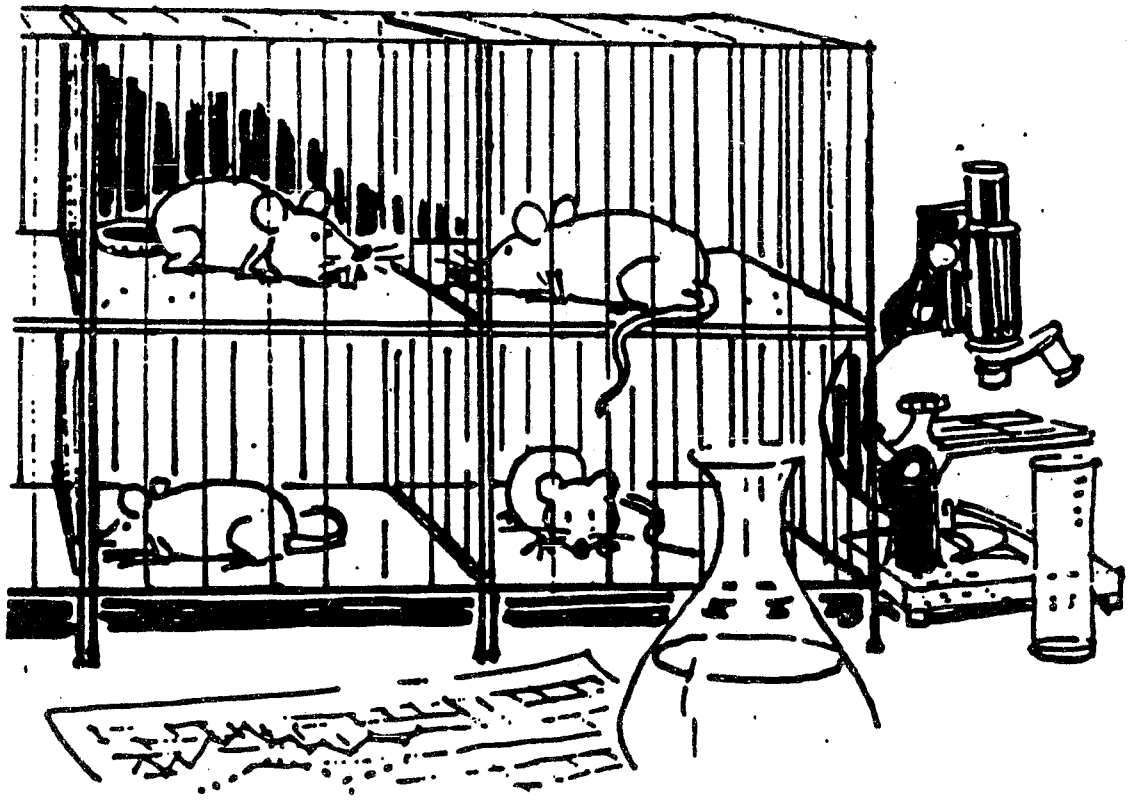
(3) Detox Van.

(4) Police Car.

Confinement of contaminated subjects.

(1) Separation from others.

(2) Location easily disinfected.

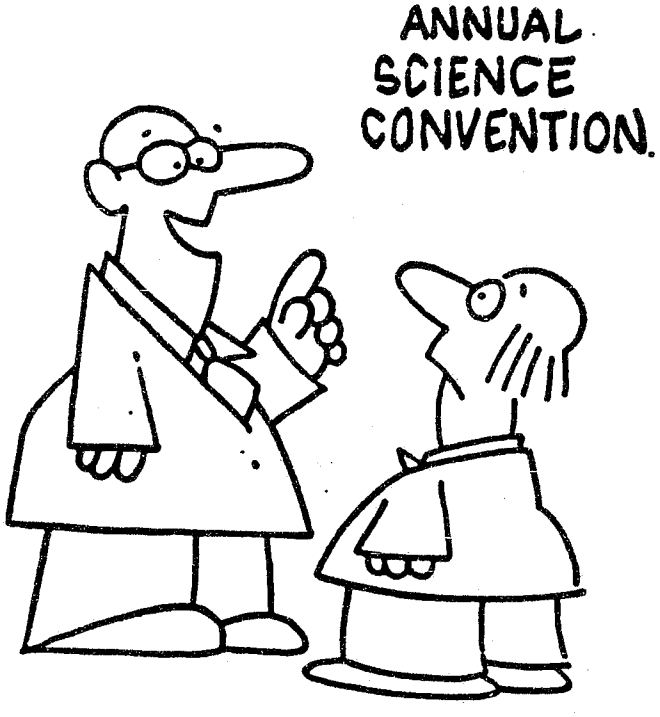


"Me, too. There must be something going around."

EATING ESTABLISHMENTS

&

OFFICER ANXIETY



"It's a fact that people will eat hotdogs no matter what you put in them. Which brings me to my idea for disposing of nuclear waste...."

USING PROPER PROCEDURES

OFFICER PRECAUTIONS :

1. Covering open cuts or sores. (Rubber gloves)
2. Verbally negotiated arrests. (Resistances)
3. Frisk and Searching with caution. (Needlesticks)
4. Evidence gathering. (Body fluid contamination)

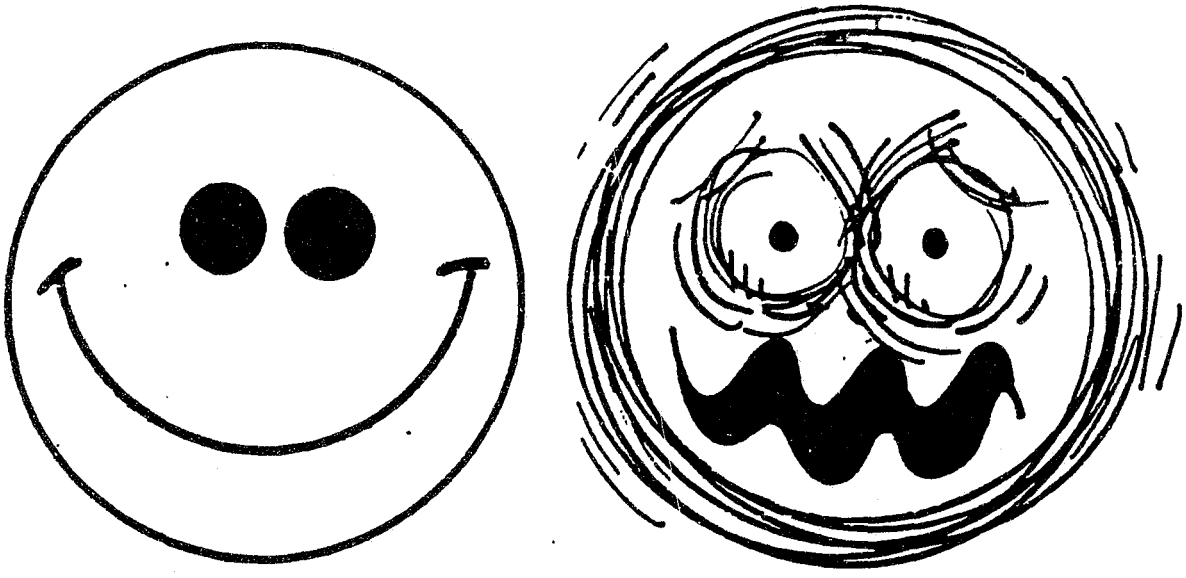
INTER-AGENCY COOPERATION

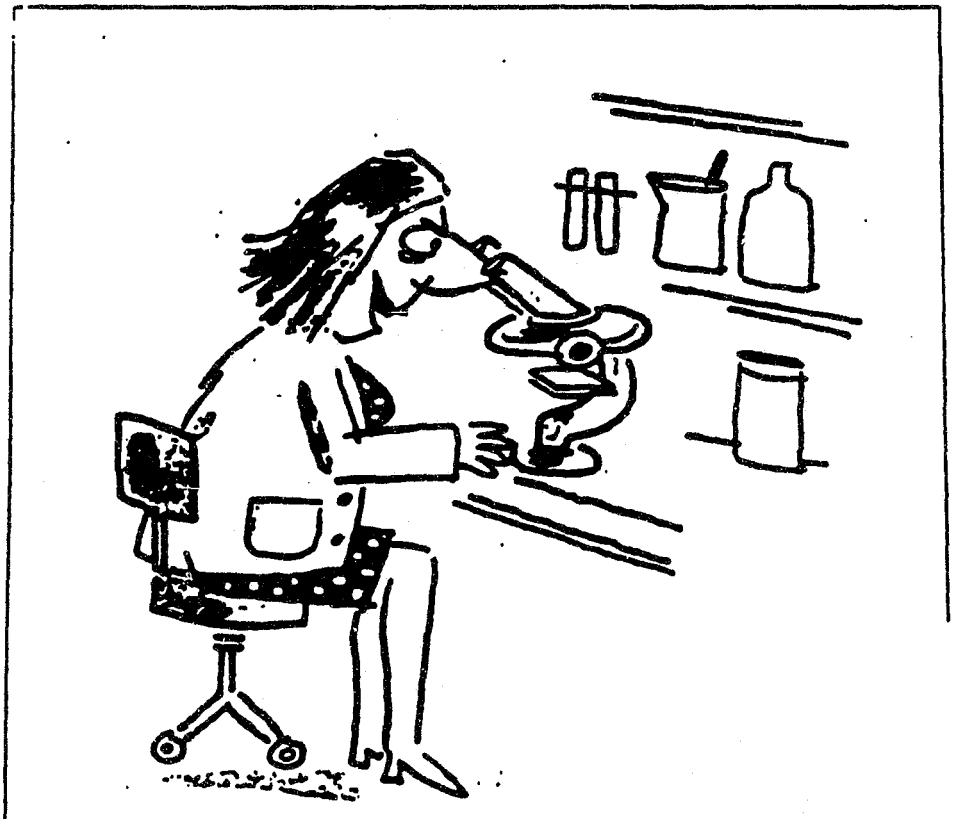
The nice thing about teamwork is that you always have others on your side.

Officers have an obligation to inform other support personnel (Firefighters, Paramedics, Sheriffs, Detox Personnel, etc.) whenever change or transfer of custody occurs and the subject has blood or bodily fluids present on their person, or if the subject has made a voluntary statement that they have a contagious disease.

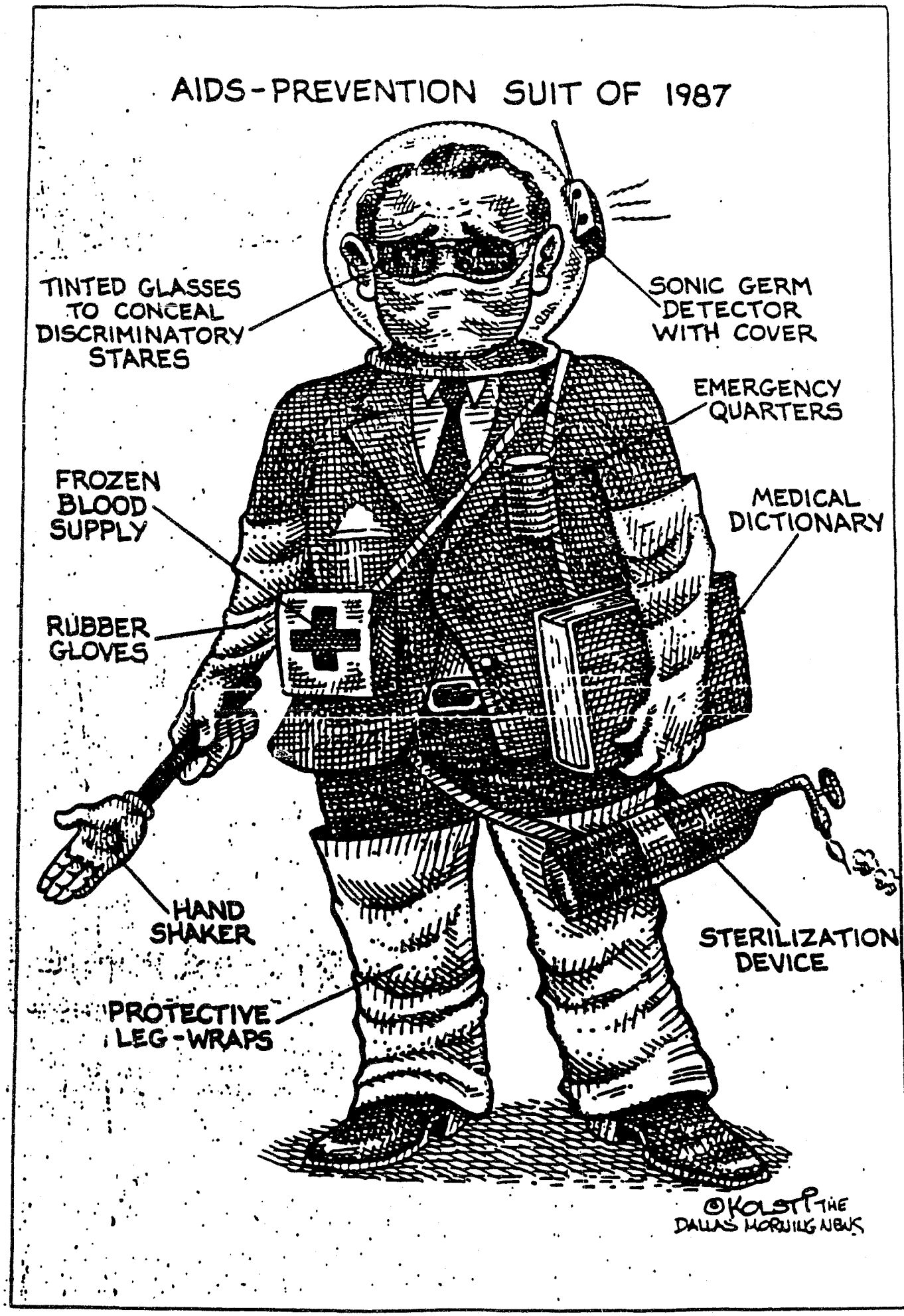
LINE OF DUTY EXPOSURE

Infectious disease contaminated materials





"Tell him you've got a headache!"


AIDS-PREVENTION SUIT OF 1987
TINTED GLASSES TO CONCEAL DISCRIMINATORY STARES
SONIC GERM DETECTOR WITH COVER
EMERGENCY QUARTERS
FROZEN BLOOD SUPPLY
MEDICAL DICTIONARY
RUBBER GLOVES
HAND SHAKER
STERILIZATION DEVICE
PROTECTIVE LEG-WRAPS
©KOLSTAD THE DALLAS MORNING NEWS

SECTION TWO

DENVER POLICE DEPARTMENT DIRECTIVES
(Precautions and Procedures)

DENVER POLICE DEPARTMENT

DEPARTMENT DIRECTIVE

NO. 87-13

DATE Sept. 14, 198

TO All Officers

FROM Chief Rudolph M. Phannenstiel

SUBJECT Infectious Disease Risk Reduction

Public Safety personnel routinely come into contact with the public. At some point in time, they will predictably come into contact with a person who has an infectious disease. While Acquired Immune Deficiency Syndrome (AIDS) is the topic of this Directive, hepatitis and other infectious diseases should be considered.

In performance of their duties, public safety personnel should demonstrate an increased understanding of possible implications when they contact a person who has been infected with AIDS. Also, they should commence taking precautions to prevent the spread of infectious diseases in total.

AIDS is a rapidly growing epidemic, however, prudent precautions can reduce the spread of the virus.

This Directive has been developed so that we may manage those things which we can reasonably predict will occur in the performance of our duties.

INFECTIOUS DISEASE PRECAUTIONS

(1) Discretion should be used by officers to limit their exposure to contagious diseases.

(2) Protective disposable gloves and other infectious disease control materials should be used by officers to prevent transmission of contagious diseases. Direct contact with blood and other bodily fluids should be avoided whenever possible. Officers are required to carry issued protective disposable gloves while on their tour of duty.

(3) Officers shall not eat, drink or smoke at crime scenes where bodily fluids are present, or other contagious factors exist.

(4) Officers should be aware that certain prescribed medications suppress their immune system, e.g. steroids, asthma medications, and may make them more susceptible to infectious disease. Officers should consult with their private physician if they are taking prescription drugs.

(5) Pregnant officers should be advised to report to their physician any direct contacts with bodily fluids in the line of duty. Infectious virus can cause severe problems in newborns.

INFECTIOUS DISEASE TRAINING

The Division Chief of Training will designate an Infectious Disease Control Coordinator. The coordinator will be responsible for disseminating up-dated information and coordinating additional roll call and/or in-service training.

PROCEDURES

SUPPLIES

(1) Commanding Officers shall ensure that adequate supplies are available for infectious disease control within their District, Bureau, Section, or Unit.

(2) Commanding Officers will be responsible for the inventory and dissemination of supplies for infectious disease control. They will also initiate re-ordering procedures from Stationary Supply before supplies become depleted.

(3) Officers using supplies stored in police vehicles are responsible for replacing them in accordance with Operations Manual Section 112.01(2)(c). Protective disposable gloves, other first aid supplies, and disinfecting materials will be made readily available at all times at the District, Bureau, Section or Unit level.

(4) Supplies at the District, Bureau, Section, or Unit level will include:

a. Three pairs of coveralls - one each size.
b. Protective disposable gloves.
c. Red plastic bags and sealing ties.
d. Spray bottles.
e. Liquid and aerosol germicidal cleaner.
f. Disposable handwipes (70% Isopropyl Alcohol).
g. Absorbent chux.
h. Other absorbent materials, i.e. sponges, mop heads, etc.
i. "Isolation Area - Do Not Enter" signs, DPD Form #429.

(5) Supplies in the supervisors' cruisers will include:

a. Red plastic bags and sealing ties.
b. Protective disposable gloves.
c. "Isolation Area - Do Not Enter" signs, DPD Form #429.
d. Absorbent chux.
e. Disposable handwipes (70% Isopropyl Alcohol).

CUSTODY PROCEDURES

(1) Whenever it is necessary to transport a subject who has blood or bodily fluids present on their person or clothing, officers should request a Scout Car for transportation to the Detention Facility, except in situations where the subject's welfare would be jeopardized by the delay. Ambulances should be summoned when transport is necessary to D.G.H. or another health care facility.

(2) Subjects with blood or bodily fluids present on their person should be transported separately from other subjects when possible.

(3) Officers will inform the Communications Bureau when a subject should be transported alone. Communications Bureau personnel will notify the responding Scout Car, Ambulance or Detox Van when solo transportation is required.

(4) Officers have an obligation to inform other support personnel (Firefighters, Paramedics, Sheriffs, Detox Personnel, etc.) whenever change or transfer of custody occurs and the subject has blood or bodily fluids present on their person, or if the subject has made a voluntary statement that they have a contagious disease.

(5) Persons taken into custody with blood or bodily fluids on their person shall be taken directly to Headquarters and placed in the designated holding area for processing, currently located in the DUI holding cell area. An "Isolated Area - Do Not Enter" sign shall be posted. Contact with the isolated person shall be made exclusively by those officers whose duty requires interaction with the subject.

(6) During the hours of 1530 to 0730, 3rd Floor intake desk personnel are not available. Adult subjects taken into custody during these hours having blood or bodily fluids present on their person or clothing, shall NOT be taken to Juvenile Division areas. These subjects will be taken to the designated holding area while necessary processing is completed.

(7) Officers should indicate on GSS&C, S&I and Traffic Arrest forms when a subject taken into custody makes a voluntary statement that they have an infectious disease; also, verbatim narratives made by the suspect will be included when preparing Offense Reports. A notation should also be made when a subject has blood or bodily fluids present on their person or clothing, (i.e., "Bodily Fluids Present").

(8) Officers responding to a call for service where a complainant is alleging that they have been intentionally infected with an infectious disease, shall summon a supervisor to respond to the scene. Departmental correspondence to the Investigative Division outlining the details of the alleged occurrence shall be initiated.

VEHICLE MAINTENANCE

(1) Disinfection procedures shall be effected when a police vehicle requires maintenance after blood or other bodily fluid discharges.

(2) A supervisor shall be notified and the vehicle taken or towed to the Service Center as soon as possible.

(3) Service Center Personnel will effect disinfection procedures.

(4) Recommended disinfection procedures are as follows:

a. Affected vehicles shall be immediately designated by the posting of an "Infectious Disease Contamination" sign upon arrival at the Service Center and while awaiting disinfection. Signs will be available at the Service Center.

b. **PROTECTIVE DISPOSABLE GLOVES WILL BE WORN DURING ALL PHASES OF DISINFECTION.**

1. Officers and maintenance personnel should be aware that rings, jewelry, or long fingernails may compromise the structural integrity of the gloves. They should make certain the gloves are not torn before they attempt to begin any phase of the maintenance process.

c. Any excess of blood or bodily fluids should first be wiped up with a disposable absorbent chux or other approved absorbent materials. Afterwards, the absorbent material should be immediately placed in a red plastic bag and placed in the designated "Contaminated Item Receptacle".

d. A broad-spectrum activity virucidal-germicidal solution shall be prepared precisely to the prescribed standards.

e. The affected area shall be cleansed with the virucidal-germicidal solution and allowed to air dry for ten (10) minutes.

f. All disposable contaminated cleaning items shall and the "Infectious Disease Area - Do Not Enter" sign shall be placed in red plastic bags and placed into the designated "Contaminated Item Receptacle".

g. Maintenance personnel and Officers shall be careful not to contaminate themselves during this cleaning regimen or when taking off their disposable protactive gloves.

(5) When Service Center personnel are not available, the following procedures will apply:

a. Officers shall contact a supervisor and respond to the Service Center Parking Area, 12th Avenue and Lincoln Street.

b. An "Isolated Area - Do Not Enter" sign will be provided by the supervisor and posted on the driver's seat. A notation should be made on the reverse side of the sign indicating the nature and location of the blood or bodily fluid discharge, and the vehicle securely locked.

c. A supervisor will provide a pool vehicle to the officer(s) for the remainder of their shift. Officer(s) or relief will take vehicle keys to the Service Center as soon as it re-opens.

d. Service Center Personnel will disinfect the vehicle and place it back into service as rapidly as possible.

CELL CONTAMINATION

(1) An "Isolated Area - Do Not Enter" sign shall be immediately posted on the cell.

(2) The supervisor will be responsible for ensuring that the cell will be properly disinfected or sealed off.

(3) Recommended disinfection procedures are as follows:

a. **PROTECTIVE DISPOSABLE GLOVES WILL BE WORN DURING ALL PHASES OF DISINFECTION.**

1. Officers and maintenance personnel should be aware that rings, jewelry, or long fingernails may compromise the structural integrity of the gloves. They should make certain the gloves are not torn before they attempt to begin any phase of the maintenance process.

b. Any excess of blood or bodily fluids should first be wiped up with a disposable absorbent chux or other approved absorbent materials. The absorbent material should be immediately placed in a red plastic bag and placed in the designated "Contaminated Item Receptacle".

c. A broad-spectrum activity virucidal-germicidal solution shall be prepared precisely to the prescribed standards.

d. The affected area shall be cleansed with the virucidal-germicidal solution and allowed to air dry for ten (10) minutes.

e. All disposable contaminated cleaning items and the "Isolated Area - Do Not Enter" sign shall be placed in red plastic bags and placed into the designated "Contaminated Item Receptacle".

f. Maintenance personnel and officers shall be careful not to contaminate themselves during this cleaning regimen or when taking off their disposable protective gloves.

HANDLING AND STORAGE OF EVIDENCE

(1) Property Section personnel will adhere to a precise regimen when handling, processing, and storing potentially infectious disease contaminated evidence/property.

(2) Any clothing or evidence known to be contaminated with suspected AIDS, Hepatitis B or other contagious disease will be placed in Bins W-98, W-99 or W-126 and clearly labeled. Label in this manner: Known AIDS, possible Hepatitis B, etc.

(3) All bloody clothing will be treated as if it is contaminated.

(4) All bloody clothing or evidence and sacks containing the clothing or evidence will be handled with protective disposable gloves.

(5) Property Section personnel will furnish protective disposable gloves to officers, detectives, DA's or others handling bloody clothing while in the Property Section.

(6) Any clothing known or suspected to be contaminated with any contagious disease, bloody or not, will be handled by Property Section personnel only after those persons double glove with protective disposable gloves.

(7) The Property Section personnel shall wash their hands thoroughly with germicidal soap after handling any possibly contaminated clothing or evidence.

(8) All property for disposal shall be kept in red plastic bags and placed in the infectious disease receptacle in the Property Section.

PROPERTY CONTAMINATION

(1) When Department issued or personal property is contaminated by blood or bodily fluids, in the line of duty, officers will place the items in a sealed red plastic bag and respond to the Property Section for disinfection of those items. The officer will verbally inform the Property Section personnel when possible infectious disease contaminated items are transferred to their custody.

(2) If Property Section personnel determine that effective disinfection procedures are not practical, officers will leave the property with Property Bureau personnel for disposal and direct a letter through the chain of command to their Division Chief for replacement.

(3) The correspondence should include:

a. The circumstances by which the property became contaminated.

b. The name of the officer in the Property Section who confirmed disinfection procedures were not practical.

c. Whether any person was charged with destruction of public or private property due to the circumstances by which it became contaminated.

(4) District Stations and the Property Section will have coveralls available when uniforms become contaminated and the officer requires a change of clothing. Officers will be responsible for the prompt return of the issued coveralls.

LINE OF DUTY EXPOSURE TO INFECTIOUS DISEASE OR CONTAMINATED MATERIALS

(1) Documentation will be prepared when officers have cause to believe they have had high risk exposure during line of duty activity.

Examples of high risk exposure are:

a. Handled bloody or wet items and notices scratches, cuts or open sores on the area of contact.

b. Direct contact with bodily fluids from a subject on an area where you have an open sore or cut.

c. Given direct mouth to mouth resuscitation (C.P.R.)

d. Received a cut or puncture wound as a result of searching or arresting a subject.

e. Had other high risk exposure.

(2) A supervisor will be contacted and a Non-Traffic Accident report will be completed detailing the extent of exposure.

(3) In addition, the following forms will be completed by a supervisor and forwarded to the Safety Coordinator:

a. ADM 4/SC Employee Work Injury Report.

b. ADM 6/SC Clinic Pass for Admittance to DGH or other health care facility.

c. DPD 650 Sick & Injured Report.

(4) Officers will be evaluated clinically and serologically for evidence of infection after the exposure. This will be done through D.G.H., the Employees Medical Clinic, or by referral to the officer's private physician.

(5) See the attached City and County of Denver, Department of Health and Hospitals Protocol for care of city field personnel, including Police Officers, with suspected exposure to victims of blood borne infectious disease. Officers are to comply with this Protocol in addition to (2), (3), and (4) above.

CITY AND COUNTY OF DENVER

DEPARTMENT OF HEALTH AND HOSPITALS

INTER-OFFICE CORRESPONDENCE

PROTOCOL FOR CARE OF CITY FIELD PERSONNEL WITH SUSPECTED EXPOSURE TO VICTIMS OF BLOOD BORNE INFECTIOUS DISEASE (HEPATITIS/AIDS):

When field personnel are treating a patient whom they suspect has a blood borne infectious disease (Hepatitis/AIDS), the following protocol shall apply:

A. If blood or bodily secretions contaminate scene, or medical intervention is anticipated to place field personnel at risk for such contamination. → Wear personal protection.

B. If field personnel have avoided contamination with body fluids from the patient, as a result of their use of personal protection or because no body fluids contaminate scene. → No further action is required.

C. If field personnel are contaminated by any of the following routes of exposure:

1. Patient secretions in eye
2. Needle stick from contaminated needle
3. Mouth-to-Mouth resuscitation of patient
4. Prolonged contact with blood or other body fluids from patient on abraded skin of field personnel

→

a. Notify paramedic crew of contamination and request evaluation of patient by Emergency Department physician at receiving hospital to include appropriate corroborative blood tests as deemed necessary by the physician.

b. Obtain the following information concerning the patient from paramedics at scene:
   1. Patient name
   2. Date of Birth
   3. Address of incident
   4. Time of incident
   5. Intended receiving hospital
   6. Name of paramedics
   7. Trip number

c. Complete ADM-4 and report to EMC within 72 hours of exposur for evaluation, consultation, and follow up. Employees are NOT to call or report to the Denver General Hospital Emergency Department unless the employee has sustained other injuries.

Norm Dinerman, M.D.
APPROVED: AIDS Task Force Committee, 7/1/87

SECTION THREE

DISINFECTION AND SUPPLIES

DENVER POLICE DEPARTMENT

INTER-DEPARTMENT

CORRESPONDENCE

TO Chief Rudolph M. Phannenstiel, Acting D/C Dennis K. Kennaugh, and D/C Michael T. O'Neill DATE 07-13-87

FROM Sgt. Wayne Dudley and Tech. Bobbet Hines, Training Bureau

SUBJECT Purchase of Supplies

Sirs:

We respectfully request your consideration of the purchase of supplies which may be used with the implementation of an "Infectious Disease Management Program".

Thank you for your review of the following proposed items:

ITEM	USE	COMMENTS
Quatsyl 256-PMQ	- Disinfection of holding cells - Disinfection of Police Vehicles when saturated blood or body fluid spill occurs.	- Antimicrobial chemicals are currently the most effective measure which can be used to contain the spread of micro-organisms from inanimate objects. - Verified effective in inactivating HIV-III by Center for Disease Control, Atlanta, GA. - Pre-measured soluble packet for uncomplicated preparation.
TOR (AERO)	- Weekly vehicle interior cleaning regimen for reduction of existing micro-organisms.	- Exceeds HIV-III kill requirements of Quaternary-Ammonium Chloride specifications. "Infections in Medicine", March, 1987, P. 108. - Residual odor is minimal.
Hibistat Disposable Hand Wipe	- Inactivates micro-organisms when blood or body fluid contact occurs.	- Useful for officers when blood or body fluid smears occur. - Reduces likelihood of further contamination of equipment or vehicle, i.e. steering wheel, gear selector, radio microphone, etc.

ITEM	USE	COMMENTS
(Habistat Disposable Hand Wipe, cont.)		- Can be stored in vehicle First Aid Kit.
Disposable Chux	- Protective absorbent plastic barrier for use inside of police vehicle when it is necessary to transport subject with body fluid contamination.	- Minimizes contamination of police vehicle. - Carried in cruisers. Only available upon officer request.
55 Gallon Drums	- Sealed container for storage and disposal of contaminated items.	- Located at Service Center and Property Section.
Laerdol-Pocket C.P.R. Masks	- One way directional air flow masks. Eliminates microbe or micro-organism contamination of officer when lifesaving responses are required.	- Recommend issuance of mask to each officer individually. - Compact construction of mask facilitates portable storage. - Cost effective when civil liability issues are considered.

Respectfully Submitted,

Wayne Dudley

Sgt. Wayne Dudley, 78015

Bobbet Hines

Tech. Bobbet Hines, 79068
Training Bureau

WD/BH:mll

DATE
07 10 87

PURCHASE REQUISITION
CITY AND COUNTY OF DENVER

DEPARTMENT/AGENCY	DIVISION	INDIVIDUAL TO CONTACT	PHONE EXT.	REQUESTED DEL.
:ver police Dept	Training Division	Sgt. W. Dudley	X2041	

ENTER VENDOR OR TYPE OF FIRM TO CONTACT (SHOW NAME, ADDRESS, ZIP CODE NO., INDIVIDUAL TO CONTACT)

_enver Barrel
1120 Blake St
Denver, Co
Perry Komenski-295-0404

SHIP TO (SHOW COMPLETE NAME & ADDRESS AND ANY SPECIAL DELIVERY INSTRUCTIONS)

Denver Police Department
Stationary Supply
1331 Cherokee St.
Denver, Co. 80204

BUYER

PURCHASE FROM	VENDOR I.D. NO.	
	BID NO.	
	DELIVERY TO BE MADE BY ➡ / /	TERMS / FOB POINT

I hereby certify that the articles or services requested are necessary for the operation of this agency and are properly chargeable to the fund/organization and account shown hereon and to the quarterly allotment on file with the Auditor for which sufficient unencumbered balance exists.

PURCHASING CONTACT

DEPARTMENT HEAD

ITEM	FUND/ORG.	ACCT.	TASK	OPT.	ACTIVITY	AMOUNT
1						
2						
3						
4						
5						

CMRA MAX. MO. EXPENDITURE WILL NOT EXCEED $

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	EXTENSION AMOUNT
	4		55 gal. Drums DOT17C(OH)	$36.00	$144.00

☐ CONTINUATION SHEET ATTACHED NUMBER OF PAGES 1

TOTAL ➡ $144.

BUDGET OFFICER — APPROVED BY MANAGER, DEPARTMENT OF GENERAL SERVICES — BUYER — P.O. PREPARED

DATE RECEIVED — EXAMINED BY — DATE RECEIVED — P.O. NO.

CHECKED BY — DATE — PURCHASED BY — CHECKED BY

ACM 11 Rev 6/83) WHITE - General Services BLUE - Agency

DATE
07 10 87

PURCHASE REQUISITION
CITY AND COUNTY OF DENVER

REQ CMRA

DEPARTMENT/AGENCY	DIVISION	INDIVIDUAL TO CONTACT	PHONE EXT.	REQUESTED DEL.
:ver Police Dept	Training Division	Sgt. W. Dudley	X2043	

(CITES VENDOR OR TYPE OF FIRM TO CONTACT (SHOW NAME, ADDRESS, PHONE NO., INDIVIDUAL TO CONTACT)
Medline Industries, Inc.
6958 S. Madison Wy
Littleton Co. 80122
770-3752/David Kleeb

SHIP TO (SHOW COMPLETE NAME & ADDRESS AND ANY SPECIAL DELIVERY INSTRUCTIONS)
Denver Police Department
Stationary Supply
1331 Cherokee St.
Denver, Co. 80204

BUYER

PURCHASE FROM	VENDOR I.D. NO.	
	BID NO.	
	DELIVERY TO BE MADE BY / /	TERMS / FOB POINT

I hereby certify that the articles or services requested are necessary for the operation of this agency and are properly chargeable to the fund/organization and account shown hereon and to the quarterly allotment on file with the Auditor for which sufficient unencumbered balance exists.

PURCHASING CONTACT

DEPARTMENT HEAD

ITEM	FUND/ORG.	ACCT.	TASK	OPT.	ACTIVITY	AMOUNT
1						
2						
3						
4						
5						

CMRA MAX. MO. EXPENDITURE WILL NOT EXCEED $

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	TOTAL AMOUNT
	4 cases		Non 28-1242 Disposable Chucks "23x36"	25.46	
			150/case		$101.84

☐ CONTINUATION SHEET ATTACHED NUMBER OF PAGES 1

TOTAL $101.

BUDGET OFFICER — APPROVED BY MANAGER, DEPARTMENT OF GENERAL SERVICES — RECEIVED

DATE RECEIVED — EXAMINED BY — DATE RECEIVED — P.O. NO.

CHECKED BY — DATE — PURCHASED BY — CHECKED BY

ADM 11 (Rev 6/83) WHITE - General Services BLUE - Agency

DATE
07 10 87

PURCHASE REQUISITION
CITY AND COUNTY OF DENVER

REQ. NO.

DEPARTMENT/AGENCY	DIVISION	INDIVIDUAL TO CONTACT	PHONE EXT.	REQUESTED DEL.
ver Police Dept.	Training Division	Sgt. W. Dudley	X2043	

ENTER VENDOR OR TYPE OF FIRM TO CONTACT (SHOW NAME, ADDRESS, I.D. NO., INDIVIDUAL TO CONTACT)

Huntington Laboratories, Inc.
7346 S. Kendall Blvd.
Littleton, Co. 80123
Norm Kramer, 292-1156

SHIP TO (SHOW COMPLETE NAME & ADDRESS AND ANY SPECIAL DELIVERY INSTRUCTIONS)

Denver Police Department
Stationary Supply
1331 Cherokee St.
Denver, Co. 80204

BUYER

PURCHASE FROM	VENDOR I.D. NO.	
	BID NO.	
	DELIVERY TO BE MADE BY / /	TERMS / FOB POINT

I hereby certify that the articles or services requested are necessary for the operation of this agency and are properly chargeable to the fund/organization and account shown hereon and to the quarterly allotment on file with the Auditor for which sufficient unencumbered balance exists.

PURCHASING CONTACT

DEPARTMENT HEAD

ITEM	FUND/ORG.	ACCT.	TASK	OPT.	ACTIVITY	AMOUNT
1						
2						
3						
4						
5						

CMRA MAX. MO. EXPENDITURE WILL NOT EXCEED $

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	AMOUNT
	11 cases		TOR (Aerosol) Germicidal Cleaner & Deodorant	$26.00	
			#104417		$286.00

☐ CONTINUATION SHEET ATTACHED NUMBER OF PAGES 1

TOTAL ▶ $286

BUDGET OFFICE — APPROVED BY MANAGER, DEPARTMENT OF GENERAL SERVICES — BUYER — P.O. PREPARED

DATE RECEIVED — EXAMINED BY — DATE RECEIVED — P.O. NO.

CHECKED BY — DATE — PURCHASED BY — CHECKED BY

ADM 11 (Rev. 6/82) WHITE - General Services BLUE - Agency

DATE
07 10 87

PURCHASE REQUISITION
CITY AND COUNTY OF DENVER

DEPARTMENT/AGENCY	DIVISION	INDIVIDUAL TO CONTACT	PHONE EXT.	REQUISITION
:ver Police Dept	Training Division	Sgt. W. Dudley	x2043	

LISTED VENDOR OR TYPE OF FIRM TO CONTACT (SHOW NAME, ADDRESS, PHONE NO., INDIVIDUAL TO CONTACT)

National Laboratories
9371 W. Brittany
Littleton, Co. 80123
Dwayne Mauro - 971-0929

SHIP TO (SHOW COMPLETE NAME & ADDRESS AND ANY SPECIAL DELIVERY INSTRUCTIONS)

Denver Police Department
Stationary Supply
1331 Cherokee St.
Denver, Co. 80204

BUYER

PURCHASE FROM	VENDOR I.D. NO.	
	BID NO.	
	DELIVERY TO BE MADE BY ➡ / /	TERMS / FOB POINT

I hereby certify that the articles or services requested are necessary for the operation of this agency and are properly chargeable to the fund/organization and account shown hereon and to the quarterly allotment on file with the Auditor for which sufficient unencumbered balance exists.

PURCHASING CONTACT

DEPARTMENT HEAD

ITM	FUND/ORG.	ACCT.	TASK	OPT.	ACTIVITY	AMOUNT
1						
2						
3						
4						
5						

CMRA MAX. MO. EXPENDITURE WILL NOT EXCEED $

ITM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	AMOUNT
	2 cases		Quatsyl 256 (PMQ) Premeasured soluble	$46.87	
			600/¼ oz per case		$93.74

CONTINUATION SHEET ATTACHED NUMBER OF PAGES 1

TOTAL ➡ $93.7

SUBMIT COPIES TO APPROVED BY MANAGER, DEPARTMENT OF GENERAL SERVICES DATE P.O. NO.

DATE RECEIVED EXAMINED BY DATE RECEIVED

CHECKED BY DATE PURCHASING AGENT CHECK NO.

AGM 11 (Rev 6/80) WHITE - General Services BLUE - Agency

DATE
07 10 87

PURCHASE REQUISITION
CITY AND COUNTY OF DENVER

REQ CMRA #

DEPARTMENT/AGENCY	DIVISION	INDIVIDUAL TO CONTACT	PHONE EXT.	REQUESTED DEL.
ver Police Dept	Training Division	Sgt. W. Dudley	X2043	

LISTED VENDOR OR TYPE OF FIRM TO CONTACT (SHOW NAME, ADDRESS, ZIP NO., INDIVIDUAL TO CONTACT)

McPeck Motor Coach Co.
4700 Brighton Blvd.
Denver, Co.
295-2450/Leo Branstetter

SHIP TO (SHOW COMPLETE NAME & ADDRESS AND ANY SPECIAL DELIVERY INSTRUCTIONS)

Denver Police Department
Stationary Supply
1331 Cherokee St.
Denver, Co. 80204

BUYER

PURCHASE FROM	VENDOR I.D. NO.	
	BID NO.	
	DELIVERY TO BE MADE BY ➡ / /	TERMS / FOB POINT

I hereby certify that the articles or services requested are necessary for the operation of this agency and are properly chargeable to the fund/organization and account shown hereon and to the quarterly allotment on file with the Auditor for which sufficient unencumbered balance exists.

PURCHASING CONTACT

DEPARTMENT HEAD

ITEM	FUND/ORG.	ACCT.	TASK	OPT.	ACTIVITY	AMOUNT
1						
2						
3						
4						
5						

CMRA MAX. MO. EXPENDITURE WILL NOT EXCEED $

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	AMOUNT
	200		Laerdal Pocket Masks w/one-way valve	$8.50	
			(wo/O_2 nipple and headstrip)		$1700.00
2	20		Laerdal One Way Valve #82-0300	$2.50	$0.00

☐ CONTINUATION SHEET ATTACHED NUMBER OF PAGES One TOTAL ➡ $1750.0

BUDGET OFFICER APPROVED BY MANAGER, DEPARTMENT OF GENERAL SERVICES BIDS

DATE RECEIVED EXAMINED BY DATE RECEIVED P.O. NO.

CHECKED BY DATE PURCHASED BY CHECKED

ADM 11 (Rev 6/82) WHITE - General Services BLUE - Agency

DATE 07 10 87

PURCHASE REQUISITION
CITY AND COUNTY OF DENVER

REQ CMRA

DEPARTMENT/AGENCY	DIVISION	INDIVIDUAL TO CONTACT	PHONE EXT.	REQUESTED DEL.
Denver Police Dept	Training Division	Sgt. W. Dudley	X2043	

ENTER VENDOR OR TYPE OF FIRM TO CONTACT (SHOW NAME, ADDRESS, PHONE NO., INDIVIDUAL TO CONTACT)
McPeck Motor Coach Co.
4700 Brighton Blvd.
Denver, Co.
295-2450/Leo Branstetter

SHIP TO (SHOW COMPLETE NAME & ADDRESS AND ANY SPECIAL DELIVERY INSTRUCTIONS)
Denver Police Department
Stationary Supply
1331 Cherokee St.
Denver, Co. 80204

BUYER

PURCHASE FROM	VENDOR I.D. NO.	
	BID NO.	
	DELIVERY TO BE MADE BY / /	TERMS / FOB POINT

I hereby certify that the articles or services requested are necessary for the operation of this agency and are properly chargeable to the fund/organization and account shown hereon and to the quarterly allotment on file with the Auditor for which sufficient unencumbered balance exists.

PURCHASING CONTACT

DEPARTMENT HEAD

ITEM	FUND/ORG.	ACCT.	TASK	OPT.	ACTIVITY	AMOUNT
1						
2						
3						
4						
5						

CMRA MAX. MO. EXPENDITURE WILL NOT EXCEED $

ITEM	QUANTITY	UNIT	DESCRIPTION	UNIT PRICE	AMOUNT
	1375		Laerdal Pocket Masks w/one-way valve	$7.23	$9,941.25
			(wo/O_2 nipple and headstrap)		
2	20		Laerdal One Way Valve #82-0300	$2.50	$ 50

☐ CONTINUATION SHEET ATTACHED NUMBER OF PAGES One

TOTAL $9,991.

BUDGET OFFICE — APPROVED BY MANAGER, DEPARTMENT OF GENERAL SERVICES — BUYER — P.O. NO.

DATE RECEIVED — EXAMINED BY — DATE RECEIVED

CHECKED BY — DATE — PURCHASED BY — CHECKED

ACM 11 (Rev 6/83) WHITE - General Services BLUE - Agency

That original Information Bulletin on AIDS cited the use of a one to ten dilution of household bleach to disinfect surfaces contacted by blood and other specimens from AIDS patients. Undoubtedly, in response to the growing number of inquiries relative to disinfection against the virus, Dr. Linda S. Martin et al., of the Centers for Disease Control (CDC) have published the results of their study on this subject in the August 1985 issue of the Journal of Infectious Disease.

Here are the particulars of that article:

SUBJECT: Disinfection and Inactivation of the Human T-Lymphotropic Virus, Type III/Lymphodenopathy-Associated Virus (AIDS VIRUS).

AUTHORS: Linda S. Martin, Ph.D., J. Steven McDougal, M.D., Sherry L. Loskoski, M.T.

From the Immunology Branch, Division of Host Factors, Center for Infectious Diseases, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, Georgia 30333.

Address reprint request to Linda S. Martin, Immunology Branch, 1-1202, Centers for Disease Control, Atlanta, GA 30333.

THE ARTICLE NAMES SEVEN CHEMICALS WHICH WERE FOUND TO BE EFFECTIVE IN INACTIVATING THE VIRUS AT VARIOUS CONCENTRATIONS. THEY ARE: LYSOL BRAND DISINFECTANT (EPA REGISTRATION NUMBER 675-19), HYDROGEN PEROXIDE, ETHYL AND ISOPROPYL ALCOHOL, PARAFORMALDEHYDE, HOUSEHOLD BLEACH AND A DETERGENT CALLED NONIDET P-40.

In their study on Lysol Brand, the authors chose the most concentrated label recommended dilution of 3% (3:100) and continued testing to the least concentrated dilution recommended which is 0.5% (1:200). **LYSOL BRAND DISINFECTANT WAS FOUND TO BE EFFECTIVE AT BOTH 0.5% AND 3% IN INACTIVATING HTLV-III/LAV.**

A large number of individuals within our sales force and outside of it, typically Hospital Infection Control and Housekeeping personnel have inquired as to the effectiveness of our various healthcare products against AIDS. To date, the only product tested by the CDC has been Lysol Brand Disinfectant and so it is the only one which we may cite as effective by their testing.

You will be informed of further developments as they occur.

JEB BARGMANN
Technical Service Manager

JB:bp

SECTION FOUR

INFORMATION UPDATES/SOURCE DIRECTORY/SPECIFIC RESOURCES

A.I.D.S. INFORMATION

Acquired Immune Deficiency Syndrome (AIDS) breaks down the immune system and renders the body defenseless to disease.

Potential infectious disease transmitters:

- Sexual intercourse
- Sharing of needles or syringes
- Blood transfusions
- Infected mother to new-born infants
- Sharing of tooth brushes or razors
- Body fluid contact (blood, urine, feces, semen, sputum, saliva, sweat, tears)
- Saliva/Mucous membranes

Since 1985, 80% of the reported AIDS cases have died within six (6) months. The remaining persons have expired within three (3) years.

The ELISA test and Western Blot have been developed to detect antibodies in the blood, which indicate that a person has been infected.

The period of time from when you may have been infected to the time it can be determined that you are infected, can range from six (6) weeks to eight (8) months.

80% of reported AIDS have occurred in the 20 years to 49 years age group.

Symptoms of the Human Immunodeficiency Virus (HIV) infections are most often not apparent. Some symptoms that may develop are:

- Tiredness
- Fever
- Loss of Appetite and Weight
- Diarrhea
- Night Sweats
- Swollen Glands (lymph nodes)
- Unexplained bruising

High risk groups of reported AIDS statistics nationally reflect that 73% are Homosexual and Bisexual Men and 17% are abusers of intravenous drugs.

Of the AIDS cases reported in Denver, 88% are male homosexuals and 6% IV drug users.

(Two out of four homosexual males are estimated to have HIV infection in the San Francisco area. One out of four in the Denver area.)

Treatment of persons with AIDS is costly. Three weeks of hospital care averages $21,000. Three weeks of home care averages $1,200 (Connecticut).

HIGH RISK SUBJECTS:

Realistically, every police officer by the nature of police work is at some risk. However, particular concern must be paid when (1) officers come into physical contact with any of the high risk groups (Cuban and Haitian immigrants, intravenous drug users, homosexuals with multiple partners, hemophiliacs), or (2) when any mucosal contact occurs with any body secretion, or (3) when a high risk subject looks especially thin, in poor health, or exhibits any of the related symptoms.

"AIDS INFORMATION"

1987 Statistical & Informational Reports:

ENCOURAGING DATA:

The outer layer of skin totally blocks the virus. (Micro injury exceptions).

Few children have AIDS even though they usually get most infectious diseases.

Concentration of the virus in coughs and sneezes is not enough to cause infection through inhalation.

The virus only reproduces by using the genetic material of a functioning cell.

1985-86 Red Cross of Minnesota reports from 300,000 blood donor men and women, no women tested HIV positive.

Two infected woman of a Minnesota sex club did NOT infect their 25 male partners during group sex encounters.

A Swedish woman HIV positive since 1981 has not had advanced stage symptoms.

The U.S. Army reports one documented drug addict who has been HIV positive since 1976. He has not advanced into ARC or AIDS stages.

There exists a heat treating process for hemophiliacs which kills HIV infected cells in blood clotting concentrates.

"AIDS INFORMATION"

1987 Statistical and Informational Reports:

DISCOURAGING DATA:

Present potential for infected women nationally is 400,000. One woman in 56 from Manhatten tested by Armed Services tested positive.

Black and Hispanic women in New York City are a high risk group due to IV drug abuse and/or being the sexual partner of men at high risk.

High concentrations of the virus is found in semen; it is also found in pre-ejaculatory fluid.

The average number of lifetime partners of sexually active heterosexuals is 23.

Miami AIDS Clinical Research Unit reports 86% of women having unprotected sex with infected husbands became infected.

One woman in the CDC (Atlanta) group became infected after having sex only once with her husband after he had a blood transfusion.

Women with steady exposure to HIV positive partners have 40% risk potential at present (20% risk in short term relationships).

Walter Reed Army Medical Center reports women usually die sooner than men once they have AIDS (25 months vs. 42 months).

Hemophiliacs receive pooled blood concentrate from hundreds of donors. There are 20,000 hemophiliacs in the U.S. and the National Hemophiliac Foundation reports over half of hemophiliacs in the western world are infected.

Dr. Tom Peterman at CDC (Atlanta) reports perhaps 45,000 men having had transfusions are infected in the U.S. (Many may have died already.)

8 million Americans have had transfusions from 1977-1985.

Most of the estimated 500,000 drug addicts in the U.S. live in New York, California, New Jersey and Florida.

1987 Statistical and Informational Reports (Discouraging Data) (cont.)

Drug Addict HIV Infection Rates:

New York City	65%
Newark, New Jersey	59%
Boston	30%
Chicago	11%
San Francisco	10%
Washington, D.C.	7%
New Orleans	1%

International Drug Addict HIV Infection Rates:

Barcelona, Spain	71%
Madrid, Portugal	64%
Paris, France	64%
Geneva, Switzerland	53%
West Berlin, Germany	50%
Belgrade, Ireland	45%
Edinburgh, Scotland	41%
Stockholm, Sweden	40%

Tested Admitted Homosexual and Bisexual HIV Infection Rates:

San Francisco	75%
New York City	60%
Los Angeles	42%
Boston	30%
Minneapolis-St. Paul	15%
Ithica, New York	8%
London	32%
Amsterdam	31%
Barcelona	27%
Vancouver, Canada	27%
Copenhagen	26%
Rome	13%
Madrid	13%
Greece	11%
Stockholm	10%
Hungary	6%
Thailand	1%

1987 Statistical and Informational Reports (Discouraging Data) (cont.)

Dr. Barbara Herbert of Women's AIDS Project in Washington, D.C., reports two cases of lesbian mouth to vagina contact having become infected.

Major HIV Infection areas are:

New York
New Jersey
Delaware
Maryland
Washington, D.C.
Los Angeles
Northern California
Las Vegas
Dallas - Houston
Chicago
Southern Florida

Armed Services testing reports 13 males to one female diagnosed as AIDS cases nationally, but a 1.3 to 1 ratio of men to women from New York City.

Armed Services testing reports 3 times as many black recruits as whites are infected.

AIDS INFORMATION

September, 1987: Statistical and Informational Reports:

Armed Service Testing Reports:

Testing 2.5 million persons since 1985.

H.I.V. Infection rate is 1.5% per 1,000.

States with higher incidence of H.I.V. infection (5 per 1,000) include: California, Colorado, Maryland, New Jersey, New York, Texas and Washington, D.C..

States which had no occurrence of persons H.I.V. positive were: Alaska, Maine, Montana, North Dakota, Rhode Island, Vermont and Wyoming.

New York City reports:

32,000 persons have been tested since the Aids epidemic began

11,000 AIDS cases have been diagnosed (70% men and 30% Women)

City officials project 100,000 more persons have been infected through I.V. Drug Use.

In addition, they have 500,000 persons thought to be HIV Positive.

Autopsies performed on AIDS victims indicated 50% had tuberculosis.

People bitten by rats in 1985=311
People bitten by People in 1985=1,519.

Miscellaneous Reports:

Symptoms from HIV Infection usually show up within 26 months & in children within 8 months

25-35% of HIV Infected newborn children will not be cared for by their biological parents(June '87 survey of 25 States)

For every female victim of the disease, there are 13 male victims in the U.S..

The Soviets report that they have tested 1 milion persons and that 102 have HIV Infection(September '87)

Medical economists state that by 1991, the nation's national health care budget will be $10.9 billion.

35 million Americans have no medical insurance.

At least 1.5 million Americans are HIV Positive. No conceivable quarantine system would be adequate.

In 1991, the virus is likely to be present in 5-10 million Americans.

Dr. Robert Redfield, Walter Reed Army Medical Center states the public has been misled, people with AIDS are at the end of the virus-they represent where the virus was 5-10 years ago.

AIDS INFORMATION

September, 1987 (continued)

The National Academy of Science reports that by 1991, 270,000 Americans will be diagnosed as having AIDS and 54,000 people a year will be dying and the virus will have spread to 5-10 million persons.

Spending on AIDS-prevention education should rise to $1 billion a year by 1991.

$411 million will be spent on AIDS research in 1987 alone.

The Department of Health & Human Services will spend $87 million for risk reduction programs in 1987.

President Reagan stated that 5 million Americans are now infected with the AIDS virus.

The U.S. is currently spending $50 million a year on blood screening.

The Institute of Medicine & M.I.T. there are hundreds of mutant strains of the virus.

Myron Essex of the Harvard School of Public Health has discovered an apparently harmless AIDS-related virus in Africa named HTLV-IV.

Americans will spend $338 million on condoms this year.

The ELISA test costs about $6, however, persons are charged $30 by health care facilities.

30% of the people in southwest Uganda are sero-positive.

HIV Infection was detected in blood samples dating back to 1959, in Uganda.

The enclosure "Source Document" is provided for your perusal. It imparts comments made by those medical professionals who take issue with some of the research data and guidelines recommended by The Center of Disease Control in Atlanta.

Unfortunately, there are wide-spread controversies within the medical community and uncertainties which only time, research and development can resolve.

Society relies on those judgements made by the medical community. Therefore, until a majority concensus is advanced by research, it is prudent to develop procedures based on a "worst case scenario."

It is unacceptable for even one citizen or officer to become infected because all of the "issues" were not considered. Subsequently, a responsible posture has evolved which develops procedures, provides supplies and discusses the issues through research and training.

Since fear is an unacceptable alternative for public safety officers, setting "mental channels" to effectively respond to the "uncertainties" is a necessary requirement.

SOURCE DOCUMENTATION

TRANSMISSION OF HIV:	IN WHAT WAYS CAN PERSONS BECOME INFECTED?
Dr. I. Abrams Cancer Research Institute University of California at San Francisco	"The richest sources of HIV are semen and blood. In semen, it is not the sperm itself that is infected. Each ejaculation contains about two million lymphocytes (the white blood cells which contain the virus) and these likely transmit the virus."
Dr. William Hazeltine Dana-Farber Cancer Institute Harvard University	"Anyone that tells you categorically that AIDS is not transmitted by saliva is not telling you the truth." AIDS may in fact be transmitted by tears, saliva, bodily fluids and mosquito bites." "This system is very potent in permitting viruses to reproduce at a ferocious state. This is such a devastating disease. It is one reason this virus can be transmitted so easily from person to person . . . "
Dr. Richard Rhestack Neurologist	"HIV positive individuals probably should not be employed as food handlers."

HIV INFECTION PROJECTIONS:	HOW MANY PERSONS ARE INFECTED?
Haldon Makler World Health Organization	"There may be ten million persons infected worldwide and it may reach 100 million in five years."
Dr. James Curran Center for Disease Control Atlanta	"In many areas, HIV infection is 100 times greater than the reported cases of AIDS."
Second Annual Conference of AIDS	"Within ten years, 25% of the entire population of Africa will be dead or dying of AIDS."
Dr. Ray Schwartz Assistant Executive Vice President American Medical Association Head of AIDS Task Force	"100% of HIV positive individuals will eventually progress to AIDS."

Dr. William Hazeltine
Dana-Farber Cancer Institute
Harvard University

"The kind of readout of genetic information we see in this system is absolutely astounding. Nobody would have thought this level of transcription or gene activity was possible before we did these studies. We were shocked. It's about 1,000 times faster than the genes we know about and what we have encoded in the AIDS virus is basically the biological equivalent of nuclear war."

Jay A. Levy
Research Institute
University of California
San Francisco

"One finding has been that individuals may be able to neutralize several of the isolates from the United States but not isolates from Haiti or Africa."

Moreover, the virus-infected cells can pass infection to other cells through cell to cell contact, at which time, virus would be free of neutralizing antibodies."

"In our experience, the only individuals that maintain a virus positive antibody-negative state, have been newborn infants, born of HIV-positive mothers who are intravenous drug abusers. These children can live up to two years and make no antibodies to the virus but still have infectious virus replicating in their blood."

"As we have theorized previously, AIDS itself can be an opportunistic infection."

HIV:

IS IT A FRAIL VIRUS?

Dr. James Staff
National Institute of Health

"Unlike most other retroviruses, the AIDS virus can survive outside the body for hours to days."

Elite Viral Oncology Unit
Pasteur Institute

"As the data shows, significant numbers of viral particles were inactivated after 7 days - but some infectious particles were still present since release of the virus was still seen on day 10."

"The resistance of the AIDS virus at room temperature may explain the appearance of AIDS in non-risk groups."

MUTATION:

WHAT ARE THE RAMIFICATIONS OF THIS CHANGING VIRUS?

Dr. I. Abrams
Cancer Research Institute
University of California
San Francisco

"The French recently reported a new AIDS like virus they found in people from an island off the west coast of Africa, which partially cross reacts with the human AIDS virus and partially reacts with the monkey AIDS virus. It is like a hybrid virus."

Dr. Luke Montanee
French AIDS Researcher
Pasteur Institute
Discoverer of AIDS Virus

"The greatest danger of the disease is the genetic variability of the virus . . . change in routes of transmission cannot be discounted."

"The potential for a genetic variation is perhaps the greatest danger in the future of the AIDS epidemic."

"It will make it difficult to design efficient vaccines protective against all strains. And a further change of the virus in its tropism or ability to affect types of cells and ways of transmission cannot be excluded."

CENTRAL NERVOUS SYSTEM COMPLICATIONS:

WILL OFFICERS BE CONFRONTED WITH MORE CALLS FOR SERVICE FOR PERSONS WHOSE MENTAL CAPACITY IS DIMINISHED?

Dr. Paul Volgerding
San Francisco General Hospital

"It is entirely reasonable to speculate that everyone who is seropositive will develop central nervous system complications. They take the form of varying degrees of dementia."

Dr. Richard Tedder
British Virologist

"If people don't get killed by immuno-suppression, they'll die from chronic dementia."

Dr. Robert Gallo
Discoverer of AIDS Virus

"Infecting the brain, the AIDS virus can cause dementia and cause death directly. These cases often go unreported because they are not showing up as AIDS but brain disease."

Dr. June Osborne
University of Michigan
School of Public Health
Member of Institute of Medicine
National Academy of Science Panel

"It's a uniformly expressive and uniformly lethal virus. A new manifestation of the virus, a severely debilitating neurologica condition, is beginning to show up in patients who have been positive for the AIDS virus 5 years or longer, but do not develop immune suppression.

COST COMPILATIONS:

Ann Hardy, PhD
Epidemiologist
Statement from:
Centers for Disease Control
Public Health Service
U.S. Department of Health
& Human Services

HOW MUCH STRAIN WILL HIV PUT ON OUR ECONOMY?

"Average daily charge of $838 reported by Dr. Peter Arno, for AIDS patients admitted to San Francisco General Hospital . . . the result was an estimated $1,473,000,000 in expenditures for 10,000 patients over the course of their illness . . .

"The cost of work years lost for AIDS patients 15 years old and older . . . we used 1980 data provided by Dr. Thomas Hodgson of the National Center for Health Statistics . . . we estimated that the 10,000 AIDS patients will lose 8,387 years of work due to disability while in the hospital) . . . Future earnings lost following premature death was calculated to be $4.68 billion . . . The average AIDS patient will be hospitalized 168 days before dying at a hospital cost of $147,000 per patient. The loss per patient in terms of future income is $470,000 . . .

****

AIDS HOTLINES

NATIONAL HOTLINE: CENTER FOR DISEASE CONTROL		800-447-AIDS
BAMA Birmingham	Birmingham Aids Outreach	205-930-044-
CALIFORNIA		
Costa Mesa	Aids Response Team	714-534-0862
Fresno	Central Valley Aids Team	209-264-2437
Los Angeles	Aids Project	800-922-2437 (In California)
	Los Angeles Lesbian & Gay Community Services Center	213-464-7400
San Diego	San Diego Aids Project	619-543-0300
San Francisco	San Francisco Aids Foundation	415-853-2437
San Rafael	Marin Aids Support Network	415-457-2437
COLORADO Denver	Colorado Aids Project	303-837-0166
CONNECTICUT		
Hartford	Aids Project, Hartford	203-247-2437
New Haven	Aids Project, New Haven	203-624-2437
DELAWARE Wilmington	State Aids Program Office	800-422-0429 (In Delaware)
	Delaware Lesbian/Gay Health Advocates	same
DISTRICT OF COLUMBIA Washington	Aids Education Fund	202-332-5939
FLORIDA		
Fort Lauderdale	Aids Center One	800-325-5371
Miami	Health Crisis Network	305-634-4636
West Palm Beach	INFORUM	305-582-4357
ILLINOIS Chicago	Howard Brown Memorial Clinic Aids Action Project	312-871-5696 800-AID-AIDS (In Illinois)
IOWA Des Moines	Aids Project of Central Iowa Red Cross	800-445-2437 (In Iowa)

MARYLAND		
Baltimore	Health Education and Resources Organization (HERO)	301-685-1180
MASSACHUSETTS		
Boston	Aids Action Committee	800-235-2331 (In Massachusetts)
NEVADA		
Las Vegas	Aids for Aids of Nevada	702-369-6163
NEW MEXICO		
Santa Fe	New Mexico Aids Services	800-858-2437
NEW YORK		
Albany	Aids Council Of Northeastern New York	518-445-2437
Buffalo	Western New York Aids Project	716-847-2437
New York City	Department Of Health	718-HTLV-111
	Gay Men's Health Crisis	212-807-6655
Rochester	Adis Rochester	716-232-4430
Huntington Station	Long Island Association for Aids Care	516-385-2437
Syracuse	Central New York Aids Task Force	315-475-2437
OHIO		
Cleveland	Health Issues Task Force	216-651-1448
Columbus	Columbus Aids Task Force	614-224-0411
PENNSYVANIA		
Philadelphia	Philadelphia Aids Task Force	215-732-2437
TENNESSEE		
Nashville	Nashville CARES	615-321-0118
TEXAS		
Austin	Austin Aids Project	512-452-9550
Dallas	Aids Resource Center	214-521-5124
Houston	Aids Foundation	715-524-2437
UTAH		
Salt Lake City	Aids Project Utah	801-486-2437
WISCONSIN		
Milwaukee	Milwaukee Aids Project	800-334-24[illegible]

ORGANIZATIONS
SPECIFIC RESOURCES

FOR WOMEN

San Francisco Aids Foundation
Women's Program
Nancy Shaw, Coordinator
333 Valentia Street
San Francisco, California 94103
415-864-4376

AWARE
Ward 84
San Francisco General Hospital
995 Potrero Avenue
San Francisco, California 94110
415-476-4091

The Women's Aids Project
8235 Santa Monica Blvd.
West Hollywood, California 90046
213-650-1508

Aids Action Committee
Women at Risk Group
661 Boylston St.
Boston, Massachusetts 02116
617-437-6200
Contact: Pat Giulino

Gay and Lesbian Counseling Services Alternative Test Site
Hamilton Pl.
Boston, Massachusetts 02108
617-542-5188
Contact: Clay

Stuyvesant Polyclinic
Women and Aids Counseling Group
137 Second Av.
New York, New York 10003
313-674-0267
Contact: Dooley Worth

Minority Task Force on Aids of the Council of Churches of the City of New York
Suki Ports, Director
92 St. Nicholas Av.
New York, New York 10026
212-749-2816

Women and AIDS Project
1209 Decater St. NW
Washington D.C. 20011

FOR PARENTS

Mothers of Aids Patients Counseling hotlines:
Betty Clare Moffitt
213-450-6485 (Santa Monica, CA.)
Barbara Cleaver
213-530-2109 (Lomita, CA.)
Mary Jane Edwards
213-541-3134 (Redondo, CA.)

Materials:
When Someone You Love Has AIDS
by Betty Clare Moffitt
Available for $9.95 from
I.B.S. Press
2339 28th St.
Santa Monica, CA. 90405
213-450-6485

San Francisco Aids Foundation
333 Valencia St.
San Francisco, CA. 94103
415-864-4376
Support groups for parents

Gay Men's Health Crisis
254 W. 18th St.
New York, N.Y. 10011
212-807-6655
Support groups for parents

FOR DRUG ABUSERS

Haight Ashbury Free Medical Clinic
529 Clayton St.
San Francisco, CA. 94117
415-431-2450

Treatment Alternatives to Street Crimes
1500 N. Halsted St.
Chicago, IL. 60622
312-787-0208

Pregnancy and Addiction Program
Boston City Hospital
818 Harrison Av.
Boston, MA. 02118
617-424-5094

ADAPT
163 Joralemon St.
Brooklyn, N.Y. 11201
212-807-5560
Newsletter and brochures available

FOR HEMOPHILIACS

World Hemophilia Aids Center
2400 S. Flower St.
s Angeles, CA.. 90007
3-742-1357
Materials:
HEMOPHILIA WORLD, quarterly newsletter on
hemophilia and internation Aids research (free)

National Hemophilia Foundation
Resource and Consultation Center for AIDS/HIV Infection
Peggy Heine, M.S.W., Director
110 Greene St.
New York, N.Y. 10012
212-219-8180

FOR STUDENTS

American College Health Association
Task Force on Aids
15879 Crabbs WY.
Rockville, MD. 20855
301-963-1100
Materials:
THE AIDS DILEMMA: HIGHER EDUCATION'S RESPONSE (video)
AIDS ON THE COLLEGE CAMPUS (special report)
AIDS--WHAT EVERYONE SHOULD KNOW (pamphlet)

tlanta University Core Aids Education Committee
dolph E. Jackson, M.D., Chairman
Morehouse School of Medicine
720 Westview Dr. SW
Atlanta, GA. 30310
404-752-1500
Developing materials for Black colleges and other colleges

FOR HAITIANS

Haitian Coalition
Marie St. Cyr, Director
50 Court St.
Brooklyn, N.Y. 11201
718-855-0972
Education and Counseling

FOR HISPANICS

Hispanic AIDS Forum
oadway
rk, N.Y. 10003
73-7320

FOR PEOPLE WITH AIDS (PWA)

National Association of People with Aids
1012 14th St. NW
Washington, D.C. 20005
202-347-1317
Materials:
HINTS FOR THE NEWLY DIAGNOSED
A book of essays by Aids patients
Free to people with Aids; $5 for others

People With Aids Coalition
263A W. 19th St.
New York, N.Y. 10011
212-627-1810
Materials:
PWA COALITION NEWSLINE
A monthly newsletter free to people
with Aids and $20 annually for others

NATIONAL EDUCATIONAL CAMPAIGNS

American Red Cross
National Headquarters
17th and D Streets, NW
Washington, D.C. 20006
202-639-3220
Materials include:
BEYOND FEAR (3-part video)
Pamphlets on every aspect of Aids
Check local chapters for availability of home-nursing
course for those taking care of Aids patients

Southern Christian Leadership Conference
Adis Project
334 Auburn Av. NE
Atlanta, GA. 30303
404-533-1420
Pamphlets and videos on Aids and the Black community

SECTION FIVE

LEGISLATION AND CIVIL LIABILITY

HOUSE BILL NO. 1177.

BY REPRESENTATIVES Wham, Allison, Bond, Grampsas, Swenson, Anderson, Bowen, Chlouber, Entz, Epps, Fagan, Fish, Grant, Groff, Jenkins, Lawson, Masson, Owens, Reeser, Rupert, Taylor-Little, and S. Williams;
also SENATORS Allard, Bird, DeNier, Fowler, Lee, McCormick, Strickland, Traylor, and Trujillo.

CONCERNING THE DECLARATION OF HIV INFECTION, THE VIRUS WHICH CAUSES ACQUIRED IMMUNE DEFICIENCY SYNDROME, AS A COMMUNICABLE DISEASE, AND, IN CONNECTION THEREWITH, ESTABLISHING PROCEDURES FOR THE CONTROL OF THE DISEASE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 4 of title 25, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 14
HIV INFECTION AND ACQUIRED IMMUNE DEFICIENCY SYNDROME

25-4-1401. Legislative declaration. The general assembly hereby declares that infection with human immunodeficiency virus, the virus which causes acquired immune deficiency syndrome (AIDS), referred to in this part 14 as "HIV", is an infectious and communicable disease that endangers the population of this state. The general assembly further declares that reporting of HIV infection to public health officials is essential to enable a better understanding of the disease, the scope of exposure, the impact on the community, and the means of control and that efforts to control the disease should include public education, counseling, and voluntary testing and that restrictive enforcement measures should be used only when necessary to protect the public health. The general assembly further declares that the purpose of this part 14 is to protect the

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

public health and prevent the spread of said disease.

25-4-1402. Reports of HIV infection. (1) Every attending physician in this state shall make a report in writing to the state or local department of health, in a form designated by the state department of health, on every individual known by said physician to have a diagnosis of AIDS or HIV related illness, including death from HIV infection, within twenty-four hours after such fact comes to the knowledge of said physician.

(2) All other persons treating a case of HIV infection in hospitals, clinics, sanitariums, penal institutions, and other private or public institutions shall make a report to the state or local department of health, in a form designated by the state department of health, on every individual having a diagnosis of AIDS or HIV related illness, including death from HIV infection, within twenty-four hours after such fact comes to the knowledge of said person.

(3) Only one report shall be required for each individual having HIV infection.

(4) The reports required to be made under the provisions of subsections (1) and (2) of this section shall contain the name, date of birth, sex, and address of the individual reported on and the name and address of the physician or other person making the report.

(5) Good faith reporting or disclosure pursuant to this section or section 25-4-1403 shall not constitute libel or slander or a violation of the right of privacy or privileged communication.

(6) Any person who in good faith complies completely with this part 14 shall be immune from civil and criminal liability for any action taken in compliance with the provisions of this part 14. Compliance by a physician with the reporting requirements of this part 14 and with any regulations promulgated by the state department of health relating thereto shall fulfill any duty of such physician to a third party.

25-4-1403. Reports of HIV infection by laboratories. All clinical laboratories rendering diagnostic service shall report to the state department of health or appropriate local department of health, within twenty-four hours after diagnosis, the name, date of birth, sex, and address of any individual whose specimen submitted for examination tests positive for HIV antibody or virus. Such report shall include the test results and the name and address of the attending physician and any other person or agency referring such

positive specimen for clinical diagnosis.

25-4-1404. Use of reports. (1) The reports required to be submitted by sections 25-4-1402, 25-4-1403, and 25-4-1405 (8) and held by the state or local department of health or a health care provider or facility, third-party payor, physician, clinic, laboratory, blood bank, or other agency shall be strictly confidential medical information. Such information shall not be released, shared with any agency or institution, or made public, upon subpoena, search warrant, discovery proceedings, or otherwise, except under any of the following circumstances:

(a) Release may be made of medical or epidemiologic information for statistical purposes in a manner such that no individual person can be identified.

(b) Release may be made of medical or epidemiological information to the extent necessary to enforce the provisions of this part 14 and related rules and regulations concerning the treatment, control, and investigation of HIV infection by public health officials.

(c) Release may be made of medical or epidemiological information to medical personnel in a medical emergency to the extent necessary to protect the health or life of the named party.

(2) No officer or employee of the state or local department of health shall be examined in any judicial, executive, legislative, or other proceeding as to the existence or content of any individual's report retained by such department pursuant to this part 14 or as to the existence of the contents of reports received pursuant to sections 25-4-1402 and 25-4-1403 or the results of investigations in section 25-4-1405. This provision shall not apply to individuals who are under restrictive actions pursuant to section 25-4-1406 or 25-4-1407.

25-4-1405. Disease control by state and local health departments. (1) It is the duty of state and local health officers to investigate sources of HIV infection and to use every proper means to prevent the spread of the disease.

(2) It is the duty of state and local health officers, as part of disease control efforts, to provide public information, risk reduction education, confidential voluntary testing and counseling, educational materials for use in schools, and professional education to health care providers.

(3) The state department of health shall:

(a) Prepare and disseminate to health care providers circulars of information and presentations describing the epidemiology, testing, diagnosis, treatment, medical, counseling, and other aspects of HIV infection;

(b) Provide consultation to agencies and organizations regarding appropriate policies for testing, education, confidentiality, and infection control;

(c) Conduct health information programs to inform the general public of the medical and psychosocial aspects of HIV infection, including updated information on how infection is transmitted and can be prevented. The department shall prepare for free distribution among the residents of the state printed information and instructions concerning the dangers from HIV infection, its prevention, and the necessity for testing.

(d) Prepare and update an educational program on HIV infection in the workplace for use by employers;

(e) Develop and implement HIV education risk-reduction programs for specific populations at higher risk for infection; and

(f) Develop and update a medically correct AIDS prevention curriculum for use at the discretion of secondary and middle schools.

(4) School districts are urged to provide every secondary school student, with parental consent, education on HIV infection and AIDS and its prevention.

(5) It is the duty of every physician who, during the course of an examination, discovers the existence of HIV infection or who treats a patient for HIV infection to inform the patient of the interpretation of laboratory results and measures for preventing the infection of others.

(6) Any local health department, state institution or facility, medical practitioner, or public or private hospital or clinic may examine and provide treatment for HIV infection for any minor if such physician or facility is qualified to provide such examination and treatment. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination and treatment. The physician in charge or other appropriate authority of the facility or the licensed physician concerned shall prescribe an appropriate course of treatment for such minor. The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any

person other than the minor except for purposes of a report required under sections 25-4-1402, 25-4-1403, and 25-4-1405 (8) and a report containing the name and medical information of the minor made to the appropriate authorities if required by the "Child Protection Act of 1975", article 10 of title 19, C.R.S. If the minor is less than sixteen years of age or not emancipated, the minor's parents or legal guardians may be informed by the facility or physician of the consultation, examination, and treatment. The physician or other health care provider shall counsel the minor on the importance of bringing parents or guardians into the minor's confidence about the consultation, examination, or treatment.

(7) When investigating HIV infection, state and local health departments, within their respective jurisdictions, may inspect and have access to medical and laboratory records relevant to the investigation of HIV infection.

(8) (a) No physician, health worker, or any other person and no hospital, clinic, sanitarium, laboratory, or any other private or public institution shall test, or shall cause by any means to have tested, any specimen of any patient for HIV infection without the knowledge and consent of the patient; except that knowledge and consent need not be given:

(I) Where the health of a health care provider or a custodial employee of the department of corrections or the department of institutions is immediately threatened by exposure to HIV in blood or other bodily fluids;

(II) When a patient's medical condition is such that knowledge and consent cannot be obtained;

(III) When the testing is done as part of seroprevalence surveys if all personal identifiers are removed from the specimens prior to the laboratory testing;

(IV) When the patient to be tested is sentenced to and in the custody of the department of corrections or is committed to the Colorado state hospital and confined to the forensic ward or the minimum or maximum security ward of such hospital.

(b) Any patient tested for HIV infection pursuant to this subsection (8) without his knowledge and consent shall be given notice promptly, personally, and confidentially that a test sample was taken and that the results of such test may be obtained upon his request.

25-4-1406. Public health procedures for persons with HIV infection. (1) Orders directed to individuals with HIV infection or restrictive measures on individuals with HIV

infection, as described in this part 14, shall be used as the last resort when other measures to protect the public health have failed, including all reasonable efforts, which shall be documented, to obtain the voluntary cooperation of the individual who may be subject to such an order. The orders and measures shall be applied serially with the least intrusive measures used first. The burden of proof shall be on the state or local health department to show that specified grounds exist for the issuance of the orders or restrictive measures and that the terms and conditions imposed are no more restrictive than necessary to protect the public health.

(2) When the executive director of the state department of health or the director of the local department of health, within his respective jurisdiction, knows or has reason to believe, because of medical or epidemiological information, that a person has HIV infection and is a danger to the public health, he may issue an order to:

(a) Require a person to be examined and tested to determine whether he has HIV infection;

(b) Require a person with HIV infection to report to a qualified physician or health worker for counseling on the disease and for information on how to avoid infecting others;

(c) Direct a person with HIV infection to cease and desist from specified conduct which endangers the health of others, but only if the executive director or director has determined that clear and convincing evidence exists to believe that such person has been ordered to report for counseling as provided in paragraph (b) of this subsection (2) and continues to demonstrate behavior which endangers the health of others.

(3) If a person violates a cease and desist order issued pursuant to paragraph (c) of subsection (2) of this section and it is shown that the person is a danger to others, the executive director of the state department of health or the director of the local department of health may enforce the cease and desist order by imposing such restrictions upon the person as are necessary to prevent the specific conduct which endangers the health of others. Any restriction shall be in writing, setting forth the name of the person to be restricted and the initial period of time, not to exceed three months, during which the order shall remain effective, the terms of the restrictions, and such other conditions as may be necessary to protect the public health. Restrictions shall be imposed in the least restrictive manner necessary to protect the public health. The executive director or the director issuing an order pursuant to this subsection (3) shall review petitions for reconsideration from the person affected by the

order. Restriction orders issued by directors of local departments of health shall be submitted for review and approval of the executive director of the state department of health.

(4) (a) Upon the issuance of any order by the state or local department of health pursuant to subsection (2) or (3) of this section, such department of health shall give notice promptly, personally, and confidentially to the person who is the subject of the order stating the grounds and provisions of the order and notifying the person who is the subject of the order that he has a right to refuse to comply with such order and a right to be present at a judicial hearing in the district court to review the order and that he may have an attorney appear on his behalf in said hearing. If the person who is the subject of the order refuses to comply with such order and refuses to cooperate voluntarily with the executive director of the state department of health or the director of the local department of health, the executive director or local director may petition the district court for an order of compliance with such order. The executive director or local director shall request the district attorney to file such petition in the district court, but, if the district attorney refuses to act, the executive director or local director may file such petition and be represented by the attorney general. If an order of compliance is requested, the court shall hear the matter within ten days after the request. Notice of the place, date, and time of the court hearing shall be made by personal service or, if the person is not available, shall be mailed to the person who is the subject of the order by prepaid certified mail, return receipt requested, at his last-known address. Proof of mailing by the state or local department of health shall be sufficient notice under this section. The burden of proof shall be on the state or local department of health to show by clear and convincing evidence that the specified grounds exist for the issuance of the order and for the need for compliance and that the terms and conditions imposed therein are no more restrictive than necessary to protect the public health. Upon conclusion of the hearing, the court shall issue appropriate orders affirming, modifying, or dismissing the order.

(b) If the executive director or local director does not petition the district court for an order of compliance within thirty days after the person who is the subject of the order refuses to comply, such person may petition the court for dismissal of the order. If the district court dismisses the order, the fact that such order was issued shall be expunged from the records of the state or local department of health.

(5) Any hearing conducted pursuant to this section shall be closed and confidential, and any transcripts or records

relating thereto shall also be confidential.

25-4-1407. Emergency public health procedures. (1) When the procedures of section 25-4-1406 have been exhausted or cannot be satisfied as a result of threatened criminal behavior and the executive director of the state department of health or the director of a local department of health, within his respective jurisdiction, knows or has reason to believe, because of medical information, that a person has HIV infection and that such person presents an imminent danger to the public health, the executive director or local director may bring an action in district court, pursuant to rule 65 of the Colorado rules of civil procedure, to enjoin such person from engaging in or continuing to engage in specific conduct which endangers the public health. The executive director or local director shall request the district attorney to file such action in the district court, but, if the district attorney refuses to act, the executive director or local director may file such action and be represented by the attorney general.

(2) Under the circumstances outlined in subsection (1) of this section, in addition to the injunction order, the district court may issue other appropriate court orders including, but not limited to, an order to take such person into custody, for a period not to exceed seventy-two hours, and place him in a facility designated or approved by the executive director. A custody order issued for the purpose of counseling and testing to determine whether such person has HIV infection shall provide for the immediate release from custody and from the facility of any person who tests negative and may provide for counseling or other appropriate measures to be imposed on any person who tests positive. The person who is the subject of the order shall be given notice of the order promptly, personally, and confidentially stating the grounds and provisions of the order and notifying such person that he has a right to refuse to comply with such order and a right to be present at a hearing to review the order and that he may have an attorney appear on his behalf in said hearing. If such person contests testing or treatment, no invasive medical procedures shall be carried out prior to a hearing being held pursuant to subsection (3) of this section.

(3) Any order issued by the district court pursuant to subsection (2) of this section shall be subject to review in a court hearing. Notice of the place, date, and time of the court hearing shall be given promptly, personally, and confidentially to the person who is the subject of the court order. Such hearing shall be conducted by the court no later than forty-eight hours after the issuance of the order. Such person has a right to be present at the hearing and may have an attorney appear on his behalf in said hearing. Upon

conclusion of the hearing, the court shall issue appropriate orders affirming, modifying, or dismissing the order.

(4) The burden of proof shall be on the state or local department of health to show by clear and convincing evidence that grounds exist for the issuance of any court order pursuant to subsection (1) or (2) of this section.

(5) Any hearing conducted by the district court pursuant to subsection (1) or (2) of this section shall be closed and confidential, and any transcripts or records relating thereto shall also be confidential.

(6) Any order entered by the district court pursuant to subsection (1) or (2) of this section shall impose terms and conditions no more restrictive than necessary to protect the public health.

25-4-1408. Rules and regulations. The state board of health may adopt such rules and regulations as are in its judgment necessary to carry out the provisions of this part 14.

25-4-1409. Penalties. (1) Any attending physician or other health care provider required to make a report pursuant to section 25-4-1402, or any clinical laboratory required to make a report pursuant to section 25-4-1403, who fails to make such a report commits a class 2 petty offense and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars.

(2) Any physician or other health care provider, any officer or employee of the state department or local departments of health, or any person, firm, or corporation which violates section 25-4-1404 by releasing or making public confidential medical information or by otherwise breaching the confidentiality requirements of said section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than five hundred dollars nor more than five thousand dollars or by imprisonment in the county jail for not less than six months nor more than twenty-four months, or by both such fine and imprisonment.

25-4-1410. Repeal of part. (1) This part 14 shall be repealed, effective July 1, 1990, unless the general assembly, acting by bill, continues said part 14.

(2) As part of his other department of health reviews to be done in 1989, the state auditor shall conduct an analysis and evaluation of the regulatory provisions of this part 14. Such analysis and evaluation shall be completed by January 1, 1990, and a written report based upon the analysis and

evaluation, along with such supporting materials as may be requested, shall be submitted by the state auditor to the general assembly no later than January 15, 1990.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Carl B. Bledsoe
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Ted L. Strickland
PRESIDENT OF
THE SENATE

Lee C. Bahrych
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Marjorie L. Nielson
SECRETARY OF
THE SENATE

APPROVED June 8, 1987 at 2:11 PM

Roy Romer
GOVERNOR OF THE STATE OF COLORADO

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the
Regional Manager
Office for Civil Rights

Region VIII
Federal Office Building
1961 Stout Street
Denver, Colorado 80294

For information contact:

Vada Kyle-Holmes, Regional Manager
(303) 844-2024

Duane Niemczyk, AIDS Coordinator
(303) 844-4774

YOUR RIGHTS AS A PERSON WITH AIDS OR RELATED CONDITIONS

Persons with Acquired Immune Deficiency Syndrome (AIDS) or related conditions who feel they have been discriminated against on the basis of handicap may file a complaint with the Office for Civil Rights, U. S. Department of Health and Human Services. Section 504 of the Rehabilitation Act of 1973 prohibits discrimination based on the disabling effects of AIDS or related conditions. In addition, it prohibits discrimination against persons who are regarded as having a handicapping condition. Section 504 applies to employers and organizations which receive Federal financial assistance from any Federal department or agency, including the Department of Health and Human Services.

WHAT IS DISCRIMINATION AGAINST PEOPLE WITH AIDS OR RELATED CONDITIONS?

Section 504 of the Rehabilitation Act prohibits discrimination "solely by reason of ...handicap" against any otherwise qualified handicapped person in any program or activity receiving Federal funds or conducted with Federal funds. People with AIDS or related conditions have been terminated from their jobs, denied access to services, or denied medical treatment because of their handicapping condition. Such discrimination may be illegal if the institution or organization receives Federal funds.

WHAT CAN YOU DO IF YOU HAVE BEEN DISCRIMINATED AGAINST?

If you, as a person with AIDS or a related condition, feel that you have been discriminated against on the basis of handicap, you may file a complaint with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. OCR is authorized to investigate and resolve complaints of discrimination. Once a complaint is lodged with OCR, the law prohibits the alleged discriminating party from taking any retaliatory actions against a complainant or any person who provides information to OCR regarding a complaint. OCR should be notified immediately in the event of retaliatory action. Under Section 504, you also have the right to consult a private attorney and to seek relief through the filing of a private lawsuit against the organization that you allege discriminated against you.

(over)

AIDS CONTINUED

Haldon Makler, MD, of the World Health Organization, estimates 10 million people may currently be HIV-positive, and unless strong preventive measures are taken, the infected population could reach 100 million in five years.

THE FINANCIAL COSTS

According to *Public Health Reports*, national personal medical care expenditures for AIDS treatment is expected to rise from $630 million in 1985 to $8.5 billion in 1991.

AIDS TESTING

The most accurate indicator of AIDS virus is the presence of the AIDS antibody in blood, since the virus itself cannot be routinely identified with available blood tests. It is believed that most, if not all, people who test positively for the antibody (HIV-positive) are actively infected with the virus and capable of transmitting it to others.

"In about two to four weeks, after an individual is exposed to HIV, antibodies develop. A person is generally most infectious before the antibodies develop, but remains so afterwards as well," explains Dr. Miguel Mogyoros, Kaiser Permanente infectious disease consultant and internist at the Lakewood Medical Office. "With an HIV-positive we assume the person still carries the virus."

Kaiser Permanente will test members who request it if they think they have been exposed, are at high risk or had a blood transfusion between 19[illegible] and 1985. (Saint Joseph Hospital will test patients who had transfusions there.) All blood donations are now routinely tested for HIV. If the test is HIV-positive, a Western Blot — a more definative test is done to confirm the results. The tests are simple blood draws. The first test results take about one week and the Western Blot takes about two weeks.

The personal physician counsels those who tested HIV-positive about the possibility of developing AIDS or AIDS-Related Complex (ARC), about safe sex, promiscuity and IV drug use.

"Here at Kaiser Permanente we take stringent measures to assure confidentiality for AIDS patients and those testing HIV-positive," Dr. Mogyoros explains. "It is a reportable test, but under state law, an HIV test result must be kept confidential."

AIDS GLOSSARY

AIDS: Acquired Immune Deficiency Syndrome

ARC: AIDS-Related Complex

HIV: Human Immunodeficiency Virus. This was formerly called Human T Lymphotrophic Virus, Type III (HTLV-III). Occasionally the laboratory test is still called HTLV-III, however, HIV is the official name for the AIDS virus.

AZT: drug Zidovudine, brand name Retrovir.

Immune System: the body's ability to recognize and defend itself from foreign substances such as bacteria and viruses.

Antibody: A substance produced by the body's immune system to fight infection.

TREATING AIDS

Currently, no antiviral drugs exist that cure AIDS, although research for such drugs, as well as a vaccine is speeding ahead. However, HIV is like no other virus for which vaccines have been developed. HIV is extremely complex genetically and has the capacity to mutate to a multitude of variants. As a result, there is no guarantee that researchers will ever be able to make a safe and effective AIDS vaccine.

The drug Zidovudine (AZT), brand-named Retrovir, was recently made available for some AIDS patients. Retrovir is distributed by its manufacturer, Burroughs Wellcome, which claims the $8,000 to $10,000 a year price tag is necessary to reclaim its development costs of more than $80 million. AIDS patients who have suffered Pneumocystis carinii pneumonia or show a low level of a particular type of white blood cells because of attack by the virus seem to benefit the most from the drug, and are the first eligible to receive it. Retrovir pro longs some AIDS patients' lives but its toxicity makes it intolerable for some patients. Physicians treating AIDS patients apply directly to Burroughs Wellcome — in effect "registering" the patients with the company. Upon approval, Kaiser Permanente members with AIDS who fit the criteria obtain Retrovir through our pharmacies. This process takes about three to four weeks according to Dr. Mogyoros. Approximately 80 percent of our members have prescription drug coverage, and Retrovir is covered for approved AIDS patients as is any other drug. "This drug helps the symptoms, but is not a cure," Dr. Mogyoros emphasizes.

PREVENTION

"The need for education (about AIDS and HIV) is enormous if not overwhelming," Dr. Mogyoros says. "The initial hysteria and paranoia seem to be over and

CONTINUED

Planning For Health

SUMMER 1987

KAISER PERMANENTE

AIDS
Fight fear with facts

"Heterosexuals and AIDS: The second stage of the epidemic."
"Two-thirds of '82 Colorado AIDS patients now dead"
"AIDS education brings drop in new Chicago cases"
"AIDS Update: Grim statistics and small successes."

These are just a sample of the alarming headlines that have appeared in recent months as the media attempts to tell the story of the most deadly epidemic of our time. We've learned that at the end of April, there were 35,068 reported cases of acquired immune deficiency syndrome (AIDS) in the U.S. and 370 in Colorado. The death toll so far is 20,241, and because there is no known cure for the disease, the rest are expected to die.

We've also learned that the Centers for Disease Control (CDC) estimates that 1.5 million Americans have been exposed but not yet stricken by the AIDS virus. It is not known whether all these people could infect others.

In this issue of *Planning for Health*, we will address AIDS background, its spread scope and costs, testing for it and preventing it, as we understand it today.

BACKGROUND

Just what is AIDS? It was first identified in 1981 when physicians in New York and California reported the deaths of a few dozen homosexual men from Kaposi's sarcoma, a rare form of cancer, and noted that they also had abnormalities of the immune system. Scientists were unsure of the cause of the disease, which was also identified as a killer of intravenous (IV) drug users. In 1983, the virus — now called human immunodeficiency virus (HIV) — was isolated. The origin of the disease is unknown.

Since the CDC in Atlanta began tracking the disease in 1981, they have been trying to define the deadly syndrome. They have revised their original description several times to reflect new knowledge.

SPREADING AIDS

Although 90 percent of the United States AIDS patients are those in the high risk groups — homosexual or bisexual men or intravenous (IV) drug users, it is not their disease alone: AIDS threatens millions of Americans. HIV is currently believed to be spread in four ways: (1) sexual contact and contact with other bodily secretions; (2) sharing intravenous needles with someone infected with HIV; (3) receiving HIV-infected blood products or blood transfusions; (4) being born to a mother with the virus. Close, nonsexual contact with HIV-infected persons in the home, school and workplace does not appear to put uninfected people at risk.

However, the CDC recently reported that three hospital workers are believed to have contracted the AIDS virus through blood spilled on their skin. But the health authorities believe that the women contracted the virus because they had chapped skin, dermatitis or breaks in the skin through which the virus might have passed. And in another recent development, transplanted organs gave two recipients the virus.

Officials at the CDC say that there is "still no evidence that the AIDS virus could be transmitted through casual contact."

THE SCOPE

The federal government predicts that by the end of 1991, diagnosed AIDS cases will number 270,000 in the United States and 179,000 will have died unless more effective treatment is found. According to the *New York Times*, the 54,000 Americans expected to die of AIDS in the year 1991, represents an annual loss comparable to the death toll of the entire Vietnam War. Worldwide predictions vary.

CONTINUED

OCTOBER 1987

POLICE

THE LAW OFFICER'S MAGAZINE

AIDS: Fact vs. Fiction

Police officers all over the world are coming into contact with the frightening and mysterious disease known as AIDS. The illness, technically described as Acquired Immune Deficiency Syndrome, appears to have come out of nowhere and is wreaking havoc on all areas of society.

Unfortunately, as the number of reported AIDS cases grows, so too, does the number of myths surrounding its transmission. There are tales of breathing the virus in from the air, contracting it from mosquito bites, telephones, hugs, handshakes...ad infinitum. All of these stories stem from one thing: lack of education.

In an attempt to rectify the problem of fact versus fiction, the National Institute of Justice has issued a report that provides AIDS information and policy recommendations for members of the law enforcement profession. The report, which emphasizes that AIDS is not passed on through casual contact, encourages police departments to develop clear-cut policies dealing with people infected by the virus. This, states James K. Stewart, director of the institute, is because law enforcement officers are in frequent contact with high-risk subjects, such as drug addicts and prostitutes.

Although there are no documented cases of police officers having contracted a Human Immunodeficiency Virus infection in the performance of their duties, it is suggested that police departments establish procedures that closely follow the guidelines developed by the Centers for Disease Control to prevent HIV transmission. Such procedures include thorough hand washing after contact with any individual known or suspected of being infected with HIV; the use of protective gloves if there is a likelihood of contact with the blood or bodily fluids of an individual known or suspected of being infected; and the prompt cleanup of blood or fluid spills with a 1:9 solution of household bleach.

Many departments have already established guidelines for AIDS control. In Colorado, for example, the Denver Police Department has initiated its own Infectious Disease Control Program. The program, developed by Sergeant Wayne Dudley, includes specialized disinfecting protocols for vehicles and clothing and the use of CPR masks. The department is also using bio-hazard bags to incinerate all contaminated materials. Anyone in the department who is contaminated by any bodily fluids is treated as if those fluids are AIDS infected, according to Bobbet Hines, the Infectious Disease Control coordinator.

One of the central problems associated with AIDS is a tendency to overreact when faced with the disease. This reaction is often due to fear caused by ignorance. For instance, much of the controversy surrounding AIDS children in school stems from the fallacy that they may bite their classmates and transmit the disease. However, the danger of infection through bites, not to mention children deliberately biting their classmates, is extremely remote. The report states that the HIV virus has been isolated in very small concentrations in saliva. This information is important to police officers, as they are often in situations where arrestees are spitting and biting.

It is essential that law enforcement personnel receive regular education presenting the up-to-date facts about possible HIV infections.

"As with any other crisis," Stewart says, "rumor and misinformation pose a great threat to public safety. Accurate information can improve understanding of the disease and its transmission, thus enabling law enforcement workers to effectively perform their duties."

To obtain a copy of the report, "AIDS and the Law Enforcement Officer: Concerns and Policy Responses," contact the National Criminal Justice Reference Service, P.O. Box 6000, Rockville, MD 20850.

—Tara C. Regan

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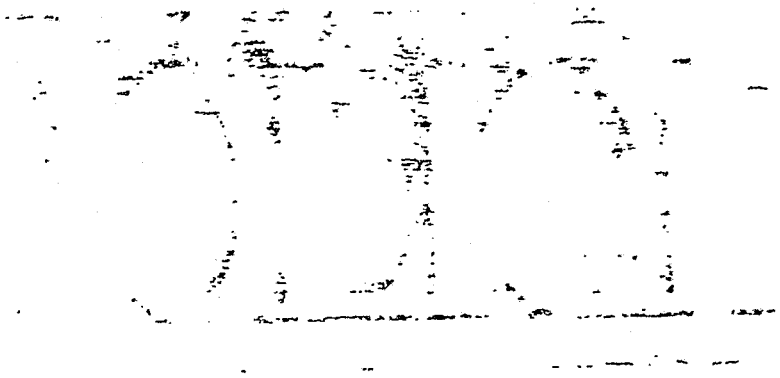

SECTION SIX

EDUCATIONAL PUBLICATIONS AND PRINT MEDIA

CASE RULE

Where a patient with an infectious disease was not advised about the nature of the condition, resulting in another person contracting the infection, the hospital where she was admitted had no legal duty to advise her. The court found this to be the responsibility solely of the treating physician. Otherwise, imposing such a legal duty on the hospital could require the hospital to interfere with the relationship between physician and patient. *Derrick v. Ontario Community Hospital, 47 CA3d 145, 120 CR 566 (1975).*

§1B-5. FAILURE TO GIVE WARNING
§1B-5.3 WARNING OTHER PEOPLE

SYNOPSIS

If a patient's condition creates a danger to others, the health care provider may be required to notify appropriate persons.

CASE RULES

If a health care provider is or should be able to reasonably foresee that the patient poses a danger to another person, the health care provider must use reasonable care to protect the other person. Depending on the circumstances, such care may require warning the potential victim or others who can reasonably be expected to transmit the warning, or notifying the police. In a case involving a psychotherapist and a homicidal patient, when the psychotherapist determined or should have determined that a patient posed a serious danger of violence to another, the psychotherapist had a legal duty to exercise reasonable care to protect the foreseeable victim from that danger. *Tarasoff v. Regents of the University of California, 17 C3d 425, 131 CR 14 (1976). BAJI 6.00.1.*

The therapist is not liable for injuries caused by his patient if his judgment proves wrong, so long as his judgment was reasonable under the circumstances. *Mavroudis v. Superior Court — County of San Mateo, 102 CA3d 594, 162 CR 724 (1980).*

A foreseeable victim need not be specifically named to be identifiable for the purpose of giving warning. *Mavroudis v. Superior Court — County of San Mateo, 102 CA3d 594, 162 CR 724 (1980).*

DISCUSSION

This rule was first promulgated for a situation involving a psychotherapist with a patient homicidal toward a specific victim. In order to remain consistent, however, with the purpose for the rule, future courts may enlarge the meaning of "identifiable victim" to include everyone in a group (eg., all the occupants of a building which a patient threatens to burn, or all the passengers on a commercial airliner which a patient threatens to bomb).

CASE RULES

The requirement to give warning applied in a case where defendant psychologists failed to warn the plaintiff's mother of threats of violence against her made by their patient. The minor plaintiff was then injured in an attack on his mother by the patient. Since the attack on the mother, and incidental injury to her child, were considered foreseeable, the defendant psychologists could be found liable for their failure to warn. *Hedlund v. Superior Court of Orange County, 34 C3 695, 194 CR 805 (1983).*

The duty of the health care provider to give warning to others is limited to situations where the patient creates a danger of injury to another person. It does not apply where the risk is of self-inflicted harm to the patient or mere property damage. *Bellah v. Greenson, 81 CA3d 614, 148 CR 535 (1977).*

The duty to warn applies only where the danger is serious and imminent. *Mavroudis v. Superior Court — County of San Mateo, 102 CA3d 594, 162 CR 724 (1980).*

DISCUSSION

The court in the *Mavroudis* case, above, did not define "serious" or "imminent" for the purposes of this rule. "Serious" probably means capable of causing substantial physical harm to a person. "Imminent" probably means likely to happen within hours or days rather than weeks or months.

CASE RULE

Where the circumstances are such that giving warning is not practical, there is no requirement to give warning. A hospital had no legal duty to warn others of the danger arising from the hospital discharge of a patient with a contagious disease because there is no practical way a hospital could give warning to all the people who might be affected. *Derrick v. Ontario Community Hospital, 47 CA3d 145, 120 CR 566 (1975).*

DISCUSSION

The statement in the *Derrick* case, above, refers to a duty to notify potential victims, and should be distinguished from the duty to notify the Department of Health which is required by statute.

Most of the cases dealing with the duty to warn other people have involved psychotherapists with dangerous patients. The same rules can be expected to apply, however, to any health care provider whose patients endanger others due to their physical conditions. Harm is foreseeable when a patient informs the health care provider that he will continue to operate heavy machinery at work despite the knowledge that a medical disorder or medication makes such conduct hazardous to fellow employees. A telephone call to the employer by the health care provider would probably result in action to protect the foreseeable victims, and may be the health care provider's legal duty. Even the patient who insists on driving home from the hospital while still sedated, posing an imminent danger to every other person on the road, can often be prevented from driving by a telephone call to the police. Such warning is practical, and if timely, can effectively protect potential victims as well as the patient.

§1B-5. FAILURE TO GIVE WARNING
§1B-5.4 CONTROLLING PATIENT CONDUCT

SYNOPSIS

Although patients and others can be warned about dangerous mental disorders, health care providers cannot control the patient's conduct outside of a hospital.

CASE RULES

A health care provider has no legal duty to control the conduct of a patient whose medical condition may endanger others. *Myers v. Quesenberry, 144 CA3d 888, 193 CR 735 (1983).*

There is no legal authority to control the dangerous conduct of a patient outside a hospital. A patient on medications capable of affecting the operation of an automobile, who was warned by a physician about the danger of driving, was permitted to drive away from the hospital and struck the plaintiff's automobile. There was no liability of the hospital for permitting the patient to drive since the hospital had no legal authority to control the patient's conduct. *Harland v. State of California, 75 CA3d 475, 142 CR 201 (1977).*

DISCUSSION

Direct control over the patient should be distinguished from the exercise of indirect control through notification of a law enforcement agency. In some cases, there may be a legal duty to notify the police. See §1B-5.3.

CASE RULE

Within a hospital, the hospital must exercise reasonable care toward a patient as required by the patient's physical and mental condition. If the hospital is on notice that the patient would be likely to harm himself or others unless preclusive measures are taken, then the hospital must use reasonable care to prevent such harm. *Tarasoff v. Regents of the University of California, 17 C3d 425, 131 CR 14 (1976). Vistica v. Presbyterian Hospital, 67 C2d 465, 62 CR 577 (1967).*

DISCUSSION

The requirement of preclusive measures, above, suggests that hospital personnel are obligated to take appropriate precautions or to use reasonable physical force to prevent patients from harming themselves or others.

Employees of some City departments, in the course of their duties, may come into close contact with persons who have AIDS or the virus. Those departments already have taken action to protect their employees. Workers in Health and Hospitals, Safety and Social Services should be familiar with their department's policies. This includes implementing procedures for proper disposal of blood products, needles and other contaminated items at DGH and providing special mouth-to-mouth resuscitation devices to the county jail, police, firefighters, and paramedics.

To further inform City employees and the community at large, a program about AIDS will be broadcast on Mile Hi Cable Channel 58, the City government channel, eight times in the next four weeks. This informative half-hour program is a discussion about AIDS by two Health & Hospitals experts, Dr. Frank Judson, Director of Disease Control, and Dr. Norm Dinerman, Medical Director of the Paramedic Division.

The program will be broadcast prior to City Council Meetings on March 24, March 31, April 7, and April 14 at 6:00 p.m. and after the Mayor's Press Conference on March 26, April 2, April 9 and April 16 at 6:00 p.m.

The program is available on 3/4 or 1/2" video tape to use in training sessions in all City work places. Supervisors are being encouraged to arrange showings in the work place for those employees who do not see the program on Channel 58. The video tape may be borrowed from the Department of Health & Hospitals by calling Bob Van Cleave, Training Director, DHH, 893-7733.

In the future a training presentation on AIDS will be part of regular supervisory training conducted by the Career Service Authority. All city employees with supervisory responsibilities are encouraged to attend a training session on this topic.

Federico Peña
MAYOR

City and County of Denver
CITY AND COUNTY BUILDING • DENVER, COLORADO • 80202
TELEPHONE (303) 575-2721

March 25, 1984

MAYOR'S AIDS TASK FORCE

Several months ago Mayor Peña established a task force to study issues surrounding Acquired Immune Deficiency Syndrome (AIDS disease) and its possible impact on City employees. The task force looked at what policies the City should enact to protect its employees from any risk of acquiring the AIDS-causing HTLV-III virus while doing their jobs.

After a review of all aspects of AIDS, including how the virus is transmitted and the guidelines being provided to employers by the medical community, the task force concluded that the City should follow the guidelines distributed by the National Centers for Disease Control (CDC). Departments having special circumstances, i.e., Departments of Health and Hospitals, Social Services and Safety have developed individual policy and procedure statements.

Concurrently, the Board of Health and Hospitals endorsed, for use by all employers in Denver, the guidelines established by the CDC concerning prevention of transmission of the HTLV-III (AIDS) virus in the work place. These decisions are also endorsed by the Mayor and the Career Service Board.

The CDC emphasizes that the virus is not spread by "the kinds of non-sexual, person-to-person contact that occurs among workers, clients and consumers in the work place." It also states that HTLV-III virus "is not transmitted through preparation or serving of food and beverages." Studies indicate that only 5 to 20 per cent of those infected with the HTLV-III virus will develop AIDS.

The CDC guidelines explain that workers known to be infected with the HTLV-III virus need not be restricted from work on this account, nor should they be restricted from using telephones, office equipment, toilets, showers, eating facilities or water fountains.

Because there is no hazard of transmitting the HTLV-III virus through normal social contact, persons who test positive for the virus or who have AIDS are not a danger to others and may continue their employment without restriction. In fact, discrimination by employers or supervisors against such persons may violate State and Federal law because several courts have determined that AIDS is a handicap.

AIDS CONTINUED

now we must concentrate on educating health care providers, the community and the patient."

The U. S. Public Health Service recommends that the following steps be taken to prevent the spread of HIV infection and AIDS:

Recommendation for the General Public

- Don't have sex with multiple partners or with persons who have had multiple partners (including prostitutes).
- Avoid sex with persons with AIDS, members of the risk groups or persons who have had an HIV-positive result. If you do have sex with a person you think is infected, protect yourself by taking appropriate precautions to prevent contact with the person's body fluids. ("Body fluids"include blood, semen, urine, feces, saliva, and women's genital secretions.)
- Use condoms, which may reduce the possibility of transmitting the virus.
- Avoid practices that may injure body tissues (for example, anal intercourse).
- Avoid oral-genital contact.
- Avoid open-mouthed, intimate kissing.
- Don't use intravenous drugs. If you do, don't share needles or syringes.

Recommendations for Persons at Increased Risk*

Those at increased risk of infection should follow all of the recommendations given above for the general public. In addition, because it is possible to carry HIV without knowing it and thus transmit it to others, the following recommendations should also be heeded:

- Consult your physician for counseling. Ask to take the HIV antibody test.
- During sexual intercourse, protect your partner from contact with your body fluids.
- Don't donate blood, plasma, body organs, other body tissue, or sperm.

*Persons at increased risk of HIV infection include: homosexual and bisexual men; present or past intravenous drug users; male or female prostitutes and their sex partners; persons with hemophilia who have received clotting factor products.

Recommendations for Persons With a Positive HIV Antibody Test

- Seek regular medical evaluation and followup.
- Either avoid sexual activity or inform your prospective partner of your antibody test results and protect him or her from contact with your body fluids during sex. Use a condom, and avoid practices that may injure body tissues (for example, anal intercourse). Avoid oral-genital contact and open-mouthed, intimate kissing.
- Inform your present and previous sex partners, and any persons with whom needles may have been shared, of their potential exposure to HIV.
- Don't share toothbrushes, razors, or other items that could become contaminated with blood.
- If you use drugs, enroll in a drug treatment program. Needles and other drug equipment must never be shared.
- Clean blood or other body fluid spills on house hold or other surfaces with freshly diluted household bleach — 1 part bleach to 10 parts water. (Don't use bleach on wounds.)

Miguel Mogyoros, MD, Kaiser Permanente infectious disease consultant

ADDITIONAL RESOURCES

Please discuss your concerns and questions with your Kaiser Permanente physician. For further information about AIDS and HIV antibody testing contact the following organizations:

The Colorado Department of Health (303) 331-8305
Call 24 hours a day, seven days a week for the times and locations of confidential HIV antibody test sites.

The Colorado AIDS Project (303) 837-0166
Provides support group services for persons with AIDS, HIV infection, their friends and loved ones.

Center for Disease Control AIDS Hotline 1 (800) 342-AIDS
For a free copy of the Surgeon General's report on AIDS, write: AIDS, Box 24252, Washington, D.C. 20044; or call (202) 245-6867.

AIDS CONTINUED

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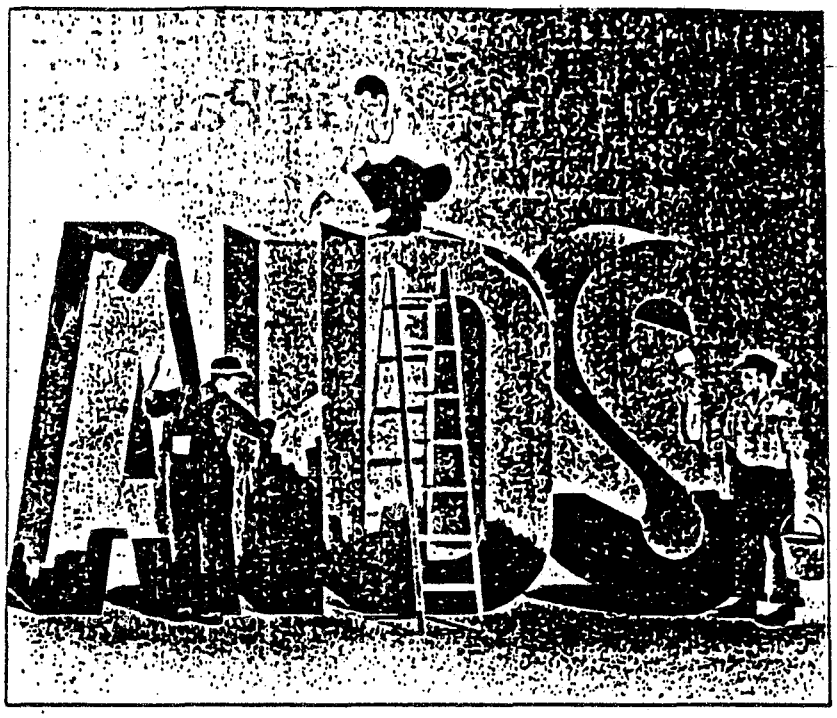
CALIFORNIA
NURSING TODAY
July / August

HOME STUDY
C.E.

Earn 4 CE hours:
Read "Diabetes" course, p.35

Is there an AIDS COVER-UP?

Nursing Today takes a long look at AIDS and the working nurse



NT interviews
Gene Antonio, author of the controversial new book,

"The AIDS Cover-Up? The Real & Alarming Facts About AIDS"

By Modesta S. Orque, BSN, MPH, Ed.D.

"Three health care workers get AIDS virus after skin contact with infected blood," "Sixty-nine percent of hospital doctors surveyed believe they can get AIDS from their patients," "New African AIDS virus threatens blood supply...."

In light of these and other recent revelations surrounding the deadly disease, *Nursing Today* asked Advisory Board Member Modesta S. Orque to interview the author of the controversial new book, "The AIDS Cover-Up? The Real and Alarming Facts About AIDS," authored by Gene Antonio and published by Ignatius Press. This interview does *not* reflect in any way the opinions of the interviewer or Nursing Today Magazine. Rather, it is published in an effort to provide a forum to our readers for the presentation and discussion of items of concern to them.

Dr. Modesta S. Orque for Nursing Today (NT): Let me begin by asking you, Mr. Antonio, what were your reasons for writing the book?

Gene Antonio (GA): I wrote the book because of my compassion for people who are stricken with this disease, and for the American public.

NT: What does the title mean? Is there an AIDS cover-up?

GA: Yes, there is a cover-up. There are certain facts about AIDS that the public has not been informed.

NT: Why do you think there is a cover-up?

GA: Because of lack of courage on the part of officials to deal with AIDS and because of political pressure from pro-homosexual groups.

NT: From the subtitle of your book, what are the "real and alarming facts" about AIDS which you present in the book?

GA: I included facts that you would generally not hear of from the media or from the medical establishment. For example, we're still being told that people do not die of AIDS, they only die of all the diseases they can't fight off as a result of a weakened immune system--from opportunistic infections. These are categorically inaccurate. Researchers have known for over two years that the virus itself invades the cerebral spinal fluid, central nervous system and causes dementia--a progressive brain disease. There was an article recently in which it was admitted that 30 percent of asymtomatic male homosexuals who are infected with HIV are developing mental impairments. This is catastrophic and has enormous ramifications in terms of employment. Do you want an airplane pilot or physician or surgeon or nurse or bus driver for that matter who is slowly losing their short-term memory, muscular coordination, and suffering from mental confusion? Should they be allowed to put other people's lives at risk? I think this is a major consideration.

NT: What facts about AIDS do you find most alarming?

GA: Besides the fact I mentioned earlier that people are not being informed that the AIDS virus kills directly by invading the brain and the central nervous system, I also included several facts in my book. One is that everyone (who is infected) is likely to be dead or dying within five to ten years after the infection occurs. *Everyone*, not merely a minority. And, the disease is spreading exponentially. By 1991, Halfdian Mahler, M.D., Director of the World Health Organization (WHO), has stated that there will be 100 million people infected worldwide. In a little publicized report, Dr. James Curran of the Centers for Disease Control (CDC) admitted, "In many areas, the number of persons infected with the AIDS

Continued on page 7

Continued from page 5

virus is at least one hundred times greater than reported cases of AIDS." In his July 1985 testimony before Congress, Dr. Dana Bolognesi of Duke University estimated that 2 million Americans were already permanently infected with the AIDS virus. She said that the number of those infected is expected to double each year. Some researchers are now calling AIDS a "species threatening" *pandemic* on par with the effects of nuclear war. The long-range mortality from AIDS should not be downplayed. With the continuing exponential growth of AIDS threatening to raise casualties into the millions, the implosion of the national health care system seems inevitable. Specialized facilities to handle the rapidly increasing influx of dying patients will have to be arranged as existing medical centers become overcrowded. Furthermore, (this epidemic could) devastate the Social Security system. Ninety percent of all AIDS patients thus far have been between the ages of 20 and 49. As soon as a person is diagnosed with AIDS, he/she immediately becomes eligible for receiving Social Security disability income. In many cases, private insurance coverage is lost due to unemployment. AIDS patients can then become eligible for Medicare or Medicaid. With the direct medical outlay per patient averaging $147,000, resource funds will rapidly become exhausted.

NT: What kind of virus causes AIDS?

GA: That information is not commonly found in other literature. The AIDS virus is a lentivirus.

NT: What is a lentivirus?

GA: It is a slow-acting virus. This is the first time in history that a lentivirus has been found in humans.

NT: Where is it commonly found?

GA: In horses, sheep and goats.

NT: So, do you think it crossed the species barrier?

GA: Yes, from monkeys to humans. It is believed that this happened in Central Africa. This could be speculative since there is no way of rolling back the tape (of time) to know.

NT: What is the significance of the AIDS virus being a lentivirus?

GA: The fact that AIDS is a lentivirus which persistently infects cells throughout the brain belies official speculation that only a minority of those infected will die as a result. Along with a team of colleagues, Dr. Jay Levy of the Cancer Institute, University of California School of Medicine, San Francisco, concludes: "The initial description in 1954 of lentivirus infections by Sigurdsson defined the acquired immunodeficiency syndrome: a long, but predictable, incubation period of months to years; an infectious agent that produces inapparent but progressive pathologic damage, and a protracted course, generally ending in serious disease or death."

AIDS lentivirus in humans most closely resembles maedi-visna lentivirus infection in sheep. Maedi-visna kills sheep through two means. It causes brain diseases and a deadly form of lung disease (chronic interstitial pneumonitis) also occurring in humans infected with the AIDS virus, especially infants. Among sheep, maedi-visna lentivirus infection results in the death of *100 percent* of the animals after an asymtomatic period of one to six years, without producing immune deficiency. It is spread by animals coughing while in close contact. A hallmark of lentivirus infections in animals is degenerative brain disease apart from immune suppression. This has dire implications for the course of AIDS lentivirus infection in humans.

Dr. Paul Volberding, head of AIDS services at San Francisco General Hospital states, "It is entirely reasonable to speculate that everyone who is seropositive (infected with the AIDS virus) will develop central nervous system complications. We are seeing an increasing number of signs of this on our ward. They take the form of varying degrees of dementia."

In addition to causing immune deficiency, the invasion of the AIDS virus into the central nervous system portends *lethal* consequences for all persons infected. Dr. Richard Tedder, a leading British virologist, asserts: "If people who've been infected by the AIDS virus don't get killed by immunosuppression, they'll die from chronic dementia...presenile dementia."

NT: If the AIDS virus is similar to the maedi-visna virus found in sheep, which can be spread by the sheep coughing while the animals are in close contact, does this mean the AIDS virus can be passed casually?

GA: Yes. According to Dr. William Hazeltine's statement in the March 18 1986 issue of *The New York Times*, "Anyone who tells you categorically that AIDS is not contracted by saliva is not telling you the truth. AIDS may in fact be transmittable by tears, saliva, bodily fluids, and mosquito bites. There are sure to be cases of true transmission though casual contact." In my book, I mentioned that we have been led to believe that AIDS cannot be transmitted by casual contact. Dr. Montagnier, the French researcher who helped co-discover the AIDS virus, has stated, "the greatest danger of the disease is the genetic variability of the virus. That is the virus is mutating and changing for so rapidly that a change in the type of cells that this virus infects and change in routes of transmission cannot be discounted."

This fact becomes even more frightening when coupled with the so-called "critical mass" theory. This holds that as you reach a critical mass of contagion--that is, as sufficient number of people become infected with this virus it will facilitate greatly the spread of infection through other means. Simply put, if you work in an office with 50 people and one of them has AIDS or is AIDS carrier, you are not as susceptible to acquiring the virus through casual means--say, by drinking out of the same cup or working in close quarters--as you would be if you worked with 15 or 20 AIDS patients or carriers. So as the epidemic grows, this will very possibly allow other means of transmission to occur.

NT: How can the AIDS virus be transmitted casually when it is a fragile virus, incapable of living outside the body for any extended period of time?

GA: Although we have been led to believe that the AIDS virus is a frail virus, it is not. It can live for a week to ten days in dry or liquid form at room temperature. Dr. James Staff, Medical Investigator at the National Institutes of Health, has reported: "Unlike most other retroviruses, the AIDS virus can survive outside the body for hours to days."

NT: What would you say about using "safe sex" techniques to help prevent the spread of AIDS?

GA: "Safe sex" is a myth. There are several egregious flaws in the "reduce your number of partners and use prophylactics" panacea for stopping

AIDS. With an estimated 2.5 million infected AIDS carriers already in the population, a little promiscuity will go a long way to spreading mass contagion. The utilization of "safe sex" techniques are of dubious help in preventing AIDS transmission. With the AIDS virus being exuded from almost every bodily orifice, pore and secretion, including saliva and probably sweat, prolonged, intimate, sexual contact of *any* kind is potentially lethal. If the Centers for Disease Control guidelines on avoiding contact with AIDS-tainted secretions are taken seriously; the only "safe" sex with an AIDS carrier would necessitate wearing surgical gowns and mask, rubber gloves and eye goggles. Guidelines issued by the Council on Scientific Affairs of the American Medical Association state specifically: "Sexual contact should be avoided with persons known to have or suspected of having AIDS."

NT: What are some of the implications of the facts revealed in your book to health care providers (e.g. to nurses and physicians)?

GA: Several cases I would like to cite especially for nurses in particular. The October 4, 1986 issue of *Lancet* describes the case of a 24-year-old student nurse who pricked the fleshy part of her index finger with a needle used to take blood from an AIDS patient. No injection of blood was noted at the time, July 12, 1985. A month later, she was found to be HIV antibody negative. Later, she presented with fever and other AIDS symptoms. Her husband was tested and he was HIV antibody negative. She was not an intravenous drug user, had not had repeated transfusions and had not had extramarital sex relations. They say that the infectious episode of September, 1985 can probably be attributed to acute HIV infection. The two month incubation period may be explained by the small quantity of virus introduced. There was merely a puncture wound without injection of contaminated blood. Now that the virus has been found in epithelial cells, I think this creates real problems.

The other case I cite was from the *New England Journal of Medicine*, August 28, 1986. A nurse, received a superficial self-inflicted needlestick injury to her finger while recapping the needle. The needle had been contaminated by the bloody pleural fluid of the patient with persistent generalized lymphadenopathy, had seroconversion to HIV and the infected medium was pleural fluid. The wound was superficial. This type of contamination emphasizes the need for strict precautions regarding the handling of needles and any body fluids from patients infected with HIV.

NT: The "Morbidity and Mortality Weekly Report" dated November 15, 1985 states that the documented risk of AIDS virus infection following a needle stick involving an infected person with AIDS is less than one percent. Why do you say that the AIDS virus can be transmitted casually?

GA: I think what has to be done--because low levels of transmission antibody generation may take a longer time to develop--are studies of virus from the person's blood supply. They should do that rather than just test for the antibody. There has to be immunological studies to determine the ration of helper to suppressor "T" cells. University of Chicago researchers contend that an antibody negative but virus positive state is the initial stage of AIDS infection.

NT: What do you mean by virus positive?

GA: Well, the person can be antibody negative but have the virus (they call it false negative). The other factor, I'd like to address to nurses, is that pregnant nurses should not work with AIDS patients.

NT: Could you elaborate on this?

GA: They will tell you when you are pregnant that you shouldn't be changing cat litter. Cat feces have Toxoplasmosis gondii, a protozoan. Toxoplasmosis is one of the infections found in AIDS patients. Another infection which AIDS patients are more prone to is Cytomegalovirus (CMV). Congenital CMV disease follows infection of a nonimmune mother during early months of pregnancy.

NT: In your opinion, should a health care provider who has HIV infection be allowed to work?

GA: I think what has to be stressed at this point is the effect of the AIDS virus on the brain and what the effect that has on job performance. Quoting from a book on the legal aspects of AIDS, "On virtually every jurisdiction, with the handicapped discrimination statutes, discrimination in employment decisions against the disabled is lawful if the physical requirements of the job cannot be performed by the individual at the time the individual is being evaluated for employment and at the time his employment performance is being reviewed." If you have a surgeon or a nurse or an airplane pilot who's infected with the virus and the virus is infecting the central nervous system and causing slow-acting dementia in which memory is impaired and mental confusion is resulting, clearly that individual should not be allowed to perform his/her job.

NT: What if you don't have dementia? In fact, recently, I read about a surgeon who was reassigned to do consultative and/or administrative work rather than primary patient care.

GA: But that's not what they're doing. The one issue is that they should be screened and their performance should be periodically evaluated. You don't wait until they slipped the knife, crashed the plane, or forgot to give the medications before you take action. You evaluate them, let's say, with whatever test they need to determine mental acuity and muscular coordination on a periodic basis. They should be screened periodically for infection with the virus. I also think that doctors, who are infected and who have not yet evidenced mental impairment, should be required to get written, informed consent from their patients regarding performance and procedures. That's what they do for Hepatitis B. I mean someone slices you open and has their hands inside your body and has blood in his veins which is infected with the virus. I've had many surgeons tell me that they sometimes nick themselves and all sorts of strange things develop while operating. Certainly it should be a patient's option to be informed.

NT: Could you comment on the issue of confidentiality and AIDS antibody testing?

GA: I think that everyone who is seropositive to the HIV should be reported to the public health authorities. It should be treated just as they do a sickness. In addition, their contacts should be traced. Sooner or later it will be done on a national le

I believe; but it's about time to stop playing around with this. You have nearly three million people infected with a deadly, contagious virus. They're spreading it, willy-nilly. No one knows where they are or who they are and it may be 10 years before they develop detectable symptoms. Instead of saying we have to find them and notify their partners--notify them and tell them to take precautions--we're saying we've got to pass out condoms to the whole country and educate school children about safe sex practices. It's time to treat this as a drastic disease, as an epidemic that has the potential to become pandemic if we don't stop it.

NT: Why do you think there's been resistance to contact tracing for AIDS?

GA: Primarily I think there are fears of violations of civil liberties. The argument for syphilis and gonorrhea is that if we can find someone infected we can tell them what to do. But AIDS will kill them and there's nothing we can tell them. And it's going to drive infected carriers underground for fear of stigmatization.

NT: Is it possible that drugs such as AZT will be used to extend the lives of people with AIDS until we find a vaccine?

GA: I don't think so. I think that they're so toxic; and the virus replicating in the central nervous system and the brain is going to preclude that. Right now we have to be realistic. We have no vaccine. We have no cure. There's not one in sight for a long time, if ever. In animals, vaccines have proved useless. I mean a vaccine against what? Against which one of the hundreds and hundreds, maybe thousands, of different strains of virus.

NT: How do you think we can stop the "AIDS juggernaut" as you have called the AIDS crisis in your book?

GA: Juggernaut was a Hindu diety. It was a very heavy statue carried around in a wagon and the people at its appearance would throw themselves under the wheels of the wagon to be crushed to offer themselves to the diety. I think we've got that here. And I think we have to treat AIDS as a public health issue. All the bathhouses have to be closed down. There has to be contact-tracing for those infected, not merely those in the end stage of the disease. There should be federal bans on all high-risk group members from donating blood or plasma, contributing semen to sperm banks or donating organs. Hospital officials must allow medical personnel to take proper precautions when dealing with AIDS patients. Proper precautions must be taken to protect non-AIDS patients from those with the disease. These are just a few of the precautions I cover in my book.

NT: It was mentioned in your book that you are working on certain legislation with the U.S. Senate and Congress regarding AIDS? Could you elaborate on this?

GA: On a state level, we're working on instituting a mandatory premarital AIDS blood test; and that's already been introduced in a number of states.

NT: If you had to revise your book, what kind of changes would you make?

GA: To point out that all our estimates about AIDS have been low, that we have been underestimating things.

Mr. Antonio holds a B.A. in Psychology and a Master of Divinity degree from Concordia Theological Seminary in St. Louis, Missouri. He has done extensive counseling with homosexuals, drug addicts and prostitutes. Armed with the concern that a number of important facts about AIDS were not being disclosed to the public, Mr. Antonio spent two years researching and writing his book. He is the president of the Foundation for the Advancement of Compassion and Truth which is designed to address the issue of AIDS and help prevent its spread by compassionate and truthful means.

**If you would like to receive a complete bibliography, please send a self-addressed, stamped envelope to Nursing Today Magazine, 114 North Sunrise Avenue, Suite B-1, Roseville, CA 95661.

AIDS: KEY WORD DEFINITIONS

AIDS (Acquired Immunodeficiency Syndrome): Presence of reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency (e.g., Pneumocystis carinii pneumonia, Kaposi's sarcoma, CNS lymphoma) occurring in a person with no known cause of underlying reduced resistance to the disease other than that due to HIV infection (e.g., immuno-suppressive therapy, Hodgkin's disease)--CDC surveillance definition.

HIV (Human Immunodeficiency Virus): The internationally accepted name for the retrovirus assumed to cause AIDS/ARC; formerly labelled HTLV-III, LAV, and ARV.

HIV Infection: Infection caused by the human immunodeficiency virus. The disease continuum can range from an asymtomatic carrier state to various levels of cellular immune system and/or neurological impairment causing symptoms of ARC or the onset of opportunistic diseases resulting in a diagnosis of AIDS.

HIV Seropositivity: Presence of antibodies in the bloodstream after exposure to HIV, as determined by the ELISA and/or Western Blot blood tests.

ARC (AIDS Related Complex): Disease condition caused by infection with HIV, excluding opportunistic infections and malignancies resulting in a diagnosis of AIDS. Clinical features may include: fever, weight loss, lymphadenopathy, persistent diarrhea, extreme fatigue, night sweats. Laboratory abnormalities include: lowered total number of helper T-cells, lowered helper/suppressor ratio, elevated serum globulins, abnormal reduction in number of all of the cellular elements of the blood (pancytopenia) and anergy (lack of or diminished reaction to an antigen) to skin tests. Not necessarily prodromal for AIDS. Usually accompanied by depressed cell-mediated immunity similar to, but less severe than that found in AIDS.

Person(s) with AIDS or ARC: These terms are preferred over "victim" or "patient."

Opportunistic Infection: Infection by a microorganism that may be common in the environment but causes disease only in a host with a poorly functioning immune system.

(Dr. Modesta S. Orque is currently in private practice doing consulting and writing on cross-cultural issues, public health, nursing education and research, planning and management. She has established a notable reputation as a scholar, speaker, writer, and a leader in the area of cross-cultural health care delivery. Included in her writing accomplishments is the award-winning book *Ethinc Nursing Care: A Multicultural Approach.* She may be contacted in care of Nursing Today Magazine, 114 Sunrise Ave., Ste. B-1, CA 95661)

NT

INFECTIOUS DISEASE

CONTAMINATION

DO NOT ENTER

DPD 429 (6/87)

SECTION SEVEN

PRECAUTIONS IN THE LABORATORY

Denver Police Department

Inter-Department

Correspondence

TO Captain Lyle Hesalroad DATE 11-6-86

FROM Detective Gary Rini

SUBJECT Procedures for Handling Biological Evidence

PRECAUTIONS IN WORKING WITH BIOLOGICAL EVIDENCE

Biological evidence is that evidence, which by its very nature, is susceptible to deterioration if not handled or packaged correctly. The packaging of biological evidence in airtight containers (heat-sealed evidence bags) enhances the deterioration process. Therefore, in order to prevent this process, bloodstained articles of clothing should be "air-dried" prior to packaging.

Currently, by the time bloodsoaked items arrive at the Crime Laboratory, they will have been handled by AT LEAST three people: the submitting officer, the Property Bureau personnel and a Crime Laboratory representative who transports the evidence to the Crime Laboratory for analysis.

In most cases, prior to analysis, the bloodsoaked evidence must be "air-dried" in a fuming hood. Those items of evidence are then either packaged and stored for future analysis or analyzed immediately.

Recently, the Crime Laboratory has seen an increase in the presence of known or suspected biohazards associated with incoming biological evidence. The most alarming of these biohazards are THE ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) and HEPATITIS B VIRUS (HBV).

At this time, the Crime Laboratory Bureau is not equipped to safely analyze articles of evidence known to be infected with Aids. Therefore, such items should be handled by the fewest number of individuals and should be maintained by the Property Bureau until a decision can be made as to their final disposition.

In order to minimize exposure to and contamination by these and other biohazards, the Crime Laboratory Bureau recommends that the following procedures be followed when handling biological evidence.

1. A separate storage and control area should be established and maintained by the Property Bureau for the exclusive purpose of controlling and storing biohazardous evidence.

2. The storage and control area should consist of at least two separate, but adjoining rooms: the preparation room and the decontamination room.

   In the preparation room, outer protective garments should be stored and accessible for use. In addition, a sink for washing and disinfecting purposes and plastic bags for disposable items should also be located in this room.

Access to the decontamination room should be through a swinging door, in order to avoid contamination of door knobs by infected items. This room should contain an autoclave, a large examination table, supplies for examining contaminated articles of evidence, and a biological safety cabinet (fuming hood) for drying wet items. The biological safety cabinet should have a filtration system capable of filtering chemical carcinogens and biological hazards in micro-gram quantities. A reputable environmental hazards inspection service should be used to monitor and certify the filtration hood on a regular basis. In addition to the ambient light source, there should be available an ultra-violet light source to serilize the room and safety cabinet.

Under these arrangements, Laboratory personnel responsible for the analysis of biological evidence can respond to the decontamination room to collect only these samples necessary for analysis. This will preclude the necessity of exposing uninvolved personnel to the effects of biohazards as it is transported from the Property Bureau to the Laboratory.

Items which are to be destroyed will be placed in appropriate autoclaving bags, autoclaved, sealed in plastic bags, and incinerated.

A. Handling Aids infected evidence.

1. Aids infected items received by the Property Bureau should be handled with extreme caution. Care should be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material.

2. Personnel assigned to the handling of these items should be cautioned to wear DISPOSABLE gloves, gowns and masks.

3. All potentially contaminated materials or clothing used should be removed and placed in an appropriate plastic, leak-proof container and decontaminated, preferably by autoclaving, before disposal or reprocessing.

4. Care must be taken to avoid contact of open skin lesions with potentially infectious materials.

5. Before removing their gloves, personnel should be disinfected by having another individual pour a disinfectant such as 0.5% Hypochlorite over the gloved hands. Care should be taken to avoid handling the disinfectant with contaminated gloved hands. the gloves then should be carefully removed and the hands likewise disinfected.

Respectfully,

Gary A. Rini

----approved
----denied

Sergeant Mark Olin

HTLV-III AND THE FORENSIC LABORATORY

Paul D. Bigbee
Serology Unit
FBI Laboratory
Washington, D.C. 20535

INTRODUCTION

Webster's New World Dictionary partially defines a paradox as "a statement that seems contradictory but may actually be true in fact." This definition may be applied to the statement, "although the possibility of infection of laboratory personnel appears to be remote, evidence bearing the body fluids of a person infected with HTLV-III (AIDS) will not be examined in the forensic laboratory due to the potential hazards associated with the virus." The disjunction of Webster's definition allows us to examine the two aspects of the paradox.

Many published studies as well as leading medical and epidemiology experts advise that the probability of the transmission of HTLV-III in clinical laboratory specimens is remote, as is the possibility of acquiring the disease through casual contact with AIDS patients. Experts from the Centers for Disease Control (CDC) in Atlanta, Georgia, have advised the FBI Laboratory that our employees are at "low risk" of acquiring a laboratory borne HTLV-III infection. Thus, it appears concern regarding the acquisition of HTLV-III by forensic laboratory workers from evidence is contradictory to that advice. However, there is still the possibility of laboratory workers acquiring an HTLV-III infection.

What are the risks of handling evidence bearing body fluids and stains derived from persons with AIDS or those testing positive for the HTLV-III antibody? Regardless of the fact that forensic laboratory workers are in the "low risk" category, is any risk acceptable?

Little research has been conducted concerning the transmission of the virus in forensic specimens and the long-term virulence of the virus in body fluid stains. Unlike other pathogenic microorganisms normally encountered in forensic specimens, such as hepatitis B, HTLV-III has two rare attributes. The first is that there is no vaccine against the virus, and if the infection results in the acquired immune deficiency syndrome, the disease is fatal. The second unusual trait is the extraordinary and unknown length of the incubation period before symptoms of the disease appear following exposure to the virus. This phenomenon could result in a laboratory worker becoming infected and unknowingly transmitting the virus to his or her spouse. It is feasible that an infected male laboratory worker could transmit the virus to his pregnant wife, who would then infect her unborn child by transplacental infection during delivery, or even through later breast feeding (Lapointe *et al.* 1985; Ragni *et al.* 1985; Thiry *et al.* 1985; Ziegler *et al.* 1985). Because many techniques employed in the forensic laboratory are unique and therefore not performed in clinical laboratories, this paper will address some aspects of HTLV-III and its transmission. Also discussed are means to deal with potential cases of HTLV-III contamination and other pathogenic microorganisms in forensic laboratories, as well as the policy of the FBI Laboratory for accepting evidence containing known HTLV-III viruses.

THE VIRUS AND ITS MECHANISM

Human T-lymphotropic virus type III (also designated lymphadenopathy-associated virus and abbreviated HTLV-III/LAV) is the etiologic agent of the acquired immune deficiency syndrome (AIDS) and AIDS-related complex (Barre-Sinoussi *et al.* 1983; Gallo *et al.* 1984; Levy *et al.* 1984; Centers for Disease Control 1986a; Coffin *et al.* 1986). The virus infects helper/inducer T-lymphocytes and possibly other cell types, with a direct cytopathic effect and/or indirect effects on cells involved in cellular and humoral immunity (Dalgleish *et al.* 1984; Fauci *et al.* 1984; Klatzmann *et al.* 1984; Montagnier *et al.* 1984; Popovic *et al.* 1984). The virus, described as a "retrovirus", utilizes the enzyme reverse transcriptase to incorporate the genetic information of the viral RNA into the DNA of the host cell.

The origin of the virus is uncertain.

According to Dr. Robert Gallo, Chief of the Laboratory of Tumor Cell Biology at the National Cancer Institute, the virus probably entered man 20 years ago. It is hypothesized that the virus was transmitted by humans in Africa who were bitten by African green monkeys. During the mid-1970's there was a cultural exchange of some 10,000 people between Haiti and Zaire, and the virus may have crossed the Atlantic in that exchange. It then may have moved from Haiti to New York when the island became a popular vacation spot for male homosexuals, according to Dr. Peter Fischinger of the National Cancer Institute (Thompson 1985).

Once the virus invades the human body, it utilizes the antigenic sites of its protein coat to adhere to a T-helper lymphocyte, the control cell in the immune system. It then injects its RNA into the T-lymphocyte, and by using reverse transcriptase, incorporates its genetic code into the DNA of the host cell. At this point, the infected T-lymphocyte may continue to function normally, with no symptoms of AIDS being seen. At some point, for reasons unknown, the viral genome activates itself and causes the lymphocyte to divide and produce new viral RNA. The new viral particles then invade other T-lymphocytes until few remain uninfected, and the host's immune system fails. When this occurs, the victim has AIDS and eventually dies. Death in AIDS patients, however, is not caused by the HTLV-III directly; it is caused by secondary weak pathogens that can no longer be immunologically defeated (Davis *et al.* 1980; Thompson 1985).

OCCURRENCE AND FREQUENCY

The HTLV-III virus has been isolated from blood, bone marrow, lymph nodes, brain tissue, semen, cell-free plasma, vaginal secretions, cervical secretions, tears and human milk (Groopman *et al.* 1984; Zagury *et al.* 1984; Salahuddin *et al.* 1985; Thiry *et al.* 1985; Vogt *et al.* 1986; Wofsy *et al.* 1986). According to CDC, the highest incidence of both infection and transmission of the virus appears in active homosexual males and intravenous drug users. Although the disease is primarily seen in homosexual males and transmitted through sexual intercourse by homosexual males, hemophiliacs that receive infected blood, nonhomosexual intravenous drug users injecting themselves with contaminated needles, and Haitians display increased rates of AIDS infections. Several cases have been reported where the virus has been transmitted by unusual means. In one case, a male hemophiliac who had been infected with the virus from blood products transmitted the virus to his wife, who then infected her child during the birth process (Ragni *et al.* 1985). In another instance, a woman delivered her child by Caesarean section and received a contaminated blood transfusion after the birth. Through consumption of human milk or some other means of transmission, the child was infected and exhibited symptoms of AIDS several months later (Ziegler *et al.* 1985). Four of eight women in Australia who were artificially inseminated with semen from AIDS carriers became positive for the AIDS antibody (Stewart *et al.* 1985). Other fetuses/infants have been positive for the HTLV-III antibody received from their mothers (Thiry *et al.* 1985). Prompt *et al.* (1985) reported the transmission of the virus by renal transplantation. To date, all published reports and data from CDC show that casual contact with any of the previously mentioned body fluids is not the cause of transmission of the AIDS virus.

Data from CDC shows that 1,758 health care workers in the United States have been studied for the presence of the HTLV-III antibody. Twenty-six (1.5%) were positive for the HTLV-III antibody, and all but three belonged to groups recognized to be at increased risks (Abbott Laboratories 1985). These cases probably represent occupational transmission of HTLV-III due to parenteral (injection by sharp instrument) exposure. A health care worker in Great Britain is believed to have developed HTLV-III antibody following parenteral exposure to the blood of an AIDS patient (Abbott Laboratories 1985). According to CDC, there have been and likely will be more instances of transmission of the virus by heterosexual intercourse.

The incidence of AIDS cases is increasing exponentially in the United States.

Dr. James W. Curran of CDC estimates that from 500,000 to 1 million people have been infected with the virus, but only approximately 20% of those infected have developed actual symptoms (Abbott Laboratories 1985). It is estimated that this number will increase, perhaps to 30%, in the future. From June 1, 1981 through September 30, 1985, CDC received reports of 13,611 cases of AIDS. Of those patients, 6,944 have died. AIDS transmitted by transfusions accounted for 236 cases; hemophiliacs with AIDS numbered 105 cases. Three states, North Dakota, Montana and Idaho have reported no cases, and 31 states have each reported more than 25 cases. The cumulative number of reported AIDS cases from Jan 1, 1986 through July 13, 1986 for selected geographical areas, many of which contribute a significant number of cases to the FBI Laboratory is as follows: Massachusetts (196), New York (1,765), New Jersey (401), Pennsylvania (172), Michigan (186), Maryland (101), the District of Columbia (114), Florida (334), Texas (330), California (1521) and Alaska (9). The total number of AIDS cases reported to CDC for this period in the U.S. was 6,146 (Centers for Disease Control 1986a).

From October 1, 1985 through March 31, 1986, the U.S. Department of Defense tested 308,076 recruit applicants for serological evidence of AIDS infection. Antibodies against the virus were found in 1.5 per 1,000 recruits. The rates varied among men, women and racial groups. It was higher among the 265,361 men of all ages (1.6/1,000) than among the 42,715 women (0.6/1,000). Prevalence varied with race. For the 237,568 whites tested the rate was 0.9/1,000, and for the 55,185 blacks it was 3.9/1,000 (Centers for Disease Control 1986b).

MANIFESTATIONS OF AIDS

Persons infected with the AIDS retrovirus may present a variety of manifestations ranging from asymptomatic infection to severe immunodeficiency and life threatening secondary infectious diseases or cancer. The CDC classifies AIDS patients in one of four categories ranging from acute infections to those classified as "other conditions". Manifestations of the disease can include a mononucleosis-like syndrome with or without meningitis, lymph node enlargement that persists for months (not caused by other disease states), cancers and myelopathy (diseases of the spinal cord). Secondary infections and death can occur from such microorganisms as *Pneumocystis carinii*, which produces a severe form of pneumonia, to unusual forms of tuberculosis (Centers for Disease Control 1986a).

PREVENTION AND CONTROL

There currently exists no vaccine or cure for the AIDS virus. One promising drug, azidothymidine or "AZT" is currently being used experimentally to treat AIDS patients (Yarchoan *et al.* 1986). The only other preventive measure for the transmission of AIDS is for those individuals who are infected with the virus to voluntarily cease such activities that further spread the disease.

The control and disinfection of HTLV-III on environmental surfaces such as laboratory bench tops and instruments is relatively simple. Ordinary bleach solutions (0.5% sodium hypochlorite) and 70% alcohol will destroy the virus within 1 minute, and the virus is susceptible to high heat (Spire *et al.* 1984; Spire *et al.* 1985; Resnick *et al.* 1986). Drying does not necessarily inactivate the virus. A study done by Resnick and coworkers showed that HTLV-III can survive in liquid and dried bloodstains for a minimum of 15 days at room temperature, and it concluded that "....infectious virus can persist in a liquid or dried state for prolonged periods of time, possibly even at elevated temperatures" (Resnick *et al.* 1986). In another study, the virus was inactivated by heating at 56° C for 30 minutes but was not inactivated by 2×10^5 rad of gamma irradiation or 5×10^3 J/m^2 ultraviolet irradiation (Spire *et al.* 1985). The use of heat for disinfection of HTLV-III is certainly appropriate with respect to inanimate objects that are not for serological examination. However, heat will denature the proteins of interest and render the specimens unsuitable for most serological and possibly other

forensic examinations. Dr. Phillip D. Markham participated in Resnick's study and has indicated the virus could be deep frozen with little effect when thawed (Markham, personal communication). Freezing prolongs the longevity of most viruses, including HTLV-III. It is standard practice in the FBI Laboratory to freeze all items of evidence prior to examination, with the exception of liquid blood samples and items to be examined for latent fingerprints. Therefore, this practice as well as refrigeration will prolong the pathogenicity of HTLV-III.

SAFETY AND HANDLING

CDC recommends that biosafety level 2 practices, containment equipment and facilities be utilized when working with any known or potentially infectious body fluid and tissues (Richardson and Barkley 1984). Additional containment equipment and special research activities involving HTLV-III-related viruses and virus-producing cell lines require biosafety level 3 practices. These recommended biosafety level practices, containment equipment and facility safeguards, which are too lengthy to be discussed in this paper, are described in detail in "Biosafety in Microbiological and Biomedical Laboratories" published by CDC (Richardson and Barkley 1984). The Advisory Committee on Dangerous Pathogens (ACDP) in Great Britain, in its AIDS Interim Guidelines published in December, 1984, recommends that laboratory workers should not be expected to receive specimens from AIDS patients without prior consultation. It recommends that laboratory staff should follow a written protocol for work with HTLV-III, and procedures with viable viruses must be done in a containment level 3 laboratory. The ACDP (1985) has advocated that a full-scale postmortem examination should not be done to confirm the cause of death when AIDS has already been established.

The World Health Organization (WHO) has placed emphasis on education of the public to the risk of AIDS infection and ensuring that health care workers are informed about management of the disease. The WHO recommendations focus on proper precautions when caring for AIDS patients and handling specimens from these patients. The agency suggests that laboratory personnel be screened periodically for the antibody to HTLV-III (Abbott Laboratories 1985).

AIDS AND THE FORENSIC COMMUNITY

The forensic crime laboratory performs examinations on items of evidence that are foreign to the clinical laboratory setting. The forensic serologist not only performs analyses of liquid blood samples in cases of violent crimes but also examines numerous items of evidence bearing dried body fluid stains. Often, large items such as blankets, sheets and carpets are suspended and scraped vigorously. This action could create potentially infectious airborne particles. Other items, such as those examined at crime scenes, are processed outside the laboratory and involve potential injury to the skin by sharp and possibly contaminated objects. In one case submitted to the Serology Unit of the FBI Laboratory, an individual received a deep puncture wound to the knee from a wrapped package concealing numerous sharp carpet nails. The nails were attached to a blood soaked carpet which was saturated during the violent stabbing death of a known homosexual. The Serology Unit and the Chemistry-Toxicology Unit also often examine hypodermic syringes and needles for the presence of blood and illicit drugs. This evidence presents potential hazards since users of drugs are in the high risk category of persons infected with both hepatitis B and AIDS. Other Units in the FBI Laboratory as well as the Latent Fingerprint Section frequently examine body fluid stained evidence and occasionally body parts potentially contaminated by HTLV-III or other human pathogens. The nature of the violent criminal and his or her personal habits increases the possibility of laboratory workers coming in contact with materials contaminated with HTLV-III.

The FBI Laboratory strives to achieve the safest work environment possible for its employees. Certain practices currently being utilized in the FBI Laboratory have been and will continue to be the focus of criticism by

some individuals as being "knee jerk" and exaggerated responses to potentially hogenic microorganisms, in particular LV-III. For example, the Serology Unit uires that employees handling liquid blood amples wear white laboratory coats, latex gloves, protective masks and protective eyewear. In addition, when handling any evidence in a manner which creates an aerosol or airborne particles, masks are required. While it is recognized that the mask provides limited protection, exposure of the oral and nasal mucosal surfaces to droplet and particulate contamination will be avoided. Latex gloves and laboratory coats are required at all times when handling any liquid or dried body fluid. Further, the FBI Laboratory requires that any case involving items from an individual with an infectious disease be worked in the laminar flow cabinet unless specimen size is prohibitive. These precautions may be considered excessive. However, if the prevention of serious disease results, it is difficult to imagine how any safety measure can be considered excessive.

FBI POLICY ON AIDS

Cases involving evidence derived from persons infected with tuberculosis or AIDS will not normally be accepted for examination by the FBI Laboratory without the contributor first obtaining authorization from the Chief of the Scientific Analysis Section. This policy is in effect because of the potential persistence of the causative agents (*Mycobacterium tuberculosis* and HTLV-III) in liquid or dried body fluid stains examined in the laboratory. Unlike such diseases as hepatitis B, which is curable and can be prevented, HTLV-III is lethal. There is no vaccine against it, and the possibility exists that an asymptomatic infection could be transmitted to others.

The FBI Laboratory will accept AIDS cases only when the following criteria have been met:

1. Prior authorization from the Scientific Analysis Section of the Laboratory has been received by the contributor.

2. The contributor must understand that currently, the submitted evidence will be treated such that the evidence will be rendered unsuitable for serological analyses (autoclaving). Other Units of the FBI Laboratory will then conduct their examinations.

3. Acknowledgement letters from both the prosecuting and defense attorneys must accompany all evidence, advising that they are aware that the serological evidence will be destroyed and that this procedure will not be subject to legal or judicial action in the future.

Contributors will also be advised that the mailing of liquid blood, other body fluids or stains bearing human pathogens is subject to the regulations of Title 42 of the Code of Federal Regulations, Part 72, which governs the interstate shipment of diagnostic specimens. The specimens and evidence are subject to applicable packaging, labeling and shipping requirements for the interstate shipment of etiologic agents. Additional information on the interstate shipment of evidence containing any microorganism that is pathogenic to humans may be obtained by writing or calling the Centers for Disease Control, Office of Biosafety, 1600 Clifton Road, N.E., Atlanta, Georgia 30333, telephone (404) 329-3883 (FTS 236-3883) (Richardson and Barkley 1984; Taylor, personal communication).

It is the goal of the FBI Laboratory to continue to perform examinations as a full service laboratory for its contributors. However, the safety and welfare of its employees is the Laboratory's highest priority and must be considered when accepting evidence. The most logical means of protecting employees against HTLV-III is to destroy or inactivate the virus without destroying or denaturing the proteins and other substances contained in or on evidence. The FBI Laboratory is currently conducting research in conjunction with the National Bureau of Standards and the National Institutes of Health on the sterilization of evidence by more elevated amounts of gamma radiation than has previously been reported. If the sterilization

of evidence can be accomplished without destroying or altering proteins and other substances, the employee will be protected, and the contributor, prosecutors, evidence technicians and any other person subsequently handling the evidence will be protected as well (McKinney, personal communication; Simic, personal communication).

CONCLUSION

The possibility of infection of forensic laboratory personnel by HTLV-III appears remote. However, this possibility still exists, as well as the possible subsequent transmission of the virus to a spouse or other contacted person. Furthermore, there is only experimental treatment for the disease, and if contracted by any means, it is ultimately fatal. In terms of known pathogens, the virus and its infectivity to man has only been recently discovered. A great deal of research must be conducted, especially in the area of forensic science, to solve the paradox of HTLV-III in the forensic laboratory.

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Collecting and Handling Evidence Infected with Human Disease-Causing Organisms

"Today ... investigators and crime scene technicians are more likely than ever before to encounter crimes of violence involving blood and other body fluids of persons with infectious diseases."

By
PAUL D. BIGBEE, M.S.
Special Agent
Serology Unit
Laboratory Division
Federal Bureau of Investigation
Washington, DC

You have been assigned as the case investigator in a homicide that has just occurred in your jurisdiction. The crime scene is an apartment which has been properly secured by the first officers arriving. Upon entering the apartment, you observe the nude body of a young man, who has been stabbed numerous times, lying in a pool of liquid and coagulated blood. His hands are bound at the wrists with rope, the body has been emasculated, and no weapon is found. You also discover a hypodermic syringe, a spoon "cooker," and a suspicious white powder near the body, and in the bathroom, three drugs, Isoniazid, Rifampin and Ethambutol, prescribed for someone at that address.

An experienced investigator could quickly ascertain that this was the scene of a homosexual murder and involves at least one intravenous drug user. The prescription drugs pose a dilemma until you later learn that they are prescribed for persons with active cases of tuberculosis.[1]

This victim is typical of one who fits into the group of high-risk people often infected with AIDS, hepatitis B, and tuberculosis. Knowing this, you resist the urge to immediately leave the apartment and begin to process the crime scene. But, how should you proceed? What precautions should you take to protect yourself and others from possibly contracting a lethal or infectious disease? And, what do you do with the evidence once it is collected?

Today, with AIDS and hepatitis B infections virtually epidemic, investigators and crime scene technicians are more likely than ever before to encounter crimes of violence involving blood and other body fluids of persons with infectious diseases. It is also likely that the patrol officer will encounter these infectious body fluids during his routine activities. For example, the mouthpieces used on breath alcohol instruments can be contaminated with the saliva of a person with a communicable disease. Officers conducting traffic accident investigations may come in contact with potentially infectious blood, and the search of a suspected drug user can and has resulted in serious puncture wounds from secreted hypodermic needles.

This article does not purport to solve all the potential problems posed to law enforcement officers when handling blood and other body fluids. Its purpose is to acquaint the officer with some of the most commonly encountered diseases from infectious body fluids and to recommend precautions that can be taken.

Human beings can be infected with pathogenic (disease-causing) micro-organisms and may or may not show symptoms of a disease state. Examples of these pathogens include bacteria,

Special Agent Bigbee

such as those responsible for tuberculosis, syphilis, and gonorrhea; viruses, such as those responsible for AIDS, hepatitis, and herpes; and fungi, such as that responsible for candidiasis. Other microscopic organisms, such as one-celled animals, can also be found in the blood of humans.

Since it is beyond the scope of this article to present a detailed listing of each potentially infectious micro-organism law enforcement officers may encounter, this article will concentrate on the disease-causing organisms responsible for AIDS, hepatitis B, and tuberculosis. However, the precautions taken when dealing with any pathogen that may be found in body fluids are essentially the same.

AIDS

Acquired Immune Deficiency Syndrome (AIDS) has a variety of manifestations that range from asymptomatic (no symptoms) infection to severe immunodeficiency and life-threatening secondary infections or cancer.[2] The virus responsible for AIDS, HTLV–III (Human T-lymphotropic Virus Type III) is a "retrovirus" which invades the victim's immune system, destroys it, and causes the patient to become highly susceptible to secondary infections, including a severe form of pneumonia caused by the one-cell animal *Pneumocystis carinii*. Kaposi's sarcoma, a form of cancer, may also develop. The Centers for Disease Control (CDC) in Atlanta, GA, advise that tuberculosis cases in the United States have recently increased because of the occurrence of tuberculosis among persons with AIDS.[3] The manifestations of this disease are usually confined to the lung area, but in AIDS patients, the bacteria often invades other areas of the body, including the lymph system.

The AIDS virus has been isolated from blood, bone marrow, saliva, lymph nodes, brain tissue, semen, cell-free plasma, vaginal secretions, cervical secretions, tears, and human milk.[4] There is currently no vaccine against this virus which, if fully developed as a disease, is fatal.

The highest frequency of AIDS cases occurs in male homosexuals, intravenous drug users, and hemophiliacs—the "high-risk" categories. The transmission of AIDS has been shown to occur from male to male, male to female, female to male, by intravenous drug users sharing infected needles, from blood and blood product transfusions, transplacentally (through the placenta), by artificial insemination, and during organ transplant.[5] In one unusual case, a male hemophiliac received the infection from a blood product, transmitted the virus to his wife, who then infected her infant after birth by Caesarian section, presumably from contaminated human milk.[6]

It appears unlikely that the virus is transmitted through casual contact or airborne particles. Cases of accidental inoculation by laboratory personnel with AIDS and hepatitis by needles and other sharp instruments have occurred.[7] Correctional facility officers should be aware that the virus has been isolated from inmates in the United States who claim both homosexual contact and intravenous drug use.[8] Because the incubation period may be years in duration, it seems logical that more prison inmates will exhibit symptoms of AIDS in the future.

In a study by the U.S. Department of Defense, conducted from October 1, 1985, through March 3, 1986, it was determined that positive tests for AIDS antibodies in military recruits was 1.5 per 1,000, a pattern that could be consistent throughout the United States in general.[9] Leading experts and epi-

"The first line of defense against infection at the crime scene is protecting the hands and keeping them clean and away from the eyes, mouth, and nose."

demiologists anticipate that in the next 20 years, this number will increase expotentially.

Researchers have determined that the AIDS virus can survive at least 15 days in dried and liquid blood samples at room temperature,[10] although the survivability of the AIDS virus in other body fluids has not been determined. It is not known how long the hepatitis B virus and the tuberculosis spore can survive at room temperature.

Hepatitis B

Hepatitis B (serum hepatitis) is a viral infection that can result in jaundice, cirrhosis, and sometimes, cancer of the liver. The virus may be found in human blood, urine, semen, cerebrospinal fluid, vaginal secretions, and saliva.[11] Injection into the bloodstream, droplet exposure of mucous membranes, and contact with broken skin are the primary hazards. There is a vaccine currently available against hepatitis B.

Tuberculosis

This bacterial disease can be transmitted through saliva, urine, blood, and in some cases, other body fluids by persons infected with it. It can enter the body through droplets that are inhaled and primarily causes lung infections. The tuberculosis bacteria forms spores, similar to seeds in plants, that are highly resistant to drying and other physical means that would easily kill other bacteria.[12]

Defenses Against Exposure

What can be done to minimize the exposure of investigators and crime scene technicians to pathogenic microorganisms? The first line of defense against infection at the crime scene is protecting the hands and keeping them clean and away from the eyes, mouth, and nose. The best protection is to wear disposable gloves. Any person with a cut, abrasion, or any other break in the skin on the hands should never handle blood or other body fluids without protection. Convenient boxes of latex medical examination gloves, in different sizes, may be purchased and kept in the crime scene kit or in the trunk of a patrol car. Always keep a plastic bag, clearly marked, which will be used for no other purpose than to collect contaminated items until they can be disposed of properly. Replace the gloves when they become heavily stained or if you leave the crime scene. When you are completely finished with the crime scene, or if you leave temporarily, wash you hands thoroughly with soap and water. If cotton gloves are worn when working with items having potential latent fingerprint value, wear cotton gloves over latex ones. Remember that under no circumstances, should anyone at the crime scene be allowed to smoke, eat, drink, or apply makeup.

Shoes can become contaminated with blood, which can then be transported from the crime scene to automobiles, the police station, or home. Protective converings made of disposable plastic or paper should be considered.

Particles of dried blood fly in every direction when a dried blood stain is scraped. Because of this, surgical masks and protective eyewear should be considered when the possibility exists that dried blood particles or drops of liquid blood may strike the face or eyes. A mask and glasses will not protect you from viruses due to their minute size, but will certainly help prevent dried or liquid blood particles, which contain viruses, from entering the mouth, nose, or eyes.

While processing the crime scene, constantly be alert for sharp objects, since hypodermic needles and syringes are often secreted in unusual places. When handling knives, razors, broken glass, nails, or any other sharp object bearing blood, use the utmost care to prevent a cut or puncture of the skin. Even seemingly innocuous items, such as metal staples in paper, present a potential hazard. For this reason, use paper or plastic tape, whenever possible, when packaging evidence.

In the event you receive an accidental puncture or cut from a needle or instrument on which blood or another body fluid is present, immediately seek medical assistance. If an antiseptic, such as rubbing alcohol is available, cleanse the wound with the antiseptic, then wash with soap and water prior to seeking medical assistance. A physician will decide the best course of remedies, depending on the situation and the type of wound.

If practical, use only disposable items at a crime scene where infectious blood is present. However, even these items, such as pens, pencils, gloves, masks, and shoe covers, should be decontaminated before disposal. Preferably, the items should be incinerated; however, if this is not possible, arrange with your pathologist or a local hospital to sterilize the items by autoclaving and then dispose of them properly.

All nondisposable items, such as cameras, tools, notebooks, etc., also must be decontaminated. These items should be cleansed thoroughly with a solution consisting of 1 cup of sodium hypochlorite (common household liquid bleach) dissolved in a gallon of water (never mix bleach with ammonia or al-

" ... protective practices ... along with exercising care and using common sense, will decrease the risk to the law enforcement officer and others."

cohol). Either a bleach solution or ordinary rubbing alcohol will kill the AIDS virus within 1 minute.[13] Remember to wear gloves to protect the hands when decontaminating.

Spilt blood that has not been analyzed as evidence should also be cleaned with the same bleach solution. The solution should be poured on these stains and allowed to air dry. Before releasing the crime scene, advise the owner of the potential infection risk.

Even after the evidence has been properly dried and packaged, it is still potentially infectious. Therefore, appropriate warnings should be placed on all items. This can be accomplished by purchasing adhesive-backed labels bearing the international biohazard symbol and a space for labeling the appropriate disease, or simply writing on each package a warning, such as "Caution! Contains Potential Hepatitis (or AIDS) Case." This will alert all persons subsequently handling the evidence, such as laboratory personnel, prosecutors, defense lawyers, and police officers, to the hazards therein. To avoid removing evidence contaminated with infectious body fluids in the courtroom, place the items in transparent packaging once they have been properly dried, with appropriate initials, marking, etc., visible for identification.

Evidence containing any body fluid contaminated with human pathogen that is shipped to a forensic laboratory by U.S. mail is subject to the Code of Federal Regulations, Part 72. This regulation specifies that appropriate warning labels must be placed on the package, and any liquid substance must be triple wrapped and sealed.[14] For further information on these procedures, contact the Centers for Disease Control, Office of Biosafety, 1600 Clifton Road, N.E., Atlanta, GA 30333 (404) 329-3883.

When conducting a crime scene investigation involving the shedding of blood from persons known to have infectious or contagious diseases, or even when it is suspected, the investigator should be very judicious with respect to the materials collected and forwarded to the laboratory for analysis. For example, in the scenario described earlier, it is obvious that the blood flowing from the victim's wounds originated from him. In another example, if John Smith is shot in the chest with a .44–caliber revolver by John Doe at a distance of 20 feet, there are several witnesses to the crime, and the assailant immediately flees the area with the weapon, it is obvious that the pool of blood underneath the body of John Smith originated from him. There is no probative value in analyzing the blood from the scene. Investigators and crime scene technicians should also consult with their local, State, or Federal forensic laboratory before submitting items for examination from persons with diseases, especially AIDS.

There are currently two opinions in forensic laboratories concerning the examination of cases with body fluids derived from persons with AIDS infections. The first is that the virus is not highly transmissible in dried stains and liquid blood samples, poses little hazard to laboratory personnel, and will be analyzed as usual. The other is that even though laboratory workers are at low risk of acquiring an AIDS infection from forensic specimens, that risk is not acceptable, especially when the laboratory worker could acquire an infection and unknowingly transmit it to his or her spouse.

The FBI Laboratory, in conjunction with the National Institutes of Health and the National Bureau of Standards, is currently conducting research into the feasibility of sterilizing forensic evidence with gamma radiation without destroying the proteins required for serological examination. This procedure, if successful, would allow the evidence to be sterilized, thereby presenting no health hazard to laboratory workers or anyone subsequently handling the evidence and allowing for a complete serological examination. Until this procedure proves successful and is adopted, the FBI Laboratory will accept AIDS cases for analysis only if prior authorization has been obtained from the Section Chief, Scientific Analysis Section. The current prerequisites for acceptance of an AIDS case in the FBI Laboratory are as follows:

1) The contributor must understand that the submitted evidence will be autoclaved, which will render the evidence unsuitable for serological analyses. Other units of the FBI Laboratory will then conduct their examinations.

2) Acknowledgement letters from both the prosecuting and defense attorneys must accompany all evidence advising they are aware that serological evidence will be destroyed and that this procedure will not be subject to legal or judicial action in the future.

3) The evidence must be properly packaged and labeled.

It is the goal of the FBI Laboratory to continue to perform examinations as a full-service laboratory for its contributors. However, the safety and welfare of its employees and the rest of the law enforcement community are the laboratory's highest priorities and must be taken into consideration when accepting and analyzing evidence.

In the event your laboratory will not process cases involving blood or other body fluids from AIDS victims or suspects, it is recommended that the inves-

tigator contact that laboratory for the name and addresses of other public or private laboratories equipped to deal with infectious diseases and willing to examine the evidence.

Conclusion

Law enforcement personnel investigating violent crimes must handle blood- and body fluid-stained evidence on a constant basis. Often, these body fluids will be contaminated with infectious and disease-causing micro-organisms. There is no sure way to prevent accidental inoculation or contraction of a disease. However, protective practices, such as those discussed in this article, along with exercising care and using common sense, will decrease the risk to the law enforcement officer and others. These safety procedures should always be used, and the officer should always assume that blood and other body fluids are potentially infectious, regardless of the source.

FBI

Footnotes

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PRECAUTIONS FOR THE HANDLING OF EVIDENCE CONTAMINATED BY INFECTIOUS DISEASES FOR THE FIELD AND LAB TECHNICIANS

JAMES M. SVAGLIC

(Editor's Note: The following article originally appeared in the March 1986 issue of the Missouri Divisjon, International Association for Identification, Newsletter, which is edited by James M. Svaglic & William George. Submitted by James Hamby.)

The recent spread of Acquired Immune Deficiency Syndrome (AIDS) has sparked many inquiries as to how it effects Evidence Technicians and Criminalists who may come in contact with victims of infectious diseases. This problem is compounded by the lack of one central authority to research and formulate precautions to take when dealing with evidence that may be contaminated by AIDS, Hepatitis B, or other infectious diseases.

The most frequent victims of AIDS are intravenous drug abusers, homosexual males, Haitian entrants, and people who require blood transfusions such as hemophiliacs. It is believed that the disease is spread by body fluids of the carrier entering the body of the recipient. This is accomplished by many methods, one of which is the use of contaminated needles. It is believed that puncturing the skin with an object that has been contaminated with the secretions of an AIDS victim can spread the disease. To date, it is believed that casual contact will not transmit the disease.

Recently, the news media reported that an infant, which had contracted AIDS by a transfusion transmitted the disease to its mother. This is believed to have occurred due to the bodily care required by a small child, ie. diapering, feeding, etc.).(1) There also has been a report of a hospital worker becoming infected by accidentally sticking herself with a needle previously used on an AIDS victim (in this case I was unable to find any authoritative source to verify the incident).

These incidents accentuate the need for a policy of carefulness by all who may come in contact with evidence from victims who may be sick with an infectious disease. But, what kinds of care must we take? As of this date, no organization we know of has addressed this problem. None have established a set of precautions and rules to use at crime scenes and with evidence. The need for precautions among the law enforcement community is obvious, as we are, in many cases, called to handle victims infected with an infectious disease when they become sick, die (or are killed), or involved in a crime.

Several questions arise in dealing with evidence. It is believed that any secretions (urine, blood, tears, fecal matter, pus, etc.) may harbor the AIDS virus. There are many questions that remain unanswered. How long will the virus remain virulent? Will clothing that a victim's body fluids contacted still be dangerous after it dries? When you place an article of evidence with body fluids contacted still be dangerous after it dries? when you place an article of evidence with body fluid on it inside a paper envelope or bag as evidence, can the fluid that sometimes seeps through the bag be dangerous to the lab staff that may handle it? What precautions should be taken at the crime scenes? Hepatitis B virus also is transmitted via the same route as AIDS. In the remainder of this paper I will address these questions and present, what I believe, are reasonable precautions to take in the lab and on the crime scenes.

FINDINGS

Dr. Mary Case, of the St. Louis County Medical Examiners Office, who has made a study on AIDS and other infectious diseases, advised that the mortality of the virus has not yet been established for AIDS. If you handle evidence that was contaminated by a fluid carrying the infection and that has dried, you can not guarantee that you will not contract the disease. You must take care in handling all items that have been contaminated. The seepage through the bag could very possible carry the infecting virus. You should therefore not make direct physical contact with it. Containers that will not permit seepage should be utilized in all cases where there is the remotest possibility of seepage. Bagging the item in plastic is a possible remedy to this problem, but then you are confronted with the problem of putrefaction (ie. mold forming and contaminating the sample, hatching larva, etc.).

A study of the available literature has given us several actions we can take in order to lessen our chances of becoming infected. One finding is that one of the few easily available chemicals that will disinfect a surface contaminated by AIDS and hepatitis B is a 1:10 dilution of 5.25% sodium hypochlorite (common household bleach). The reports I have found advise that alcohol or normal washing is not effective against the virus.

GENERAL LABORATORY PROCEDURES

All laboratories should have a designated person who should be considered the safety officer. From the standpoint of the operational point of view, this person should be familiar with laboratory practices and biohazards. The safety officer should be responsible for giving advice and consultation to the laboratory staff in matters of biohazards. This staff member would be responsible for instructing new members of the staff, procuring and maintaining protective equipment and supplies, maintaining a laboratory accident reporting system, updating safety procedures, and periodically reviewing literature which reports on serologic and disease laboratory procedures.

The safety officer would also keep a log of all evidence from cases in which the victim has been verified as having an infectious disease. Any verified cases in which soiled evidence was taken from a scene, where the victim is verified to be infected with or a carrier of an infectious disease should be recorded, along with what staff handled the evidence, where it is stored, and its disposition. It is the safety officer's duty to see that this evidence is retained only as long as necessary, and then disposed of by proper means.(2)

All laboratories should have an accident reporting system. Accidents such as "cuts, needle sticks, and skin abrasions with instruments possible contaminated with blood, and soiling of broken skin, or contamination of eyes or mouth must be reported promptly."(3) The reports should be maintained by the safety officer who would make sure proper medical treatment and consultation is available if needed.

This record keeping is necessary for the safety of the lab personnel, in the event they become sick you may provide the doctor with information relative to diseases they may have become exposed to. All evidence suspected of being contaminated with an infectious disease should be marked clearly in red so as to warn anyone who may chance to handle it.

All evidence that may be contaminated should be processed at the earliest possible time. One reason is that the evidence may spoil due to its being sealed in an air tight container. The other reason is to avoid the chance of accidental contamination of lab personnel who may unwittingly handle the specimen. After the evidence has been processed, it should be photographed for court room presentation, disinfected, and destroyed with the permission of the prosecution official.

Biological safety cabinets (Class I or II) and other primary containment devices (e.g. centrifuge safety cups) are a must whenever procedures that have a high potential for creating aerosols or infectious droplets are conducted. These include blending, centrifuging, vigorous mixing and sonicating. A clear plastic shielding between the droplet collecting area and the equipment operator should be used to lessen the risk of contamination. Primary containment devices can also be used in handling materials that might carry the infectious agents.

The use of good quality rubber gloves is essential in the handling of all evidence that may be contaminated. Labels for specimen should be the self adhering kind to avoid communication of the disease to the technician.

It is suggested that all department personnel who may handle contaminated specimens be trained by hospital laboratory or nursing instructors in the proper handling of contaminated material and the care to be taken in removing contaminated gloves and clothing. Assistance should be sought from a microbiology laboratory to assure containment and disposal facilities are adequate to permit safe laboratory testing of evidence.

All laboratories should set up personal hygiene rules and guidelines for their staff members. All eating, drinking and smoking in the lab should be prohibited. This is necessary to lessen the chance of any infectious virus gaining entry into the body of the staff members.

SUGGESTED PROCEDURES FOR STAFF MEMBERS

A) Procedures for Crime Scenes technicians and Criminalists:

1) Gloves should always be worn when handling anything that may have body fluids, excretions, blood specimens, blood-soiled items, as well as any surface, material, and object exposed to them.
2) Care should be taken to avoid accidental puncturing from sharp instruments that may have been contaminated with potentially infectious material. These items (ie. needles, knives, etc.) should be stored in leak and puncture proof containers and should be clearly marked.
3) You should avoid contact with open skin sores on possible AIDS victims.
4) A gown should be worn to protect your clothing when the your clothing coming into contact with body fluids, blood, excretions or secretions exists.
5) Care should be taken not to touch your open skin with your gloved hands or accidental flinging or splashing of contam-

inated materials when handling bodies, samples, etc.

6) The outside of the container should not be handled with the contaminated gloved hands. All sharp or pointed instruments should be stored in puncture and lead proof containers in order to guard against accidental injury by those in the chain of evidence (such as clerks and criminalists), and should be marked clearly as to the contents. If it is known at the time of the processing that infectious diseases are involved, the evidence should be marked in red to warn those who have to handle them.

7) All potentially contaminated materials or clothing used should be removed and placed in a plastic leak proof container to be decontaminated, preferably by autoclaving, before disposal or reprocessing.

8) Before removing your gloves you should have another person pour a disinfectant such as 1:10 dilution of 5.25% sodium hypochlorite over your gloved hands. You should not handle the disinfectants yourself in order to avoid contaminating the container. Then the gloves should be carefully removed and the hands likewise disinfected. Great care should be taken in their removal as there is a chance of splashing.

9) The outside of all containers should be disinfected and checked for possible leaks before transporting.

10) All specimens should be clearly marked to warn of its possible infectious nature.

11) All persons should wash their hands and arms thoroughly with soap and water.

Dr. Case advises that when she works on a victim of AIDS, she does what is commonly known as double gloving. This is the wearing of two layers of rubber gloves for extra protection.

B) **ADDITIONAL LABORATORY STAFF MEMBERS PRECAUTIONS:**

The following precautions are suggested for persons who perform laboratory tests on specimens or other potentially infectious materials, from known or suspected AIDS cases:

1) Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.

2) Laboratory coats, gowns, or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory.

3) Gloves should be worn to avoid direct skin contact with blood, blood-soiled specimens, specimens containing blood, body fluids, secretions, and excretions, to include surfaces, materials, and objects that may have been exposed to them.

4) All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.

5) All Laboratory work surfaces should be disinfected, with a solution such as sodium hypochlorite solution, following any spill of possible infectious material and at the completion of the examination.

6) All materials believed to have been contaminated in the laboratory test should be decontaminated, preferably by

autoclaving, before being disposed of or prepared for reuse.

7) All syringes and needles should be handled with caution. After their use or examination (if evidence) they should be placed in a leak proof and puncture proof container maintained for the purpose of storage or disposal. The syringe, needle and container should be marked as to the possible infectious contamination.

8) All laboratory personnel who come in contact with the possible contaminated evidence or material should wash their hands with a sodium hypochlorite solution and then wash their hands upon completion of laboratory activities, removal of protective clothing, and before leaving the laboratory.

9) All lab staff that deal with contaminated evidence should take great care to not place pencils, fingers, or other objects into their mouth.

IMMUNIZATIONS

Finally, in the case of hepatitis B virus, all staff members both in the lab and field should be offered vaccinations to protect them from the virus.(4) In 1982, a hepatitis B virus vaccine was licensed and is currently available for both pre-exposure and post-exposure prevention. It is given in a three dose series, and is over 90 percent effective in preventing HBV infections. It has minimal side effects and is recommended for protection against hepatitis B in the pre-exposure stage. Laboratory and evidence technicians, specifically those that handle human blood frequently, are at high to moderate risk of contracting hepatitis B infections and should consider taking the vaccinations. If post-exposure prophylaxis is to be given, it must take place as soon after the exposure as possible and no later than seven (7) days.

A FINAL WORD

With this article I have tried to set forth minimum procedures to protect the law enforcement personnel from contracting an infectious disease. As in all cases you can never be too careful. The above procedures will not guarantee one hundred percent that you will not be infected, but they will increase your chances of avoiding an accidental infection.

FOOTNOTES

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Isolation of HIV from Body Fluids

Substantial Quantities in Fluid	Virus Isolation (positive/total samples)
Plasma	3/3
Serum	31/60
Low Quantities in Fluid	
Tears	2/5
Urine	1/5
Saliva	2/39
Vaginal/cervical	3/8
Virus in Infected Cells	
Saliva	3/20
Vaginal/cervical fluid	4/8

***** There are approximately two million affected cells in an ejaculation of semen.

VD CONTROL PROGRAM - COLORADO DEPARTMENT OF HEALTH

Precautions in Working with AIDS Patients *

1. Care should be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material.

2. Care must be taken to avoid contact of open skin lesions with potentially infectious material.

3. Gloves should be worn when handling blood specimens, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials and objects exposed to them.

4. Hand should be washed thoroughly and immediately if they become contaminated with blood.

5. Blood and other potentially infectious substances should be cleaned with a disinfectant such as 1:10 dilution of 5.25% sodium hypochlorite (household bleach) with water.

6. Blood spills should be cleaned up with a disinfectant solution, such as sodium hypochlorite (see above).

7. Articles soiled with blood should be placed in an impervious bag prominently labeled "Blood Precautions" before being sent for reprocessing (see 5 above) or disposal. Reusable items should be reprocessed in accord with policies for hepatitis B virus-contaminated items.

*Adapted from Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs. Centers for Disease Control MMWR Nov. 5, 1982/Vol 31/ No 43

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AIDS: STATUS IN COLORADO
July 31, 1987

Number of Confirmed Cases:		422	
Cases by Sex:	Male	408	(96.7%)
	Female	14	(3.3%)
Current Mortality:	Alive	163	(38.6%)
	Dead	259	(61.4%)
Age at Diagnosis:	0- 9	2	(.5%)
	10-19	4	(.9%)
	20-29	89	(21.1%)
	30-39	200	(47.4%)
	40-49	83	(19.7%)
	Over 49	44	(10.4%)
Transmission Categories:			
Homosexual Male		305	(72.3%)
IV Drug User		20	(4.7%)
Homosexual Male and IV Drug User		58	(13.7%)
Transfusion Recipient		8	(1.9%)
Hemophiliac		10	(2.4%)
Heterosexual Contact to High Risk Individual		6	(1.4%)
Undetermined Risk/No Identified Risk Factor		14	(3.3%)
Parent at Risk/has AIDS		1	(.2%)
Geographic Distribution:			
Denver Metropolitan Area		354	(83.9%)
Southeast Colorado		10	(2.4%)
South Central Colorado		27	(6.4%)
Northeastern Colorado		16	(3.8%)
Western Colorado		15	(3.6%)

Half Year of Diagnosis:	Number of Cases		Number Deceased	(%)
1982 January-June	1	(.2/mo)	1	100
July-December	6	(1.0/mo)	6	100
1983 January-June	11	(1.8/mo)	11	100
July-December	12	(2.0/mo)	12	100
1984 January-June	19	(3.2/mo)	19	100
July-December	24	(4.0/mo)	23	96
1985 January-June	39	(6.5/mo)	38	97
July-December	50	(8.3/mo)	39	78
1986 January-June	69	(11.5/mo)	45	65
July-December	87	(14.5/mo)	42	48
1987 January-June	93	(15.5/mo)	22	24
July	11	(11.0/mo)	1	9

SECTION EIGHT

ADDENDA

DENVER POLICE DEPARTMENT
INTER-DEPARTMENT
CORRESPONDENCE

TO: Captain A. Zavaras

FROM: Sgt. Wayne Dudley

DATE: February 24, 1987

SUBJECT: AIDS Carriers/Police Officer Contacts

Sir:

Several Officers have expressed their concern to me in the last week concerning procedures that might be adopted by The Operations Division relating to Officer involvment with AIDS Carriers.

Their concerns include Handling of subjects, Handling of evidence, Transporting of Subjects, Confinement of Subjects, Record Keeping of Known AIDS Carriers, etc.

Pursuant to our conversation, I contacted Peter L. Ralin. He is the Director of Health & Hospitals' AIDS Information Service. He informed me that his resources are limited and that time limitations would not allow him to attend several roll calls throughout the city and inform officers of the most recent information available, however, he would be available to impart information to 5 or 6 Officers from our Department so that they could initiate pertinent roll call training.

He recommended that all officers have access to rubber gloves in their vehicles, when they encounter subjects who are bleeding. Hepititus, AIDS and other bacteria and virus' are spread through blood transfer in some cases.

He also stated that a 10 to 1 mixture of bleach and water be available to wipe down holding cells, cars etc., where a subject has bled.

Another alternate training method would be for him to give a roll call in-service and have Video tape it for other Districts and bureaus.

Please let me know which direction we would like to pursue and we can contact him and use his resources.

Sincerely,

Wayne Dudley

DENVER POLICE DEPARTMENT

INTER-DEPARTMENT

CORRESPONDENCE

TO Chief Phannenstiel & All Division Chiefs **DATE** August 10, 1987

FROM Sgt. W. Dudley

SUBJECT Weekly Vehicle Maintenance

Sirs:

One proposed feature of The Infectious Disease Management Program advances the concept that the general health of officers could be positively affected if specific parts within the interior of patrol vehicles were cleaned on a weekly routine regimen. Those parts include:

1. Door handles
2. Steering wheel
3. Spotlight handles
4. Gear shift lever
5. Radio microphone
6. Emergency equipment controls

The product "Tor-Aero" was chosen to effect the aforementioned cleaning because of its effectiveness in destroying a wide range of micro organisms, including cold and flu viruses and AIDS organisms. Tor-Aero also has low condensation-fast drying properties.

During the infectious disease control seminar on July 16 & 17th., a patrol vehicle was parked at the front of Headquarters and "All Service Center Personnel were present." Technician Hines and myself demonstrated the process by which the disenfectant is sprayed onto the interior vehicle surfaces listed. It was also imparted that the product dries within 90 seconds and wipe down after spraying is not required. Disenfecting the interior of a police vehicle requires 30 to 60 seconds per vehicle.

Additionally, all service center personnel were shown the video, "Handwashing, a Lifesaving Response." Further, it was emphasized that the Center For Disease Control provided documentation that 80,000 people a year in The United States die from simply touching contaminated surfaces which are not frequently cleaned. Also, that an additional 20,000 deaths a year occur in hospitals from this same hand to mouth transmission.

Sgt. Rusty Damrell has contacted me and stated that Service Center Personnel "refused" to clean the interior of the police vehicles from District Two, because it had not been demonstrated to them. As previously stated, the disenfecting process was demonstrated to All Service Center Personnel.

Lt. Sewald informed me that the time required to perform the 30 to 60 second cleaning regimen is not feasible when multiplied by 700 city vehicles(total time necessary for one person to clean 700 city vehicles= 11.7 hours weekly). I can appreciate Lt. Sewald's staff limitations and time constraints. He suggested officers perform the cleaning regimen before their tour of duty. Problems are inherent in requiring officers

to perform vehicle maintenance because calls for service are usually backed up after roll call and providing "Tor-Aero" to each officer would be cost prohibitive. Also, disposal of contaminated cleaning items in the Districts could present a problem.

Since patrol vehicles are the most frequently used, perhaps the weekly regimen could be effected on patrol vehicles only? This would result in only a 3.3 hour workload increase using one service center employee.

Your consideration and resolution to this problem is appreciated.

Respectfully submitted,

Wayne Dudley

Wayne Dudley, Sergeant

Bobbet Hines

Bobbet Hines, Technician

"INFECTIOUS DISEASE MANAGEMENT"

Dates: July 16 and 17, 1987

Program: 9:00 A.M. to 4:00 P.M

Participants:	Technical Services personnel and invited public employees.
Focus:	1. Infectious Disease Information 2. Infectious Disease Management and Control 3. Denver Police Department Policies
Featured Speakers:	Mr. Norm Kramer, Representative Huntington Laboratories Mr. Jim Keeling, Housekeeping Denver General Hospitals Bobbet Hines, Technician Wayne Dudley, Sergeant Denver Police Department
Breaks:	15 minute intervals.
Smoking:	As a courtesy, please confine smoking to designated areas outside of the Auditorium.
Questions:	Your participation is encouraged. If you require information, clarification or want to make a remark during any part of the presentation, please raise your hand.
Evaluations and Comments:	Responses may be directed to: D/C Michael T. O'Neill Training Division

PROGRAM AGENDA

9:00 - 9:15	INTRODUCTION: D/C Michael T. O'Neill Technician Bobbet Hines Sergeant Wayne Dudley
9:15 - 9:45	"Handwashing, a Life Saving Procedure" Mr. Norm Kramer
9:45 - 10:00	Break
10:00 - 10:30	"Hospital Sepsis - Contaminated Environment" Mr. Norm Kramer
10:30 - 11:00	"The Progression of AIDS" Technician Bobbet Hines Sergeant Wayne Dudley
11:00 - 11:15	Break
11:15 - 12:00	"Infectious Disease Precautions and Procedures" Technician Bobbet Hines Sergeant Wayne Dudley
12:00 - 12:15	Break
12:15 - 1:00	"Vehicle and Holding Cell Disinfection Applications" Mr. Jim Keeling

DENVER POLICE DEPARTMENT

"INFECTIOUS DISEASE MANAGEMENT"

JULY 22 - 23, 1987

ACTIVITY SCHEDULE

	WEDNESDAY July 22	THURSDAY July 23
9:00 - 9:15	Introduction: D/C Michael T. O'Neill Sgt. Wayne Dudley Tech. Bobbet Hines	
9:15 - 9:45	"The Impact of Infectious Disease Management on	"Helping Others Set Their Mental Channels"
9:55 - 10:40 --- 10:50 - 11:35	"What You Must Know About A.I.D.S."	Presentation Development
11:45 - 12:45	Lunch	Lunch
12:55 - 1:45	"Creating a Safer Environment"	Presentation Development
2:00 - 2:45	"The Progression of A.I.D.S."	"Infectious Disease Management": Trainer Presentations
2:55 - 3:40	"A.I.D.S. - The Controversy"	
3:50 - 4:20	Group Discussion (Questions and Answers)	
4:30 - 5:00		Closing Comments

"INFECTIOUS DISEASE MANAGEMENT"

Dates: July 22 - 23, 1987

Program: 9:00 A.M. to 5:00 P.M.

Participants:	Denver Police Personnel and invited guests.
Focus:	1. Infectious Disease Information 2. Infectious Disease Management and Control 3. Denver Police Department Policies
Featured Speakers:	Wayne Dudley, Sergeant Bobbet Hines, Technician
Breaks:	10 minute intervals.
Smoking:	As a courtesy, please confine smoking to designated areas outside of the Auditorium.
Questions:	Your participation is encouraged. If you require information, clarification or want to make a remark during any part of the presentation, please raise your hand.
Evaluations, Comments or Requests:	Responses may be directed to: D/C Michael T. O'Neill Training Division

DENVER POLICE DEPARTMENT
INTER-DEPARTMENT
CORRESPONDENCE

TO Infectious Disease Control Trainers DATE 08-04-87

FROM Sgt. Wayne Dudley

SUBJECT Disposal of Protective Disposable Gloves by Line Personnel

Sir:

Red plastic "Bio-Hazard" bags for disposal of contaminated materials have been designated for disposal at the Service Center and the Property Section.

We regret that provisions were not made to accommodate officers in disposing of gloves which they use during routine duties. A procedure is being developed (pending approval) to properly dispose of these items.

During the interim, we request that standard plastic bags, available from the Custodial Staff, be carried in each vehicle, and gloves which have been used during routine duties be placed in them and then discarded at the Service Center or Property Section. Gloves which are contaminated with body fluids and/or blood, should be discarded in the red "Bio-Hazard" bags as previously defined in the proposed Departmental Directive.

Your patience and "selective" use of supplies is appreciated. Manufacturers are reporting a national shortage of stock due to institutional demands throughout the country. Therefore, replenishing supplies could become a problem, in the short term.

Thanking you in advance for your continued cooperation.

Respectfully,

Wayne Dudley

Sgt. Wayne Dudley, 78015

Bobbet Hines

Tech. Bobbet Hines, 79068

WD/BH:mll

DENVER POLICE DEPARTMENT

INTER-DEPARTMENT

CORRESPONDENCE

TO Command and Supervisory Officers DATE 9/11/87

FROM Training Division

SUBJECT Infectious Disease Seminar

Sirs:

Thank you for your participation in the Infectious Disease Management Seminar. Each of us will be making some sobering decisions as a result of the AIDS epidemic. The contributions made by supervisors and command officers will have a significant impact on us all.

Your cooperation in completing the enclosed instructor evaluation and forwarding it to the Training Academy would be sincerely appreciated. Please include any further issues which you may want to see addressed in the future.

Thank you.

Sincerely,

Wayne Dudley

Wayne Dudley, Sergeant
Training Division

DENVER POLICE DEPARTMENT
INTER-DEPARTMENT
CORRESPONDENCE

TO: All Division Chiefs

FROM: Division Chief Michael T. O'Neill, 67037

DATE: 9-15-87

SUBJECT: Updated List of Infectious Disease Trainers

Sgt. Mike Phelan	Property Section
Sgt. Vicky Connors	Sheriffs Dept.
Sgt. Pulford	District 1
Sgt. Krieger	District 1
Off. Fitzgibbons	District 1
Off. R. Lopez	District 1
Sgt. J. Lueck	District 2
Sgt. R. Damrell	District 2
Tech. B. Holland	District 2
Off. D. Ryan	District 3
Off. M. Kiddoo	District 3
Off. R. Colborn	District 3
Sgt. M. Mueller	District 4
Tech. M. Danos	District 4
Tech. K. Boyd	District 4
Off. G. Jones	District 4
Tech. R. Thomas	Tactical Motorcycle Section
Tech. R. Mosier	Metro/Swat
Sgt. E. Gruininger	Parks Police
Sgt. Bill Clayton	Operations Support Bureau
Off. N. Kelsey	Radio Room
Lt. Tom Wood	Identification Bureau
Det. A. Sandoval	Community Services
Det. J. Gray	Intelligence
Sgt. J. Lindsey	Mounted Patrol
Tech. S. Flint	Airport
Tech. W. Rowe	Airport
Sgt. D. Estrada	Burg/Theft
Sgt. M. Olin	Crime Lab
Det. C. Rogers	Crimes Against Persons
Sgt. Darrell Wisdom	Vise/Narcotics
Sgt. Al Mitterer	Research & Development
Sup. Darrell Demont	Parking & Management
Off. Dave Kelleigh	Greeley P.D.
Off. Keith Andersen	Greeley P.D.
Phyllis Perez	Parking & Management
Dyanna Dolbow	Parking & Management
Barbara Martinez	Parking & Management

DENVER POLICE DEPARTMENT
INTER-DEPARTMENT
CORRESPONDENCE

TO D/C Casey J. Simpson, Investigative Division DATE 08-06-87

FROM Sgt. Wayne Dudley

SUBJECT Infectious Disease Control Training

Sir:

The Infectious Disease Control Training was initially presented to line officers and maintenance staff personnel to "promptly" reduce the risk of potential infection to them, during their police activities and routine maintenance tasks.

Lieut. Robert Baltz and Lieut. Robert Colburn were the only two command officers who were able to attend these seminars. It is readily apparent that sooner or later, command officers will be required to make some tough decisions about AIDS and the impact it has on our Department. The dimensions are sobering. Worker's rights, capital expenditures, civil lawsuit considerations, line of duty status changes, I.I.I.B. complaints and a wide range of policies and legislative concerns are some of the practical issues that will inevitably arise.

Consequently, we respectfully propose that each supervisor and command officer attend one eight hour conference-seminar to discuss the aforementioned issues. The outcome is intended to facilitate the administrative process so that decisions can be made effectively and responsibly, before employee conflicts and grievances arise.

We propose groups of 20 to 30 supervisory and command officers a day to invite discussion and "innovative measures" to deal with these issues.

The Police Auditorium will be available on August 31, and September 3, 4, 8, 10, 11, 14, 15, 17, and 18, 1987. A suggested time frame is 9:00 a.m. to 5:00 p.m.

Attached is a list of those persons whose presence is requested.

Thank you for your consideration of the aforementioned. If your affirmation is forthcoming, we respectfully request a schedule indicating those persons intending to participate and the date they would be attending.

Respectfully Submitted,

Wayne Dudley

Sgt. Wayne Dudley

Bobbet Hines

Tech. Bobbet Hines

WD:mll

Enclosure

DPD 200 (Rev 3/81)

DENVER POLICE DEPARTMENT

INTER-DEPARTMENT

CORRESPONDENCE

TO Chief R. Phannenstiel & All Division Chiefs DATE August 10, 198

FROM Sgt. W. Dudley & Tech. B. Hines

SUBJECT Infectious Disease Control Conference

Sirs:

The Infectious Disease Control Conferences for Division Chiefs, Command and Supervisory Officers will be held on the following dates:

Monday	August 31, 1987
Friday	September 4, 1987
Tuesday	September 8. 1987
Thursday	September 10, 1987
Friday	September 11, 1987
Monday	September 14, 1987
Tuesday	September 15, 1987
Thursday	September 17, 1987
Friday	September 18, 1987
Monday	September 21, 1987

CONFERENCE HOURS: 9:00 A.M.to 5:00 P.

LOCATION: DENVER POLICE HEADQUARTERS AUDITORIUM

Conference groups will accommodate up to thirty-five persons per day and the following allotments have been formulated to assist you in scheduling participants from your Division:

Division:	# of Officers per Conference Day:
Deputy Chief of Police	Three
Operations Division	Fifteen
Investigation Division	Six
Staff Services Division	Two
Electronic & Telecommunications	Three
Training Division	One
Office of The Chief of Police	Determined by Chief Phannenstiel

*It will not be necessary to inform us of the names of those Officers who will be participating on each day.

DPD 200 (Rev 3/81)

DENVER POLICE DEPARTMENT

"INFECTIOUS DISEASE MANAGEMENT"

AUGUST 31, SEPT. 4, 8, 10, 11, 14, 15, 17, 18, 21

ACTIVITY SCHEDULE

9:00-9:15	INTRODUCTION: Chief Rudolph M. Phannenstiel D/C Michael T. O'Neill Sgt. Wayne Dudley Tech. Bobbet Hines
9:15-10:40	"Micro-Organisms/Handwashing: A Life Saving Response"
10:50-11:35	"What You Must Know About AIDS"
11:45-12:45	**lunch** **lunch**
12:55-1:45	"Infectious Disease Management & Control"
1:55-2:55	"NOVA - Can AIDS Be Stopped?" (VIDEO)
3:05-3:40	"AIDS/The Controversy" (VIDEO)
3:50-4:35	"AIDS/Management and The Issues"
4:45-5:00	Closing Comments

"INFECTIOUS DISEASE MANAGEMENT"

DATES: August 31, Sept. 4, 8, 10, 11, 14, 15, 17, 18, 21

PROGRAM: 9:00 A.M. to 5:00 P.M.

PARTICIPANTS:	Denver Police Personnel
FOCUS:	1. Infectious Disease Information 2. Infectious Disease Management and Control 3. Denver Police Department Policies and Issues
FEATURED SPEAKERS:	Wayne Dudley, Sergeant Bobbet Hines, Technician
BREAKS:	10 minute intervals
SMOKING:	As a courtesy, please confine smoking to designated areas outside the Auditorium.
QUESTIONS:	Your participation is encouraged. If you require information, clarification or want to make a remark during any part of the presentation, please raise your hand.
EVALUATIONS, COMMENTS OR REQUESTS:	Responses may be directed to: D/C Michael T. O'Neill Training Division

DENVER POLICE DEPARTMENT

"INFECTIOUS DISEASE MANAGEMENT"

ACTIVITY SCHEDULE

"INFECTIOUS DISEASE MANAGEMENT"

DATES:

PROGRAM:

PARTICIPANTS:	
FOCUS:	
FEATURED SPEAKERS:	
BREAKS:	10 minute intervals
SMOKING:	As a courtesy, please confine smoking to designated areas outside the Auditorium.
QUESTIONS:	Your participation is encouraged. If you require information, clarification or want to make a remark during any part of the presentation, please raise your hand.
EVALUATIONS, COMMENTS OR REQUESTS:	Responses may be directed to: D/C Michael T. O'Neill Training Division

MEETING NOTES

SUPERVISION AND CLINICAL REVIEW

PSYCHOLOGICAL SERVICES AND PEER SUPPORT PROGRAM

September 1, 1987

Members Present	Members Absent
Mike Fetrow	Art Conrad
G.E. Fitzgibbons	Jim Egan
Mike Karasek	Joe Ferraro
Ray Libonati	George Fortunato
Joe Martinelli	Bruce Tow
Anne Montoya	
Scott Murphy	
Bill Phillips	
Miriam Reed	
Gary Rini	
Jennifer Rowe	
Dan Wyckoff	

1. Our meeting had two special guests Sgt. Wayne Dudley and Division Chief Michael O'Neill.

2. Sgt. Dudley opened our meeting discussing the AIDS problem in the public sector moving into the police dept. Topics brought up were the legal aspects, administrative involvement, employee responsibilities, changes in previous beliefs about the virus, and future developments. Any peer support counselor advising and AIDS carrier should get in contact with Dr. Scarano to discuss the rules of confidentiality and the direction the police dept. and peer support should take.

3. Also discussed concerning AIDS was that the police dept. should get some legal advice on the policies Psy. Services would adopt.

4. The PSP brochure has been sent to the printer and will be finished in a couple of weeks.

5. Discussion was made that we should have a "Hotline Phone Number" so that all officers could get information on a critical incident emergency or an injured officer directly without having to go through Denver General or the radio room.

6. Mike Karasek pointed out how well the Mini-Academy went. A Mini-Academy II maybe implemented after the first of the year which would update information and provide new programs to spouses.

7. Several conventions are coming up this fall to benefit police departments and we will be sending people from peer support provided we can get the funding for expenses.

8. Denver General Hospital will no longer be notifying an officer's family during a critical incident. It will be the responsibility of the police dept. to contact the family immediately.

9. The subject of confidentiality on all matters was discussed at length to reaffirm our position.

10. During our next meeting, Dr. Scarano will be training in procedures for critical incident emergencies.

11. The Brotherhood has offered Peer Support $ 2,000.00 for our use. Joe Martinelli and the office will be making the arrangements for that donation.

12. Dr. Scarano requests that everyone be on time for the next meeting on October 6. We will be starting at 9:00 a.m.

DENVER POLICE DEPARTMENT
INTER-DEPARTMENT
CORRESPONDENCE

TO Captain T. Lahey **DATE** 9/30/87

FROM Wayne Dudley

SUBJECT Review of Infectious Disease Control Program

Sir:

With reference to the Infectious Disease Control Program, an account of past and in-progress efforts is offered for your perusal.

I. 1987: Abridged Summary of Primary Accomplishments:

A. Research and accumulation of data relative to clinical, operational and legal developments.

B. Formation of a Coordinating Group. (Focus: Problem Solving)

1. Collectively, formulated Departmental Directives.

C. Acquisition of necessary disinfectant supplies and protective equipment.

D. Development of Unit Plans and Commencement of AIDS Awareness Programs:

1. Command Officer and Supervisor Conference. (August 31 through September 21)

2. Inter-Departmental Trainers' Seminar. (July 23 & 24)

3. Service Center, Garage and Custodial Staff Training. (July 16 & 17)

E. Consummation of a 24 hr. a day clean-up task force beginning January, 1988, through Public Office Buildings.

II. 1987; In-Progress Activities:

A. Problems Created by The Solutions:

1. Training within respective sections of the D.P.D. has not been uniform.

Results: Misinterpretations of factual data.

Solution: Infectious Disease Control Coordinators will meet with the trainers and help them clarify misinformation, discuss issues and obtain feedback.

Pending administrative approval, the coordinators will attend roll calls and prepare an "Update Seminar" for the trainers.

2. Issues involving Supplies have persisted:

Acquisition of some supplies is a vendor problem which may be resolved as "nation-wide shortages" decrease.

Placement of supplies within police vehicles has been partially resolved.

Ordering & delivery of supplies and equipment to sections within the D.P.D. has not been orderly or systematically effective.

Results: Several supply requisitions which have been submitted to Stationary Supply have not been filled and/or provided to the requesting section of the D.P.D.

Solution: All supplies should be centrally located. Consequently, inventory and re-ordering by the stock keeper would be facilitated and adequate quantities of supplies maintained.

2. Supplies:

Solution: If quantitative restraints on the number of supplies which can be ordered is compulsory because of budgetary considerations, Staff Services should initiate an Inter-Departmental Correspondence reflecting that information.

Coordination with Lt. Baltz to equip the First Aid Room is progressing.

3. Position Papers regarding Personnel Management Issues are being prepared for administrative review and discussion. These "Position Papers" will evolve from input gathered after consultation with: Dr. Judson, Director of Health & Hospitals, Dr. Scurano, D.P.D. Psychologist, Ellen Reath, Attorney for Health & Hospitals, Patti Wells, Asst. City Attorney, Chuck Lepley, ASST. D.A. and other notable sources.

They will focus and underline alternatives for Administrative Personnel of the D.P.D. to consider and offer professional recommendations and procedural remedies for those problems which require a difficult balancing of competing rights and responsibilities.

A sampling of issues is as follows:

A. Protection of "Group" Employees vs. rights against intrusion.

B. The H.I.V. Positive employee and work assignments.

C. Managing confidential situations.

D. Protecting "invitees" from "foreseeable" danger. (Rider Program)

E. Increased calls for service & deployment of manpower. e.g.: Dementia/Barricaded Suspects.

3. Position Papers/Personnel Management Issues

   F. Police involved shootings and body fluid clean-up of a public access area.

   G. Employee Refusals

   H. Adminstrators, Discrimination and Libel Suits.

4. Numerous Training Requests from outside agencies have been received. Funds to offset some of the expenditures for our Infectious Disease Control Program can be generated by "AIDS Awareness Presentations" to other interested groups.

   The information pool we have gathered will allow us to prepare one, two or three day seminars. Approximately $1,000 for each seminar day could be generated.

5. We urge consideration of video productions tailored for 15 minute roll call viewing. Approximately twenty presentations would be required to have a comprehensive compendium available.

6. Other addenda which might be included in our activities are: written informational reports for the Daily Bulletin and P.P.A. Newsletter, research on the availability of Federal or State Grants, Specific Arrest & Control Technique Training and Barricade/Hostage Responses, etc.

Your continued monitoring and administrative support of the aforementioned continues to create a safer working environment and reduce public safety officer concerns over health and civil liability issues.

Thank you for the furtherance of these objectives.

Sincerely,

Wayne Dudley

Wayne Dudley, Sergeant
Training Division

Bobbet Hines

Bobbet Hines, Technician
Training Division

cc: D/C Training C.J. Kennedy
Lt. Tina Rowe