POLICY AND PROCEDURE NO. 740

Protective Custody – Incapacitated Persons

Date Issued: January 3, 2008
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1. PURPOSE:

The purpose of this policy is to establish procedures for the protective custody of persons incapacitated by the consumption of alcohol, as authorized by M.G.L. c. 111B, §8, and of persons incapacitated by the consumption of drugs or other substances, as authorized by M.G.L. c. 111E, §9A. This policy governs the identification, custody, transportation, intake processing, medical screening, monitoring, release, and documentation of persons taken into protective custody. Protective custody is a public health intervention, not a criminal process. A person taken into protective custody shall not be considered to have been arrested or charged with a crime.

2. POLICY:

It is the policy of the Worcester Police Department to treat incapacitation resulting from alcohol, drugs, or other substances as a public health matter. Officers shall exercise protective custody authority in a manner that prioritizes the safety and well-being of the incapacitated person while protecting officers, other detainees, and the public. Officers shall apply the statutory authority that corresponds to the cause of the person's incapacitation, recognizing that the two statutes authorize different custody destinations and durations. Officers shall ensure that persons taken into protective custody receive appropriate medical screening or evaluation, are monitored continuously while in Department custody, and are connected with treatment resources when available. All protective custody actions shall be documented in accordance with this policy.

3. SCOPE:

This policy applies to all sworn personnel of the Worcester Police Department. This policy governs the conduct and responsibilities of Department personnel when taking persons into protective custody under M.G.L. c. 111B, §8 (incapacitation by alcohol) and under M.G.L. c. 111E, §9A (incapacitation by drugs or other substances). Nothing in this policy affects laws, ordinances, or regulations governing operating under the influence of alcohol or drugs, driving after drinking, or other offenses involving the operation of motor vehicles, machinery, or hazardous equipment.

4. DEFINITIONS:

A. Alcoholism

A medically diagnosable disease characterized by chronic, habitual, or periodic consumption of alcoholic beverages resulting in: (1) substantial interference with an individual's social or

economic functions in the community; or (2) the loss of powers of self-control with respect to the use of such beverages. (M.G.L. c. 111B, §3)

B. Facility

Any public or private place, or portion thereof, providing services especially designed for the detoxification of intoxicated persons or alcoholics. (M.G.L. c. 111B, §3)

C. Incapacitated by Alcohol

The condition of an intoxicated person who, by reason of the consumption of intoxicating liquor, is: (1) unconscious; (2) in need of medical attention; (3) likely to suffer or cause physical harm or damage property; or (4) disorderly. (M.G.L. c. 111B, §3)

D. Incapacitated by Drugs or Other Substances

The condition of a person who, by reason of the consumption of a controlled substance or toxic vapor or other substance other than alcohol, is: (1) unconscious; (2) in need of medical attention; (3) likely to suffer or cause physical harm or damage property; or (4) disorderly. (M.G.L. c. 111E, §9A). Consistent with guidance issued by the Executive Office of Public Safety and Security and the Municipal Police Training Committee, a person who has been administered naloxone in connection with a drug overdose remains incapacitated as a person in need of medical attention.

E. Acute Care Hospital and Satellite Emergency Facility

A hospital licensed under M.G.L. c. 111, §51, or a satellite emergency facility as defined in M.G.L. c. 111, §51½, authorized to receive persons transported for emergency medical treatment.

F. Semi-Conscious

A person who is conscious but is not alert or aware of their surroundings and may lapse into a state of unconsciousness. For purposes of this policy, a semi-conscious person is a person in need of medical attention.

G. Protective Custody

The non-criminal custody of an incapacitated person under the authority of M.G.L. c. 111B, §8, or M.G.L. c. 111E, §9A, for the purpose of ensuring the person's safety and obtaining appropriate care or treatment. Protective custody is not an arrest.

5. GENERAL PROVISIONS APPLICABLE TO ALL PROTECTIVE CUSTODY:

A. No Arrest for Intoxication Alone

In the absence of an accompanying criminal offense, officers shall not arrest a person solely for being intoxicated or under the influence of drugs. Public intoxication is not a crime in the Commonwealth of Massachusetts. When an officer encounters a person who appears to be incapacitated, the officer shall determine whether the incapacitation results from alcohol, from drugs or other substances, or from both, and shall proceed under the corresponding section of this policy.

B. Recognition of Medical Conditions

Officers shall remain alert to the possibility that symptoms of apparent intoxication or impairment may be caused by or complicated by other medical conditions, including but not limited to: epileptic seizure, insulin shock, diabetic coma, stroke, heart attack, traumatic brain injury, or drug overdose. If an officer believes a medical condition other than or in addition to intoxication may be present, the officer shall immediately arrange for medical evaluation by summoning an ambulance.

C. Body-Worn Cameras

Officers shall activate their body-worn camera in accordance with Policy 403 (Body Worn Cameras) for all protective custody encounters.

D. Safety Searches

Under both statutes, an officer is authorized to conduct a search of an incapacitated person and the person's immediate surroundings when the officer reasonably believes that the safety of the person, the officer, or other persons present requires the search. Such searches shall be limited to the extent necessary to discover items or weapons that may pose a danger. Items taken shall be inventoried; items that are not contraband or otherwise unlawfully possessed shall be returned to the person when the person is no longer incapacitated.

E. Use of Force

An officer may use such force as is reasonable and necessary to carry out protective custody procedures under either statute. Because protective custody is a non-criminal public health intervention, officers should use the minimum force necessary and should attempt verbal de-escalation before resorting to physical control measures. All uses of force during protective custody encounters shall be documented and reviewed in accordance with Policy 400 (Use of Force).

F. Non-Criminal Status

A person placed in protective custody under either statute shall not be considered to have been arrested or charged with any crime, and no record of protective custody shall be treated as an arrest or criminal record for any purpose.

6. PROTECTIVE CUSTODY – INCAPACITATION BY ALCOHOL (M.G.L. c. 111B, §8):

A. Authority and Destinations

When a person is incapacitated by the consumption of alcohol and the situation does not warrant a criminal arrest, an officer has the authority to assist the incapacitated person, with or without consent, to: (1) the person's residence; (2) a treatment facility; or (3) the police station. While consent is not required, officers should obtain consent when practical.

B. Assessment of Alcohol Incapacitation

Only persons incapacitated by the consumption of alcohol may be taken into protective custody under c. 111B. In making this assessment, officers should observe and document all indications that the incapacitation is due to alcohol consumption, including but not limited to: the odor of alcoholic beverages on the person's breath; the presence of open alcoholic beverage containers

on the person or in the immediate area; any admission by the person that they have been drinking; statements by companions or witnesses regarding the person's alcohol consumption; and any other observable indicators of alcohol use.

Officers may request that the person submit to reasonable field assessments of coordination, coherency of speech, and balance. Officers should utilize the NHTSA Standardized Field Sobriety Test (SFST) components—Horizontal Gaze Nystagmus (HGN), Walk-and-Turn, and One-Leg Stand—as validated assessment tools. Officers may supplement SFSTs with additional observations of the person's overall condition, behavior, and ability to care for themselves.

C. Taking Custody

When an officer determines that a person is incapacitated by alcohol and protective custody is appropriate, the officer shall transport the person to their residence, a treatment facility, or the police station. Officers should consider the following factors when determining the appropriate destination: the person's level of incapacitation; the availability of a responsible party at the person's residence; the availability of treatment facility services; and the need for medical evaluation.

D. Transportation

An unconscious or semi-conscious person shall never be transported in a patrol wagon or cruiser. An ambulance shall be summoned for any person who is unconscious, semi-conscious, or displaying signs of a medical emergency. Officers shall ensure that any injuries observed on the incapacitated person are treated prior to transport to the station or treatment facility. Officers shall extend the same considerations to an incapacitated person that they would offer to a person suffering from any other illness.

E. Intake Processing and Medical Screening

Any incapacitated person brought to the police station shall be processed through a receiving screening prior to being placed in a cell. The receiving screening shall be documented on the Department's intake form and shall include, at a minimum, the following information: (1) the person's identifying information and the circumstances of custody; (2) an inventory of the person's property, conducted in accordance with Policy 700 (Holding Facility and Detainee Processing); (3) the disposition of the person's property; (4) documentation of any medications currently taken by the person; (5) an evaluation of the person's behavior, including state of consciousness and mental status; (6) documentation of any trauma markings, bruises, lesions, jaundice, ease of movement, or other signs of injury or illness observed at the time of intake; and (7) documentation that the person was asked whether they require medical assistance.

The receiving screening should consider any gender-specific needs of the person in custody, including the needs of women and individuals whose gender identity or expression may require specific consideration during processing or detention.

F. Breathalyzer Testing and Notice of Rights

Any incapacitated person brought to the police station shall have the right, after arriving at the station, to request and be administered a breathalyzer test. The person shall be informed of this right in writing using the Department's Protective Custody Notice of Rights form.

Breathalyzer test results shall be utilized as follows for purposes of the protective custody presumptions established in M.G.L. c. 111B, §8: (1) If the blood alcohol content (BAC) reading is .10 or greater, the person shall be presumed to be intoxicated and shall be placed in protective custody at the police station or transferred to a treatment facility. (2) If the BAC reading is .05 or less, the person shall be presumed not to be intoxicated and shall be released from custody forthwith. (3) If the BAC reading is greater than .05 and less than .10, no presumption based solely on the breathalyzer test shall be made. In this case, the officer shall consider the totality of the person's condition, including SFST results, observable behavior, coordination, coherency of speech, and ability to care for themselves, to determine whether the person is incapacitated.

Note: The BAC thresholds referenced above (.10 and .05) are the statutory presumption levels established in M.G.L. c. 111B for protective custody purposes. These thresholds are distinct from the .08 per se limit applicable to operating under the influence offenses under M.G.L. c. 90, §24.

Any person presumed intoxicated and to be held in protective custody at the police station shall, immediately after the presumption is established, be informed of the right to make one telephone call at their own expense and on their own behalf. The person shall also be provided the Protective Custody Notice of Rights form. Any person presumed intoxicated who is assisted to a treatment facility shall have the right to make one telephone call at their own expense and on their own behalf, and shall be informed of this right upon arrival at the facility.

G. Notification and Transfer to Treatment Facility

If an incapacitated person is brought to the police station, the Officer-in-Charge or designee shall notify the nearest treatment facility forthwith that the person is being held in protective custody. If suitable treatment services are available at the facility, the person shall be transported to the facility. Officers should, when practical, provide the person or their family members with information about substance use disorder treatment and recovery resources available in the community.

H. Safeguarding at Station

An incapacitated person held in protective custody at the police station shall have the following property taken for safekeeping in accordance with Policy 700 (Holding Facility and Detainee Processing): belts, shoelaces, neckties, neck chains, drawstrings, matches, and cigarette lighters; all other articles that may pose a danger to the person or to others; and personal property and other valuables. All property shall be inventoried and stored in a secure location.

An unconscious or semi-conscious person shall never be placed in a cell. In such cases, immediate medical care shall be provided by requesting an ambulance for emergency medical treatment and transportation. If a person in protective custody displays objective signs of intoxication to a level of semi-consciousness, that person shall be transported to the hospital by ambulance for treatment.

I. Monitoring and Observation

The Officer-in-Charge or designee shall take every precaution to ensure that all persons held in protective custody are prevented from harming themselves. Persons in protective custody shall be observed at intervals of not more than fifteen (15) minutes. All observations shall be

documented in accordance with departmental procedures, including use of the Department's electronic observation-logging system.

Where the Department utilizes audio/video monitoring (CCTV) capability for detainees, a visual check of the monitoring equipment shall be conducted at least every thirty (30) minutes by agency personnel, with a face-to-face observation conducted at least hourly. Where audio/video monitoring is not available, face-to-face observations shall be conducted at least every thirty (30) minutes. The fifteen-minute observation interval required by this policy exceeds these minimums and remains in effect for all protective custody detainees.

When an officer of the opposite gender is required to supervise a person in protective custody, the officer shall follow the procedures established in Policy 700 (Holding Facility and Detainee Processing) for supervising detainees of the opposite gender. Particular attention shall be paid to situations involving individuals whose gender identity or expression may require specific consideration.

J. Segregation of Protective Custody Detainees

The Officer-in-Charge shall ensure that persons held in protective custody are appropriately segregated from the general detainee population when necessary to protect the safety of the person, other detainees, or staff. Segregation decisions shall consider the person's level of intoxication, behavior, and any indicators of violence, self-destructive behavior, suicidal ideation, or mental health crisis.

Persons in protective custody who are under the influence of alcohol, violent, self-destructive, suicidal, or exhibiting signs of mental health issues shall be handled and detained or segregated in accordance with the following: (1) persons who are violent or combative shall be isolated from other detainees and monitored continuously until the behavior subsides; (2) persons displaying self-destructive or suicidal behavior shall be placed under constant observation and evaluated for immediate medical or mental health intervention; (3) persons exhibiting signs of mental health crisis shall be evaluated for transport to an appropriate medical or mental health facility. General segregation requirements for detainees are set out in Policy 700 (Holding Facility and Detainee Processing). See also Section 8 of this policy.

K. Release Procedures

A person in protective custody shall not be held against their will unless suitable treatment at a facility is not available. When treatment is not available, the person may be held for the shorter of: (1) up to twelve (12) hours; or (2) until the person is no longer incapacitated.

Prior to release, the Officer-in-Charge or designee shall confirm the identity of the person being released. When the releasing officer does not personally know the person, positive identification shall be confirmed through photo identification, prior booking photograph comparison, or other reliable method.

Persons to be released from protective custody into their own care shall have a breathalyzer test administered to determine that their BAC is below .08. Persons whose BAC remains at or above .08, or who decline to take a breathalyzer test, shall not be released to their own custody. Such persons may be released to a responsible party who agrees to assume responsibility for the person's safety, or may continue to be held until they are no longer incapacitated or until the twelve-hour maximum is reached.

Individuals who are released on bail following an arrest for operating under the influence of alcohol may be placed in protective custody if they remain incapacitated as defined in this policy. The release procedures in this section shall apply. The Officer-in-Charge shall authorize all releases from protective custody and shall document the basis for the release decision.

7. PROTECTIVE CUSTODY – INCAPACITATION BY DRUGS OR OTHER SUBSTANCES (M.G.L. c. 111E, §9A):

A. Authority and Destinations

When an officer has probable cause to believe that a person is incapacitated by the consumption of a controlled substance, toxic vapor, or other substance other than alcohol, the officer may place the person into protective custody without the person's consent for the sole purpose of immediately transporting the person to an acute care hospital or satellite emergency facility, or otherwise immediately obtaining appropriate emergency medical treatment. Custody under this section shall not be used to bring a person to the police station or holding facility, to the person's residence, or to any destination other than emergency medical treatment.

B. Standard and Assessment

Protective custody under c. 111E, §9A is a seizure and requires probable cause, based on the totality of the circumstances, to believe that the person is incapacitated. Commonwealth v. Verrier, Mass. App. Ct. No. 24-P-446 (September 8, 2025). To determine whether a person is incapacitated, an officer may request the person to submit to reasonable tests of coordination, coherency of speech, and breath, and may rely on other information or observations, including but not limited to: the person's level of consciousness and responsiveness; depressed or labored breathing; pinpoint pupils; the presence of drugs or drug paraphernalia; admissions by the person regarding drug use; statements of witnesses or companions; and the administration of naloxone to the person in connection with an apparent overdose. Officers shall document the objective facts supporting the determination of incapacitation.

C. Duration and Limits of Custody

A person shall not be held in protective custody under this section against the person's will beyond the time required to complete the person's immediate transport to an acute care hospital or satellite emergency facility, or to otherwise immediately obtain appropriate emergency medical treatment. Custody under this section ends when the person is transferred to the care of emergency medical services personnel or receiving medical staff.

Evaluation of the person by emergency medical services personnel on scene constitutes obtaining appropriate emergency medical treatment within the meaning of the statute. Once the person has been evaluated by emergency medical services personnel or other qualified medical personnel, the purpose of custody under this section is complete and continued custody under this section is not authorized; determinations regarding the person's medical condition and capacity to refuse further treatment rest with the evaluating medical personnel, not with officers. Where emergency medical services personnel, after evaluating the person, accept the person's refusal of further treatment or transport under their own protocols, officers shall document the evaluation and the refusal in the incident report. Nothing in this section limits custody or action under an independent lawful authority where its own criteria are met,

including protective custody for alcohol incapacitation under M.G.L. c. 111B, §8 (Section 6 of this policy), or emergency evaluation under M.G.L. c. 123, §12, in accordance with Policy 830 (Emergency Mental Health Procedures) and Section 7.E.

D. Application Following Naloxone Administration

A person who has suffered an apparent opioid overdose and has been administered naloxone remains incapacitated as a person in need of medical attention, consistent with the guidance of the Executive Office of Public Safety and Security and the Municipal Police Training Committee. The duration of action of naloxone is typically shorter than that of many opioids, and a person revived by naloxone may re-enter respiratory depression as the naloxone wears off. Officers are not trained or licensed to determine that a person who has suffered an apparent overdose no longer requires emergency medical evaluation; that determination should be made by qualified medical personnel.

Accordingly, when a person who has been administered naloxone, or who has suffered an apparent overdose, refuses medical evaluation or attempts to leave the scene before being evaluated, officers should place the person into protective custody under this section for the purpose of obtaining immediate medical evaluation. Custody under this section does not require the person's consent, and the person's refusal to be evaluated, refusal to identify themselves, or attempt to leave does not end the officer's authority; a refusal of evaluation is not itself an evaluation, and custody continues until an endpoint in subsection C is reached. Officers may use the reasonable force authorized in Section 5.E to maintain custody and to prevent the person from leaving before evaluation. The determination whether a person has the capacity to refuse medical care rests with emergency medical services personnel and their medical control, not with officers; the determination whether probable cause of incapacitation exists for custody under this section rests with the officer. Where emergency medical services personnel determine that the person lacks the capacity to refuse and will be transported, officers shall assist in placing the person in the care of emergency medical services personnel for transport, using reasonable force as necessary, and an officer should accompany the transport when needed for the safety of the person or medical personnel.

Once the person has actually been evaluated by emergency medical services or other qualified medical personnel, the purpose of this custody is complete and custody ends, including where those personnel evaluate the person and then accept the person's refusal of further treatment or transport under their own protocols. The capacity to refuse further care rests with the evaluating medical personnel, not with officers. After that evaluation, this section imposes no duty on officers to hold the person and gives officers no authority under this section to compel transport of a person the medical personnel have already evaluated and who declines further care. Officers shall document the evaluation and any refusal in the incident report.

Naloxone administration procedures, post-administration monitoring, and enforcement considerations at overdose scenes, including the protections of the Good Samaritan Law, are governed by Policy 831 (Naloxone Administration and Protocols).

E. Apparent Intentional Overdose

If the circumstances indicate that an overdose may have been intentional, or the person expresses suicidal ideation, officers shall proceed in accordance with Policy 830 (Emergency

Mental Health Procedures), including the emergency evaluation provisions of M.G.L. c. 123, §12, in addition to obtaining emergency medical treatment.

8. CO-OCCURRING AND COMBINED-SUBSTANCE EMERGENCIES:

If a person appears to be incapacitated by both alcohol and drugs or other substances, the officer may proceed under either statutory authority as the facts support. Officers should prioritize immediate medical evaluation, and the medical-transport provisions of Section 7 are the preferred course whenever drug involvement is suspected. Officers should be aware that opioid overdose can present with symptoms similar to severe alcohol intoxication. Officers shall follow Policy 831 (Naloxone Administration and Protocols) when an opioid emergency is suspected, regardless of whether alcohol is also involved.

If at any point during the protective custody process a person expresses suicidal thoughts, engages in self-harming behavior, or displays signs of a psychiatric emergency, the officer shall: (1) ensure the person's immediate physical safety; (2) summon medical assistance; (3) notify the Officer-in-Charge; and (4) arrange for evaluation at an appropriate medical or mental health facility in accordance with Policy 830 (Emergency Mental Health Procedures).

9. JUVENILE PROTECTIVE CUSTODY:

Juvenile protective custody procedures are governed by Policy 710 (Juvenile Procedures and Arrests). The following statutory provisions apply specifically to juvenile protective custody and are restated here for operational reference:

Under M.G.L. c. 111B (Alcohol Treatment and Rehabilitation Law): A juvenile may be held in protective custody for up to twelve (12) hours or until no longer incapacitated, whichever is shorter.

Under M.G.L. c. 111E, §9A (drugs or other substances): A juvenile of any age placed in protective custody shall be immediately transported for emergency medical treatment as provided in Section 7 of this policy, and the officer shall notify the juvenile's parent or guardian forthwith.

Under M.G.L. c. 94C, §36 (Controlled Substances Act): A juvenile under the age of seventeen (17) who is found knowingly in the presence of controlled substances listed in M.G.L. c. 94C, Classes A, B, or C, may be held in protective custody for no longer than four (4) hours.

The parent or guardian of any person under the age of eighteen (18) held in protective custody shall be notified forthwith upon arrival at the station or as soon as possible thereafter. Upon request of the parent or guardian, a juvenile held at the police station shall be released to their custody. All rights granted to adults under c. 111B apply equally to juveniles. Any provision requiring the consent of the person requires the consent of both the juvenile and the parent or legal guardian. For all other juvenile protective custody procedures, including cell placement restrictions and documentation requirements, officers shall refer to Policy 710 (Juvenile Procedures and Arrests).

10. NOTICE OF RIGHTS:

The Department shall maintain a Protective Custody Notice of Rights form, which shall be provided to all persons taken into protective custody at the police station under M.G.L. c. 111B.

The form shall inform the person of their right to request and be administered a breathalyzer test and, if held in protective custody, their right to make one telephone call at their own expense and on their own behalf. The form shall be available in English and in other languages prevalent in the Department's service area.

11. REPORTS AND DOCUMENTATION:

A Protective Custody Report shall be completed for every person taken into protective custody under either statute. The report shall include: (1) the date, time, and location where custody was initiated; (2) the name of the assisting officer(s) and the Officer-in-Charge; (3) the statutory authority under which custody was taken (M.G.L. c. 111B, §8 or M.G.L. c. 111E, §9A); (4) the basis for the determination of incapacitation, including the objective facts and observable indicators supporting it; (5) whether the person exercised the right to make a telephone call; (6) whether the person exercised the right to a breathalyzer test and, if taken, the results; (7) any injuries observed on the person, including their apparent cause and any medical treatment provided; (8) the disposition of the person (released, transferred to facility, transported for medical treatment, etc.) and the time of release or transfer; and (9) for custody under c. 111E, §9A: any naloxone administered, the destination or emergency medical treatment obtained, the receiving medical service or personnel, the time custody ended, and any refusal of medical evaluation or transport together with any evaluation performed by emergency medical services personnel.

The protective custody report shall not be treated as an arrest or criminal record for any purpose. A departmental record of the custody shall be maintained indicating the circumstances of detention.

Officers should be aware that M.G.L. c. 123, §35 authorizes police officers and certain other persons to petition an appropriate district or juvenile court for the commitment of a person with an alcohol or substance use disorder, where there is a likelihood of serious harm as a result of that disorder, for a period not to exceed ninety (90) days to a facility designated by the Department of Public Health. Where appropriate, officers should advise the family and friends of the person of the procedures available under this law.

Note: Police officers acting in a reasonable manner and pursuant to the provisions of M.G.L. c. 111B are protected from criminal and civil liability under c. 111B, §13. Police officers acting pursuant to M.G.L. c. 123 are immune from civil suits for damages for restraining, transporting, applying for admission of, or admitting any person to a facility under c. 123, §22.

12. TRAINING:

Training for personnel assigned to holding facility duties, including intake screening, detainee monitoring, and suicide prevention, and the periodic review of detainee medical screening directives by a licensed healthcare provider, are governed by Policy 700 (Holding Facility and Detainee Processing). Officers shall be notified of this policy and will receive training on this policy periodically as directed by the Training Division.

Per:

Paul B. Saucier
Chief of Police

Revisions:

August 14, 2026–

Complete rewrite and retitle from Protective Custody – Intoxicated Persons to Protective Custody – Incapacitated Persons to conform to MPAC accreditation standards, current statutes, and current best practices. Policy 740.1 (Guidelines for Detox vs. Emergency Room Disposition, November 19, 2009) is retired upon adoption of this policy; its emergency-room disposition rules are subsumed by the medical-transport and safeguarding provisions of Sections 6.D and 6.H. Added protective custody authority for persons incapacitated by drugs or other substances under M.G.L. c. 111E, §9A (enacted 2016), which was absent from the prior policy: the new provisions restrict custody under §9A to immediate transport for emergency medical treatment with no station holding; state the probable cause standard recognized in Commonwealth v. Verrier, Mass. App. Ct. No. 24-P-446 (2025); define the end of custody at transfer to, or evaluation by, emergency medical services or other qualified medical personnel, allocate capacity determinations to the evaluating medical personnel, and preserve action under independent lawful authority (c. 111B, §8; c. 123, §12) where its own criteria are met; incorporate Executive Office of Public Safety and Security and Municipal Police Training Committee guidance that a person administered naloxone in connection with an overdose remains incapacitated as a person in need of medical attention; and direct that persons who refuse medical evaluation after naloxone administration or an apparent overdose should be placed into protective custody pending evaluation, with a cross-reference to Policy 830 for apparent intentional overdoses. Added consolidated general provisions for medical-condition recognition, body-worn camera activation, safety searches with inventory and return of property, use of force, and non-criminal status, applicable to both statutory tracks. The holding-facility standards governing segregation (72.5.4), intake screening (72.5.2), medical assistance and licensed healthcare provider review (72.6.1), 24-hour monitoring (72.8.1), released-detainee identification (72.5.7), opposite-gender supervision (72.8.3), and user-personnel training (72.1.1) are carried by Policy 700 (Holding Facility and Detainee Processing); this policy applies the requirements operative for protective-custody detainees and cross-references Policy 700 for holding-facility training and healthcare-provider directive review rather than restating them. Added formal intake processing and medical screening, including documentation of medications, behavior evaluation, trauma markings, and proof of medical-assistance inquiry. Added segregation procedures for detainees who are violent, self-destructive, suicidal, or exhibiting signs of mental health crisis. Added positive identification of detainees before release. Retained the 15-minute observation interval, which exceeds the holding-facility monitoring minimum. Modernized field sobriety assessment methodology to reference the NHTSA Standardized Field Sobriety Tests and removed non-standardized tests (coins, alphabet, finger-to-nose). Clarified that the M.G.L. c. 111B BAC presumption thresholds (.10/.05) are distinct from the .08 OUI per se limit. Tightened release criteria to require a BAC below .08 before release to own custody. Corrected statutory definition citations to M.G.L. c. 111B, §3 and conformed the definitions of incapacitation to statutory text, retaining semi-conscious as an operational category within need of medical attention. Corrected the civil commitment period under M.G.L. c. 123, §35 from fifteen (15) days to the current statutory maximum of ninety (90) days and updated its terminology to alcohol or substance use disorder. Added statutory immunity references under c. 111B, §13 and c. 123, §22. Consolidated juvenile protective custody provisions to cross-reference Policy 710

(Juvenile Procedures and Arrests), retaining statutory time limits for operational reference and adding the §9A requirements of immediate medical transport and forthwith parental notification. Expanded protective custody reporting to capture the statutory basis of custody, the objective facts establishing incapacitation, naloxone administration, the medical handoff, and any refusals or evaluations by emergency medical services personnel. Added substance use disorder resource connection guidance and gender-specific intake screening considerations. Added a body-worn camera activation cross-reference to Policy 403 (Body Worn Cameras) and a use-of-force cross-reference to Policy 400 (Use of Force). Corrected the titles of cross-referenced policies throughout. Removed embedded Notice of Rights text and replaced it with a reference to the maintained form, applicable to c. 111B station custody. Replaced the standalone cross-reference section with inline cross-references. Reformatted to the ADA-compliant policy template. Updated signing authority from Chief Gemme to Chief Saucier.

Original Issue Date: January 3, 2008